

# ACQUIRE Evaluation and Research Studies

## Bangladesh Endline Evaluation—2008

E & R Study #14 ♦ December 2008



**USAID**  
FROM THE AMERICAN PEOPLE

the **ACQUIRE** project

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## Acronyms/Abbreviations

AIDS	acquired immunodeficiency syndrome
BCC	behavior change communications
CPI	client-provider interaction
DGFP	Directorate General of Family Planning
DHS	Demographic and Health Survey
FP	family planning
FPI	family planning inspector
FWA	family welfare assistant
FWC	Family Welfare Center
FWV	family welfare visitor
HIV	human immunodeficiency virus
HMIS	health management information system
IEC	information, education, and communications
IR	intermediate result
IUCD	intrauterine contraceptive device
LAPMs	long-acting and permanent methods [of family planning]
MCWC	Mother and Child Welfare Center
MO	medical officer
MOHFW	Ministry of Health and Family Welfare
NSV	no-scalpel vasectomy
RH	reproductive health
SACMO	sub-assistant community medical officer
SO	strategic objective
STI	sexually transmitted infection
TFR	total fertility rate
TOT	training of trainers
UHC	<i>upazila</i> (sub-district) health complex
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization



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# Executive Summary

This report is an evaluation of the activities undertaken in Bangladesh between 2004 and 2007 by The ACQUIRE Project, a five-year global project funded by the U.S Agency for International Development (USAID), in support of reproductive health and development, particularly efforts to improve the delivery and expand the use of long acting and permanent methods of family planning (LAPMs). The project's global results framework was adapted to country realities. In Bangladesh, the result framework's strategic objective (SO) was as follows: "Voluntary family planning and maternal health services supported and advanced with a focus on facility-based services." Three intermediate results (IRs) contributed to this SO:

- ◆ Intermediate Result 1: Increased access to quality services
- ◆ Intermediate Result 2: Improved performance of service delivery providers
- ◆ Intermediate Result 3: Strengthened environment for family planning and maternal health service delivery

In 1971, when Bangladesh gained independence, its population was approximately 70 million. Today, it stands at 147 million (PRB, 2008), making it the world's eighth largest country. Population size, per se, is not the country's biggest demographic challenge. Rather, it's extremely high population density compounds other development challenges. With more than 1,000 people per square kilometer, Bangladesh is nearly the most densely populated country in the world.

Bangladesh is in the midst of a demographic transition. The rate of population growth has declined from 2.5% per annum (1971) to 1.5% per annum in 2007. At the same time, Bangladesh's total fertility rate (TFR) has declined from 6.3 lifetime births per woman in 1975 to 2.7 in 2007. Although fertility appeared to plateau in the 1990s, at about 3.3 births per woman, the most recent Demographic and Health Survey (DHS) data (from 2007) show that fertility has resumed its downward trend (NIPORT, Mitra and Associates, & ORC Macro, 2008). Nonetheless, two and one-half million people are added to the population each year because of the built-in momentum of population growth that results from past high fertility (MOHFW, 2008).

One of the main reasons that fertility declined is increased use of family planning (FP). The contraceptive prevalence rate increased from 8% in the mid-1970s to 56% in 2007 (WHO SEARO, 2004; NIPORT, Mitra and Associates, & ORC Macro, 2008). Eighty-six percent of couples who use any method rely on modern methods (NIPORT, Mitra and Associates, ORC Macro, 2008). Oral contraceptives are the most popular method, used by 29% of currently married women, followed by injectables (7%). Recent data suggest that with intensified FP efforts, fertility could continue to decline; unmet need for FP among currently married women has increased, from 11% in 2004 to 18% in 2007.

Among FP users, 40% use FP methods to limit their family size. LAPMs have many advantages for couples who have already achieved their desired family size. Yet, among these couples, only 20% use such methods. Furthermore, the overall percentage of couples using LAPMs has fallen, from nearly 11% in 1996 to slightly more than 7% today. Despite small declines in the percentage of users over the past decade, the annual number of implants, tubectomies, and vasectomies provided in Bangladesh increased fourfold, and the number of IUD insertions nearly doubled.

The results presented in this report are specific to Bangladesh, but they are linked to two other ACQUIRE country-level evaluations, conducted in Tanzania and Bolivia. ACQUIRE's goal was to evaluate country efforts more systematically than just through the collection of service statistics. The studies used a pretest/posttest methodology, with baseline data collected before any interventions were initiated and endline data collected several years later to assess the impact of the work. Toward the end of the project, at USAID's request, ACQUIRE developed a list of 31 single and composite core indicators that would reflect the project's major areas of focus. This report focuses on the achievements in Bangladesh as measured by these core indicators.

The study used a mix of methods, including the collection of quantitative and qualitative data and a review of project documents. The baseline data were collected in April 2004, while the endline data were gathered in July 2008. The two surveys were carried out in four districts—Chandpur, Rajbari, Chapai Nawabgonj and Dinajpur—identified in partnership with the Directorate General of Family Planning (DGFP). Of the 121 facilities sampled, 29 were *Upazila* (Sub-district) Health Complexes/Mother and Child Welfare Centers (UHCs/MCWCs), including one MCWC from each of the four districts, and 92 were Family Welfare Centers (FWCs). Through quota sampling (two providers at each FWC and 3–4 providers at each UHC/MCWC), approximately 200 providers were interviewed during the baseline and endline surveys. The studies also used quota sampling for clients (3–4 clients per facility) to interview 245 at baseline and 314 at endline. The survey data were supplemented by 13 interviews with manager-level key informants at DGFP district and central levels and six ACQUIRE Project personnel in Dhaka.

The ACQUIRE Project, in collaboration with DGFP, improved the availability of LAPMs to couples in Bangladesh. Through a systems-strengthening approach, ACQUIRE also supported steady improvements in the quality of LAPM services. As a result of this project, of the 21 core indicators with baseline and endline values, 18 showed statistically significant improvements. Engaging religious leaders to address religious misperceptions has been acknowledged as an important contribution to the FP program in Bangladesh. The ACQUIRE Project also contributed to improving the management information system (MIS) through training, review, compilation, and dissemination of MIS reports related to LAPMs. A significant number of informational booklets, posters, and charts for clients and job aids for providers were developed, and these will continue to be used after the end of project. The project also expanded the training of female welfare volunteers (FWVs) in the insertion of intrauterine contraceptive devices (IUCDs) and in counseling. These successes in LAPM programming occurred in parallel with efforts to improve the availability of infection prevention supplies and equipment.

The positive results are clear in other ways. The 2007 Demographic and Health Survey and the government's health management information system (HMIS) confirm that the decade-long decline in the use of LAPMs may have been reversed, particularly use of IUCDs and vasectomy. Through work with JSI/DELIVER and DGFP, the stock-outs of IUCDs and implants appear to have been overcome, at least for now. Given the country's population momentum, these gains need to be reinforced through high-quality programming to support LAPMs as a good choice for many couples, especially those who have achieved their desired family size.

ACQUIRE's close collaboration with the government has supported the inclusion of LAPMs in all of the DGFP's operational plans, including activities funded by the World Bank, a major funder of the MOHFW. Building on its historical collaboration with the MOHFW, the ACQUIRE Project was well-positioned to work on a number of policy issues, such as the use of paramedics to address the shortage of providers of vasectomy and implants, and to partner with the MOHFW in proposing revisions to its policy on sterilization.

The core indicators assessed for this evaluation also highlighted areas that need further attention.

#### **Recommendations for increased access to quality services**

- ◆ While continuing to promote informed choice and voluntarism, work with providers to ensure that they offer LAPMs to couples who have reached their desired family size.
- ◆ Continue to work with FWCs on infection prevention (both knowledge of infection prevention and reliable access to needed supplies).
- ◆ Continue to work with providers to enhance their critical knowledge of LAPMs, particularly implants and tubectomy.
- ◆ Continue to develop and distribute information, education, and communications materials, making sure that such materials are available at all health facilities.

#### **Recommendations for improved performance of service delivery providers**

- ◆ Continue to train providers on LAPMs, particularly implants, vasectomy, and tubectomy.
- ◆ Work with supervisors to enhance the supply chain by establishing mechanisms for communication between supervisors and supply officers.
- ◆ Work with providers to ensure that they convey critical information to clients, both verbally and by providing brochures, particularly for implants and tubectomy.
- ◆ Develop and train providers in better client-oriented counseling techniques.
- ◆ Address patient-flow issues to reduce waiting times.

#### **Recommendations for strengthened environment for FP and maternal health service delivery**

- ◆ Continue to encourage facilities to use MIS data to assess and enhance their efforts.
- ◆ Continue to work with the DGFP to change regulations regarding minimum/maximum requirements on number of children and on age for LAPM clients, and address informal requirements for spousal consent.



# Introduction

This report is an evaluation of the activities undertaken in Bangladesh between 2004 and 2007 by the ACQUIRE Project in support of reproductive health (RH) and development, particularly efforts to improve the delivery of and expand the use of long-acting and permanent methods of family planning (LAPMs).<sup>1</sup>

In 1971, when Bangladesh gained independence, its population was approximately 70 million. Today, it stands at 147 million, making it the world's eighth largest country (PRB, 2008). According to the United Nations, the population in Bangladesh will continue to grow and is projected to reach about 193 million by 2020 and exceed 254 million by 2050 (United Nations, 2007). Population size per se is not the country's biggest demographic challenge, however. Rather, it's extremely high population density compounds other development challenges. With more than 1,000 people per square kilometer, Bangladesh is nearly the most densely populated country in the world. By way of comparison, Pakistan (with 173 million people) has 217 people per square kilometer, and Nigeria (with 148 million people) has 160 people per square kilometer (PRB, 2008).

Bangladesh is in the midst of a demographic transition. Its rate of population growth has declined from 2.5% per annum in 1971 to 1.5% per annum in 2007. Nonetheless, two and one-half million people are added to the population each year because of the built-in momentum of population growth that results from past high fertility (MOHFW, 2008).

## Population and Family Planning Policies and Programs

Population policy in Bangladesh is formulated by the National Population Council, which is chaired by the Prime Minister. Since independence, population and family planning (FP) policies and programs have been included in successive five-year plans. Over the years, these efforts have gone through various phases, ranging from vertical programming to integrated programming (MOHFW, 2004). In 1976, the government adopted a multisectoral approach, which was refined in 2003–2004 to strike a balance between population and development, including poverty reduction. The following objectives relate to FP/RH (MOHFW, 2004:6):

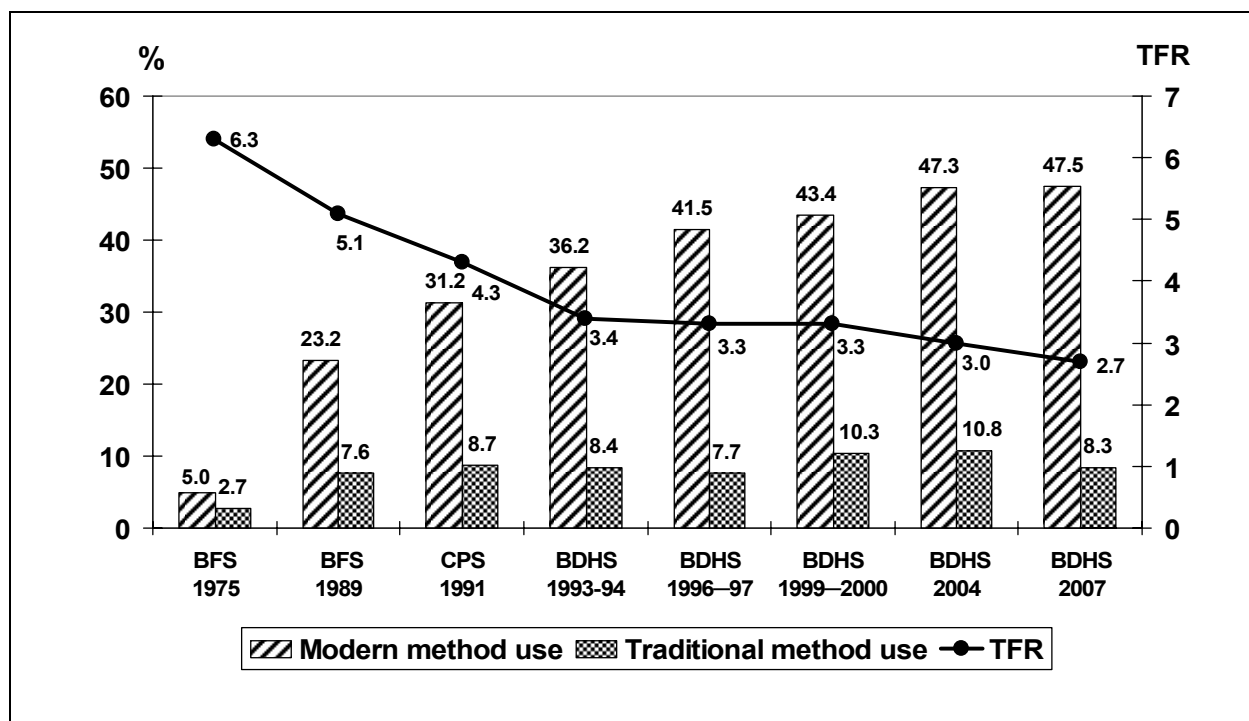
- ◆ Reduce the total fertility rate (TFR) and increase the use of FP methods among eligible couples by raising awareness of FP
- ◆ Attain a net reproduction rate of 1.0 by the year 2010, to stabilize population size by the year 2060
- ◆ Ensure the adequate availability of and access to RH information, counseling, and services, especially FP services, with a particular emphasis on hard-to reach populations, including adolescents

Bangladesh's TFR has declined from 6.3 lifetime births per woman in 1975 to 2.7 births per woman in 2007 (see Figure 1, page 2). Although fertility appeared to plateau in the 1990s, at about 3.3 lifetime births per woman, the most recent Demographic and Health Survey (DHS) data (from 2007) show that fertility has resumed its downward trend (NIPORT, Mitra and Associates, & ORC Macro, 2008).

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<sup>1</sup> LAPMs include the hormonal implant and the intrauterine contraceptive device (IUCD) as long-acting methods and male sterilization and female sterilization as permanent methods.

**Figure I. Trends in contraceptive prevalence and total fertility rate in Bangladesh, 1975–2007**



One of the main reasons that fertility declined is increased FP use. When modern method use and traditional method use are viewed together, the contraceptive prevalence rate increased from 8% in the mid-1970s to 56% in 2007 (WHO, 2004; NIPORT, Mitra and Associates, & ORC Macro, 2008) (Figure 1). Eighty-six percent of couples who use any method rely on modern methods (NIPORT, Mitra and Associates, & ORC Macro, 2008). Oral contraceptives are the most popular method, used by 29% of currently married women, followed by injectables (7%).

Recent data suggest that with intensified FP efforts, fertility could continue to decline; unmet need<sup>2</sup> for FP among currently married women has increased from 11% in 2004 to 18% in 2007. This increase may reflect problems related to the supply of FP commodities and/or an increase in the demand for FP services, both of which can be addressed with appropriate policies. However, future reductions in fertility will have to cope with not only increased demand for FP, but also with the annual increases in the reproductive-age population of about 1 million people per year (DGFP, 2006).

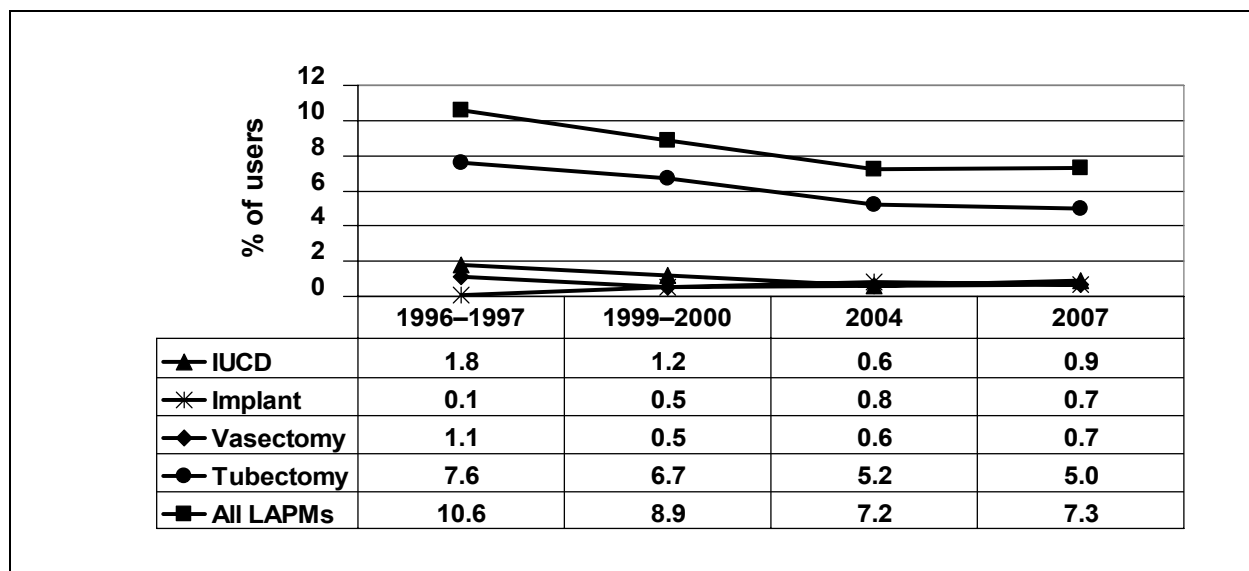
Among FP users, 40% use FP methods to limit their family size. LAPMs have many advantages for couples who have already achieved their desired family size. Yet, among these couples, only 20% use such methods. Furthermore, the overall percentage of couples using LAPMs has fallen, from nearly 11% in 1996 to slightly more than 7% today (see Figure 2).

Service statistics from the government’s health management information system (HMIS) round out the picture on the use of LAPMs in Bangladesh (see Table 1). Despite slight declines in the percentage of users over the past decade, the annual number of implants, tubectomies, and

<sup>2</sup> Unmet need refers to women who say they would prefer to avoid having a child now or in future but who are not currently using any FP method.

vasectomies provided in Bangladesh increased fourfold, and the number of IUD insertions nearly doubled. These increases reflect the growing acceptability of these methods. However, the data also illustrate challenges: The sharp decrease in the numbers of implant and IUD acceptors in 2007 reflects nationwide disruptions in the supply chain.

**Figure 2. Percentage of FP users relying on LAPMs in Bangladesh, by method, 1996–2007**



**Table I. Numbers of FP acceptors, by method, Bangladesh, 2000–2008**

	Tubectomy	Vasectomy	IUCD	Implant
Oct. 2000–Sep. 2001	26,301	15,194	141,679	49,159
Oct. 2001–Sep. 2002	30,374	29,628	167,370	63,441
Oct. 2002–Sep. 2003	35,003	40,756	183,707	55,972
Oct. 2003–Sep. 2004	62,499	47,191	200,600	84,977
Oct. 2004–Sep. 2005	84,901	59,222	210,878	107,137
Oct. 2005–Sep. 2006	68,432	56,720	253,904	51,386
Oct. 2006–Sep. 2007	106,608	98,395	196,599	11,164
Oct. 2007–Jul. 2008	89,339	75,312	234,908	193,471

A number of factors have contributed to the increases in FP use over the past 30 years:

- ◆ Strong political commitment to FP program
- ◆ Flexibility to make policy adjustment in response to emerging needs
- ◆ Multisectoral behavior change communications (BCC) interventions to establish a small family norm
- ◆ A good infrastructure for FP service delivery
- ◆ Increased involvement of nongovernmental organizations
- ◆ Strong support from the international aid community



However, key informant interviews carried out as part of this evaluation highlighted that some providers still see problems with FP services and are not yet convinced that investment in LAPMs will contribute to ongoing population goals:

*Client access to FP/RH services is not satisfactory. The service providers are not available at every facility. Besides, access also depends on FP method supplies; sometimes we did not get implant or IUCD supplies, so we did not provide these services. Sometimes, we did not have trained surgeon to do [vasectomy] or tubectomy.*

—Key informant interview, DGFP

*Mid-level managers and providers think achieving CPR is the goal and see short-acting methods as an easy way to achieved this and still need convincing about LAPMs.*

—Key informant interview, ACQUIRE

Several other challenges remain as Bangladesh's demographic transition continues:

- ◆ Residual momentum of population growth due to past high fertility.
  - ◆ Strain on programmatic resources due to the growing demand for FP
  - ◆ Weak supervision and monitoring by DGFP
  - ◆ Staff shortages and lack of recruitment
  - ◆ Lack of continuity in the supply of contraceptives, especially IUCDs and implants
  - ◆ Need for improvement in the quality of facilities and service
  - ◆ DGFP's MIS capacity and its limited use of data for decision making and local-level planning
  - ◆ Unsupportive *Kwami* religious leaders (a faction of Imams)
  - ◆ Need for increased male participation in programs
- (Sources: NIPORT, Mitra and Associates, & ORC Macro, 2008; and annual reports and workplans from ACQUIRE Bangladesh, 2004–2008)

## The Government Health System

According to Bangladesh's constitution, the government is obliged to ensure adequate health care for its citizens. To meet this commitment, 7% of the national budget is allocated to the health, nutrition, and population sector. In Bangladesh, these investments are made as part of the government's overall Poverty Reduction Strategy Paper (MOHFW, 2008).

The health care system is headed by the Ministry of Health and Family Welfare (MOHFW), which functions through five Directorates (Health; Family Planning; Nursing; the National Institute of Population Research and Training [NIPORT]; and Drug Administration) and a number of centers and departments, such as training, research, MIS, and logistics (DGFP, 2005). The management and delivery of FP services occurs primarily through the Directorate General of Family Planning (DGFP), with peripheral involvement of other directorates, centers, and departments.

Services are organized into six divisions (each with a divisional director responsible for support and human resource functions) and 64 districts (each with a deputy director responsible for FP/RH and related maternal and child health services (DGFP, 2005). There are three types of FP providers: medical officers (MOs), who are physicians; sub-assistant community medical officers (SACMOs), paramedics who have completed a three-year course on general health care and a one-year internship at a government training institute; and family welfare visitors (FWVs), female health

service providers who have completed at least 10 years of schooling and 18 months of basic training in FP services. At the district and national levels, the health and FP departments are separate, even though these departments work together at the *thana* and union levels (WHO SEARO, 2007).

A well-designed service delivery infrastructure has evolved over the years. There are 97 Mother and Child Welfare Centers (MCWCs) located at the district, *upazila*, and union levels, 407 *Upazila* Health Complexes (UHCs) and 3,500 union-level health and family welfare centers (DGFP, 2006b). On a regular basis, all four LAPM services are available at facilities at the district and *upazilla/thana* levels. At a union-level facility, only the IUCD is available regularly; the other three LAPMs are available only on special days, when an MO comes from district- or *upazilla*-level facilities. Every month, about 30,000 “satellite clinics” (outreach to lower-level facilities and communities) are organized all over the country to deliver antenatal care, FP, health education, and immunization services (UNESCAP, 2002).

## The ACQUIRE Project

The ACQUIRE Project<sup>3</sup> was a five-year global project supported by the U.S Agency for International Development (USAID) over the period 2004–2008. It worked globally to advance and support the availability, quality, and use of facility-based FP/RH services at every level of the health care system and to strengthen links between facilities and communities. ACQUIRE’s program model evolved over the life of the project to reflect lessons learned from program implementation in various countries. Key components include the following:

- ◆ **A high-quality client-provider encounter**, considered to be at the heart of ACQUIRE’s program interventions
- ◆ **Supply and demand components** to ensure a balance between investments in providers and facilities and efforts to increase clients’ awareness of and access to care
- ◆ **Advocacy**, using sound medical and programmatic evidence to promote informed decision making
- ◆ Reliance on the **fundamentals of care** as the foundation of service delivery quality (informed/voluntary choice, safety of clinical techniques/procedures, and an ongoing quality improvement and management mechanism)
- ◆ **Data for decision making**, through the use of locally generated, context-specific data and other evidence to inform policy and program decisions
- ◆ **Gender equity** as an integral component of program material, training, and implementation
- ◆ **Stakeholder participation** to inform program design and foster ownership and sustainability, and identification and nurturing of “champions” to bridge gaps between various stakeholder groups toward a common goal—increasing women’s access to FP/RH services.

The ACQUIRE activities carried out in Bangladesh were based on these components, as reflected in comments from key informants:

*In Bangladesh, we care a lot for [the fundamentals of care]. Before we start any program activity, we look at [the fundamentals of care]. Be these training or materials development, we maintain [the fundamentals of care].*

—Key informant interview, ACQUIRE

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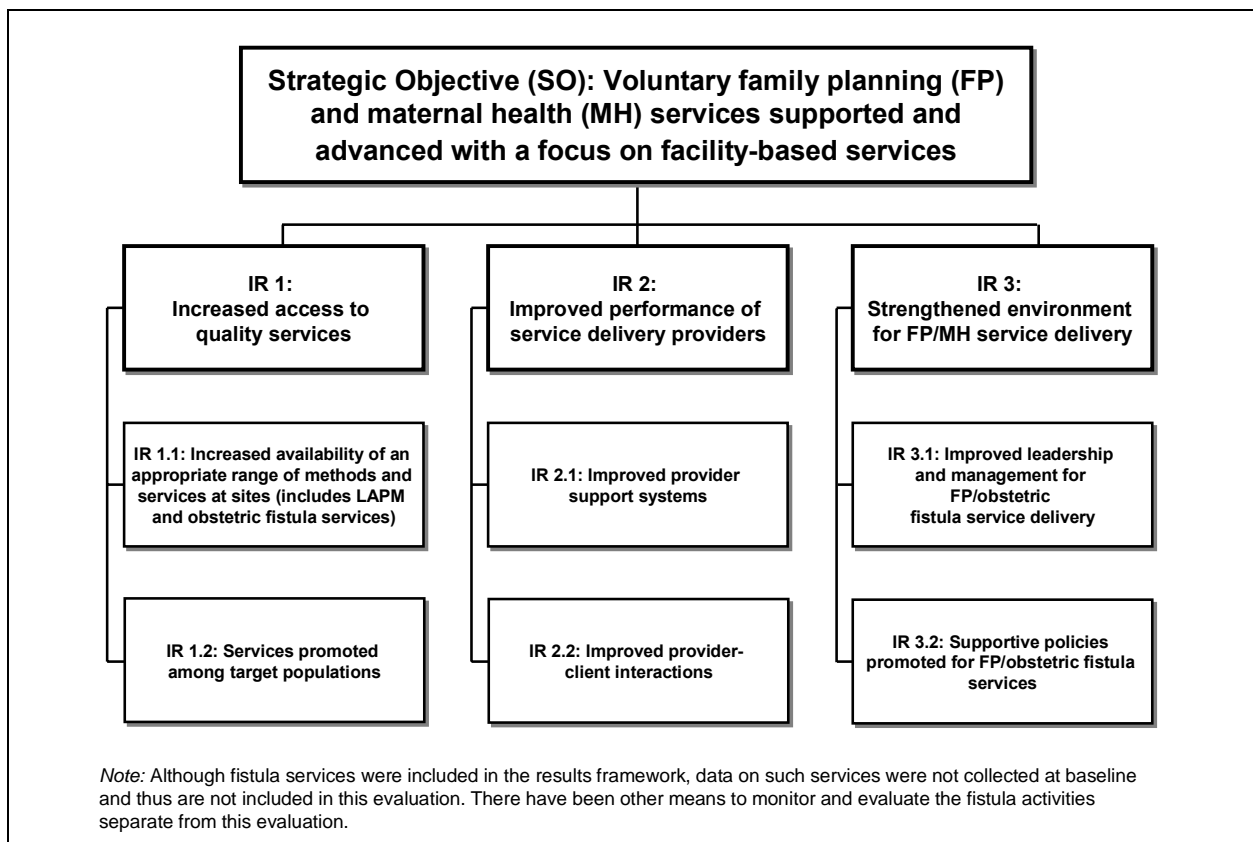
<sup>3</sup> ACQUIRE stood for Access, Quality, and Use in Reproductive Health. EngenderHealth was the managing partner of the ACQUIRE Project, in partnership with the Adventist Development and Relief Agency International (ADRA), CARE, IntraHealth International, Inc., Meridian Group International, Inc., and the Society for Women and AIDS in Africa (SWAA). In Bangladesh, the work was carried out only by EngenderHealth Bangladesh, in partnership with the DGFP.

*If we address client rights and providers needs, this will result in quality care.*  
 —Key informant interview, ACQUIRE

The ACQUIRE Project’s global results framework was adapted to country realities. In Bangladesh, the result framework’s strategic objective (SO) was as follows: “Voluntary family planning and maternal health (MH) services supported and advanced with a focus on facility-based services (see Figure 3). Three intermediate results (IRs) contributed to this SO:

- ◆ IR 1: Increased access to quality services;
- ◆ IR 2: Improved performance of service delivery providers
- ◆ IR 3: Strengthened environment for FP/MH service delivery.

**Figure 3: ACQUIRE/Bangladesh results framework**



Each IR had two sub-IRs, with one or more project activities under each sub-IR (highlighted in the results sections below) contributing to the IRs (and through them, to the SO).

ACQUIRE collaborated with the DGFP to carry out project activities, which were built on previous activities undertaken by EngenderHealth’s Bangladesh Country Office to strengthen clinical FP services, particularly for LAPMs.<sup>4</sup> A joint assessment undertaken in 2000 with DGFP and the United Nations Population Fund (UNFPA) to assess why a smaller percentage of people were using LAPMs also helped to inform ACQUIRE’s activities. The priority recommendations from that review for strengthening of systems involved in service delivery are listed below. At the heart of the

<sup>4</sup> Several other agencies, such as DELIVER/JSI, SMC, USAID NGO sector service delivery program (NSDP/Smiling Sun Franchise Project), and the Directorate General of Health Services, also contributed to specific activities.

ACQUIRE Project was a conscious strategy to work in partnership with various levels of government:

- a) District- and upazila-level service organizations and management
- b) BCC and counseling
- c) Training
- d) Infection prevention
- e) Postpartum clinical contraception
- f) Vasectomy
- g) Male involvement
- h) Involving the private sector

### **ACQUIRE's Contribution to USAID Mission Strategy**

USAID/Dhaka is committed to continuing to support expanded use of LAPMs. ACQUIRE was USAID's main partner in this area, working with the Government of Bangladesh to understand and adopt the requirements of the Tiaht Amendment and all other USAID requirements. For example, a Tiaht wall chart included comprehensible information on FP methods, one of the requirements to ensure informed and voluntary choice in USAID-supported programs. The DGFP also issued a national guidance requiring compliance with these requirements. ACQUIRE worked with facilities at all levels to build commitment to reproductive rights:

*[The project] addresses USAID concern about voluntarism by including training on informed choice and voluntarism for FWAs [family welfare assistants], since they are the primary FP motivators in communities.*

—Key informant interview, ACQUIRE



# Methodology

The results presented in this report are specific to Bangladesh, but they are linked to two other ACQUIRE country-level evaluations, in Bolivia and Tanzania (Goldberg et al., 2006; Jain et al. 2006). The ACQUIRE Project's goal was to evaluate country efforts more systematically than just through the collection of service statistics. The studies used a pretest/posttest methodology, with baseline data collected before interventions were initiated and endline data collected several years later, to assess the impact of the work. Toward the end of the project, at USAID's request, ACQUIRE developed a list of single and composite core indicators to reflect the project's major areas of focus globally. This report focuses on the achievements in Bangladesh as measured by these core indicators. The list was developed after the baseline data had already been collected in Bangladesh and includes somewhat different indicators than that survey. Thus, some of the core indicators covered in this report will not have baseline/endline comparisons. However, comparisons are available to assess the ACQUIRE's main activities in Bangladesh.

## Data Collection Methods and Sample Size

The study used a mix of methods, including quantitative and qualitative data collection and a review of project documents. For the quantitative data, evaluators collected information on facilities, providers, and clients. Under the qualitative assessment, evaluators explored with key informants the reasons for program successes and challenges. The document review provided insights into program activities and implementation.

### Quantitative Component

The baseline data for Bangladesh were collected in April 2004, while the endline data were collected in July 2008. The two surveys were carried out in the four districts—Chandpur, Rajbari, Chapai Nawabgonj and Dinajpur—identified in partnership with the DGFP (see Figure 4, page 10). At baseline and at endline, the characteristics of the provider sample were similar. Almost 70% were women, and they had about 20 years of health service experience. The clients were also broadly similar across baseline and endline surveys: About 90% were women, all were married, they averaged about 29 years of age, and they had slightly more than 2.5 children. Additional details on the numbers and characteristics of the sampled health workers and clients can be found in Appendix 1.

In general, ACQUIRE used the same design and data collection approaches in the baseline and endline surveys. The endline evaluation was conducted at the same 121 facilities (UHCs/MCWCs and FWCs) in the four districts where the baseline survey was conducted in 2004. These four districts were purposively selected based on the level of LAPM services during the period of October 2000 to September 2001.<sup>5</sup>

Of the 121 facilities sampled, 29 were UHCs/MCWCs, including one MCWC from each of the four districts, and 92 were FWCs. At baseline, in 34 of the FWCs, only the facility audit was used. Thus, the complete suite of survey instruments, including facilities information and interviews with providers and clients, was used in 87 facilities. Through quota sampling (two providers at each

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<sup>5</sup> For details on the sampling of facilities, please refer to Mahboob-E-Alam et al., 2006).

FWC and 3–4 providers at each UHC/MCWC), approximately 200 providers were interviewed during the baseline and endline surveys across these 87 facilities. The distribution of the number of staff interviewed at the UHCs/MCWCs and FWCs varied from the baseline to the endline because of staff availability on the days of the surveys.

**Figure 4. Map of Bangladesh, showing baseline and endline districts**



There were some slight methodological differences between the baseline and the endline. In addition to the new core indicators added at the endline, the endline study took a slightly different approach to assessing client-provider interactions (CPIs). Because of the relatively low number of LAPM clients, extensive observation of CPIs proved to be difficult within the timeline and research budget allocated to the endline survey. At endline, a purposive sample of no more than two clients from a single facility was used to select and observe 52 CPIs. Almost all of these observations were done at UHCs/MCWCs, and for almost 90% of these observations, the provider was a male MO. In the endline, assessment of CPI used triangulation of four tools (the facility audit checklist, the provider interview questionnaire, the client exit interview questionnaire, and the CPI observation) and corroboration of information from client exit interviews and provider interviews.

The studies also used quota sampling for clients (3–4 clients per facility) at each of the 87 facilities where client exit interviews were carried out. The sample of clients at the UHCs/MCWCs was larger at endline than at baseline. This increase (from 245 to 314) is due to the greater availability of LAPM clients at endline, since the interviews were purposefully conducted on days that the health facilities had designated as “LAPM days.”

### **Qualitative Component**

The survey data were supplemented by 13 interviews with managerial-level informants at DGFP district and central levels and six ACQUIRE personnel in Dhaka. These respondents were asked their views on program design, program implementation, and lessons learned. Additional information was gleaned from a review of program and trip reports, research, curricula, and other materials, based on a brief document checklist to review. This document review provided insights into the process of program implementation.

### **Interviewer Training**

For the endline survey, the individuals recruited to collect the data and the data-collection supervisors attended five days of training that provided background on the ACQUIRE Project and detailed review of the survey instruments. Classroom training was supplemented by field training at Savar (a suburb of Dhaka), a geographic area similar to the study districts. As a result of the field training, several small changes were made to the flow of the questionnaires and to the Bangla translation of some questions. The qualitative interviewers were provided with a day-long training on the discussion guides and qualitative interview techniques

### **Study Limitations**

Because of several methodological choices, the results of this study may not be generalizable to Bangladesh as a whole:

- ◆ The surveys were conducted in four purposively identified districts out of Bangladesh’s 64 districts and may not be representative of conditions countrywide.
- ◆ The use of quota sampling of providers and clients may mean that the results do not represent the entire range of provider and client responses from the sample facilities.
- ◆ Clients sampled on LAPM service days during the endline may not be representative of FP service delivery and use in general.
- ◆ There may be response and recall bias in self-reports.
- ◆ Since the baseline/endline design, chosen for funding efficiency, did not include control areas, it is difficult to assess whether changes were due to ACQUIRE interventions.





## Findings

Key data are presented here for each of ACQUIRE’s Bangladesh IRs. This section reviews findings for the core indicators, as well as other results from the facility audits, provider and client questionnaires, and the key informant interviews. Appendix 2 provides details on the number of activities undertaken in support of the IRs.

### IR 1: Increased Access to Quality RH/FP Services

The activities undertaken to achieve IR 1 focused on expanding client choice by increasing both access to and the quality of clinic-based FP services, particularly LAPMs, and by providing high-quality BCC materials to help people better understand their FP options. Activities included the following:

- ◆ Reinvigorating LAPM service delivery
- ◆ Strengthening availability of LAPM service providers
- ◆ Facilitating expansion of LAPM services in hard-to-reach areas
- ◆ Piloting youth-friendly and male-friendly services
- ◆ Strengthening public-sector LAPM services
- ◆ Initiating partnerships with the private sector for LAPM services
- ◆ Supporting improvement in the quality of service delivery
- ◆ Coordinating with DGFP and JSI/DELIVER to strengthen the logistics and supply system
- ◆ Supporting local-level BCC efforts

(Source: EngenderHealth Bangladesh Country Office, 2004–2008)

Table 2 (see page 14) presents the core indicators for IR 1. The results show that for many of these core indicators, the situation at sampled clinics improved. Looking first at results for sub-IR 1.1 (Increased availability of an appropriate range of methods and services at sites), Core Indicator 1—the percentage of clients receiving/referred for FP—shows that a higher proportion of clients were referred for LAPMs, increasing from 13% at baseline to 47% at endline. Two points must be noted, however:

1. Injectables remain the most common method.
2. The endline survey was done on “LAPM days.”

Taken by themselves, these results may not reflect a true increase. Yet the in-depth interviews highlighted that LAPMs are becoming increasingly accepted. For example, one interviewee said:

*Now there are some providers who do more than 200 [no-scalpel] vasectomies (NSVs) per month. Earlier, there were men wearing lungis coming for NSVs and now men wearing pants are coming for NSVs [indicating upward mobility in the profile of NSV clients].*

—Key informant interview, ACQUIRE

There were also great increases in the percentage of facilities prepared to provide LAPMs (Core Indicator 3) for all methods but tubectomy.

**Table 2. Core indicators for Intermediate Result (IR) I**

Indicator	Baseline		Endline	
	N	%	N	%
<b>IR 1.1: Increased availability of an appropriate range of methods and services</b>				
1. Percentage of clients receiving/referred for FP (by method/type of client)	245		314	
Condom		15		1
Pill		21		5
Injectable		49		40
IUCD		3		13
Implant		1		10
Vasectomy		6		9
Tubectomy		3		15
2. Percentage of facilities providing an appropriate range of modern methods <sup>1</sup>				
Family Welfare Center (FWS)	92	95	92	97
Upazilla Health Complex/Mother & Child Welfare Center (UHC/MCWC)	29	93	29	100
3. Percentage of facilities <sup>2</sup> prepared to provide LAPM (method specific) <sup>3</sup>				
IUCD	23	52	118	87*
Implant	19	32	35	86*
Vasectomy	21	19	39	74*
Tubectomy	28	4	36	8
4. Percentage of facilities with essential infection prevention supplies <sup>4</sup>				
Family Welfare Center	92	2	92	35*
Upazilla Health Complex/Mother & Child Welfare Center	29	24	29	93*
5. Percentage of providers <sup>5</sup> with critical knowledge of LAPM services (method-specific) <sup>6</sup>				
IUCD	126	72	135	85*
Implant	24	13	19	5
Vasectomy	16	88	18	44
Tubectomy	27	19	19	11
Baseline figures are based on a limited set of critical knowledge				
<b>IR 1.2: Services promoted among target populations</b>				
6. Percentage of facilities with an outreach program	121	89	121	86
7. Percentage of facilities with family planning brochures/handouts available	121	1	121	32
8. Percentage of facilities with signage for family planning services	121	28	121	84*

Note: \*Difference between baseline and endline is statistically significant at p<.05 level.

- Appropriate range of methods** is defined as Health and Family Welfare Centers offering all short-acting methods and IUCD, and higher level facilities offering all short-acting methods and at least three LAPMs.
- Only for health facilities providing specific LAPMs.
- Prepared to provide** is defined as the following: For **IUCDs**—IUCD, exam gloves, and antiseptic solution; for **implants**—1% lidocaine without epinephrine, implant (Norplant, Implanon, or Jadelle), exam gloves, and antiseptic solution; for **male sterilization**—anesthetic, sterile gloves, antiseptic solution, and supplies for occluding vas, according to surgeon's preference for ligation; and for **female sterilization**—anesthetic, atropine, analgesic, Promethazine, 1% lidocaine without epinephrine, sterile gloves, and antiseptic solution.
- Essential infection prevention supplies** are defined as: autoclave or steam sterilizer, soap/soap for hand washing, surgical gloves/sterile gloves/clean gloves, bleach/bleaching powder/chlorine base compound, Iodine/iodine polyvidone, and water (any type).
- Only for providers providing specific LAPMs.
- Critical knowledge of LAPMs** is defined as: for the **IUCD**, any one warning sign related to bleeding or infection; for **implants**, spotting after intercourse; for **male sterilization**, medical status of client; and for **female sterilization**, medical status of client and check for infection.

However, the data also show areas that need improvement, particularly related to infection control supplies at the Family Welfare Centers (FWCs) and to essential provider knowledge. Providers of specific LAPMs were asked about what conditions in clients they check for prior to providing them with a method (see Table 3).

The data show improvements in appropriate levels of care in some areas and ongoing weaknesses in others:

- ◆ *IUCD*: Compared with baseline, more providers at endline were checking for clients' pregnancy status, menstrual or bleeding abnormalities, and infections; however, the level was still too low, at about 50%. At endline, more than 95% of providers at all levels of health facility were checking clients for gynecologic or obstetric conditions, such as distortions in the uterine cavity, uterine fibroids, cancers (ovarian, endometrial, or cervical), or pelvic inflammatory disease.
- ◆ *Implant*: More providers at endline ascertained the pregnancy status of clients. For this hormonal method, extra care in checking for eligibility is required. Additional questions at endline showed that only 21% of providers checked for a history of breast cancer and that only about half reported checking for menstrual or bleeding abnormalities and cirrhosis or other problems associated with the liver.
- ◆ *Vasectomy and tubectomy*: At baseline and endline, almost 90% of providers checked with clients on their number of children. However, the percentage of vasectomy providers checking on clients' medical or infection status declined by almost 50%. At endline, although more tubectomy providers were checking for the pregnancy (53%) or medical status (68%) of their clients, these numbers are quite low. The percentage checking for infection was low at baseline and declined to a very low level at endline—16%.

**Table 3: Percentage of providers reporting that they usually check for certain conditions before providing LAPMs, by method, according to type of provider and baseline/endline**

Conditions checked	% of providers					
	UHC/MCWC		FWC		Total	
	Baseline	Endline	Baseline	Endline	Baseline	Endline
<b>A. IUCD</b>	<i>n</i> =67	<i>n</i> =55	<i>n</i> =59	<i>n</i> =80	<i>N</i> =126	<i>N</i> =135
Pregnancy status	38.8	43.6	30.5	53.8	34.9	49.6
Menstrual or bleeding abnormalities	76.1	81.8	67.8	87.5	72.2	85.2
Gynecological or obstetrical problems	—	94.5	—	98.8	—	97.0
Infections or STIs	55.2	67.3	66.1	68.8	60.3	68.1
<b>B. Implant</b>	<i>n</i> =23	<i>n</i> =19	<i>n</i> =1	—	<i>N</i> =24	<i>N</i> =19
Pregnancy status	47.8	68.4	0.0	—	45.8	68.4
Menstrual or bleeding abnormalities	—	47.4	—	—	—	47.4
History of breast cancer	—	21.1	—	—	—	21.1
Cirrhosis or other problems with liver	—	63.2	—	—	—	63.2
<b>C. Vasectomy</b>	<i>n</i> =15	<i>n</i> =16	<i>n</i> =1	<i>n</i> =2	<i>N</i> =16	<i>N</i> =18
Number of children	86.7	100.0	100.0	100.0	87.5	100.0
Medical status	86.7	43.8	100.0	50.0	87.5	44.4
<b>D. Tubectomy</b>	<i>n</i> =27	<i>n</i> =19	—	—	<i>N</i> =27	<i>N</i> =19
Number of children	85.2	89.5	—	—	85.2	89.5
Medical status	59.3	68.4	—	—	59.3	68.4
Pregnancy status	40.7	52.6	—	—	40.7	52.6
Infection	29.6	15.8	—	—	29.6	15.8

Source: Provider interview

The provision of all FP methods, but particularly permanent methods, requires informed choice and voluntarism. To get a better understanding of adherence to these principles, at endline, providers of vasectomy and tubectomy services were asked what information they provided to prospective users of permanent methods (see Table 4).<sup>6</sup> All vasectomy providers informed prospective clients that vasectomy is a permanent method. However, none of them mentioned informing their clients that the facility also offered temporary methods or that vasectomy is not effective immediately and requires use of a back-up method. Few providers reported that they told their clients that they could switch to an alternative FP method or even that while vasectomy is a highly effective method, there is still a small possibility of method failure. More than 70% of vasectomy providers informed their prospective clients that vasectomy entails surgery and that, as with any surgery, there are attendant risks and side effects.

**Table 4. Percentage of providers who provide certain method-related information to clients prior to vasectomy and tubectomy, by type of provider (endline only)**

Information provided to clients	% of providers		
	UHC/MCWC	FWC	Total
<b>A. Vasectomy</b>	<i>n</i> =16	<i>n</i> =2	<i>N</i> =18
Vasectomy is a permanent method.	100.0	100.0	100.0
Facility offers temporary methods.	0.0	0.0	0.0
The client can change his mind and choose another method.	12.5	0.0	11.1
Vasectomy entails a surgical procedure.	75.0	50.0	72.2
There are risks/side effects associated with any surgical procedure.	81.3	50.0	77.8
Vasectomy is a highly effective method, but there is a possibility of method failure.	31.3	0.0	27.8
Vasectomy is not effective immediately (i.e., there is a need for a back-up method)	0.0	0.0	0.0
<b>B. Tubectomy</b>	<i>n</i> =19	—	<i>N</i> =19
Tubectomy is a permanent method.	94.7	—	94.7
The facility offers temporary methods.	100.0	—	100.0
The client can change her mind and choose another method.	15.8	—	15.8
Tubectomy entails a surgical procedure.	63.2	—	63.2
There are risks/side effects associated with any surgical procedure.	89.5	—	89.5
Tubectomy is a highly effective method, but there is a possibility of method failure.	31.6	—	31.6

Source: Provider interview

Almost all tubectomy providers informed prospective clients that tubectomy is a permanent method and that the facility also offers temporary methods. More than 60% of tubectomy providers informed their prospective clients that tubectomy entails surgery or that, as with any surgery, there are attendant risks and side effects. Similar to the findings for vasectomy, few tubectomy providers reported informing prospective clients that they could choose another FP method or that there is small possibility of method failure.

<sup>6</sup> These permanent methods are only offered at UHCs/MCWCs. At endline, two providers interviewed at FWCs may have provided vasectomy services elsewhere in the past.

The key informant interviews provide deeper insights into some of the challenges to expanding access and quality. Staffing is a challenge, particularly open positions at health facilities. As one interviewee said:

*After [the] ACQUIRE intervention, when client flow was increasing, we did not have enough trained manpower to provide quality services to all of them.*

—Key informant interview, DGFP

ACQUIRE worked with the government to address this problem, through, for example, the introduction of a system whereby some providers travel to a cluster of 3–4 facilities to provide needed services. The project also suggested the use of paramedics, such as SACMOs and FWVs, to provide NSV and implant insertion, respectively, an idea that has been cleared for a pilot test.

Improvements in logistics occurred through ACQUIRE’s collaboration with JSI/DELIVER to develop IUCD and Sterilization Kits (34 items for tubectomy and 22 items for NSV) containing all medical and surgical requirements in one box. These kits were piloted in four districts and found to be effective.

Under the ACQUIRE Project, 39 FWCs were upgraded to provide all LAPMs. To make it easier for providers to perform counseling and FP consultations, pelvic models, job aids, flipcharts, and infection prevention materials were distributed to health facilities. However, very few providers were observed using these job aids.

## **IR 1.2 Services Promoted among Target Populations**

Sub-IR 1.2 was the demand side of the equation. ACQUIRE provided information, education, and communications (IEC) materials and conducted outreach activities to support informed choice and help communities understand what FP services were available. Core indicators 6–8 highlight the results of these activities (Table 2, page 14).

Core Indicator 8 shows that from baseline to endline, the percentage of facilities with signage advertising the availability of FP services improved significantly (from 28% to 84%). And Core Indicator 7 shows that at baseline, almost none of the sampled health facilities had FP brochures or handouts available for clients to take home. Observations at endline revealed that these materials were now available at 32% of facilities.

Several of the respondents to the in-depth interviews commented on the demand side of the equation. While one respondent said that “Equal attention was not paid to the demand side” (key informant interview, ACQUIRE), others mentioned breaking through religious conservatism with the book *Family Planning in the Light of Islam*, wide dissemination of a Tiahrt chart to further the notions of informed choice and voluntarism, and the NSV communications campaign for increasing wider acceptability of this method:

*Nowadays, clients are getting information through radio, TV, family planning workers, so they are becoming aware of it and coming for service.*

—Key informant interview, DGFP

*During the NSV campaign, TV spots were run. These TV spots are now being shared with cinema hall owners and cable network operators at the district level.*

— Key informant interview, ACQUIRE

ACQUIRE placed special emphasis on male sterilization, particular the new technology of NSV.

Activities were designed to counteract 1) a decline in the agent system (during 1980s and early 1990s, “agents” were used to refer vasectomy clients); 2) FP workers’ bias in favor of short-term, temporary methods; and 3) myths and misconceptions about vasectomy among FP workers and potential clients.

ACQUIRE developed a communications strategy to raise awareness of NSV. A local advertising agency, Unitrend, was given a subaward to undertake the NSV campaign. Although the activity was designed in 2005, the final campaign was undertaken only on a limited scale in 2007 and 2008. It included two TV spots and a poster, 98,000 of which were distributed in the four baseline districts. Unfortunately, the NSV campaign could not be done on the scale initially proposed, and the campaign had other problems. For example, stakeholders were not satisfied with the NSV campaign message, or even with the term “NSV,” which was not at all well-known among common people. However, orientations of workers and community leaders about NSV helped to dispel myths and misconceptions about vasectomy, demonstrated NSV procedures, provided on-site coaching of unskilled NSV surgeons, and created satisfied NSV acceptors who then become the proponents of NSV. As a result, the number of NSVs performed started to increase gradually and consistently. In 2000, yearly vasectomy performance was 15,444, but by 2007 this number had grown to 98,395.

Project documents highlighted additional details about IR1.2 activities. Outreach activities included community meetings to increase awareness about LAPMs among health workers and formal and informal community leaders, including elected female Union Parishad members, religious leaders, teachers and Family Planning Inspectors (FPIs). Starting in October 2003, ACQUIRE conducted 314 meetings at upazila headquarters with 23,080 participants. These upazila-level orientation meetings were helpful for updating providers and workers on LAPMs and for deepening awareness among community leaders. Performance analysis revealed that after implementation of an upazila-level program, LAPM performance usually went up for six months. However, these increases were not sustained, and the activities were not repeated by the DGFP to support ongoing improvements. ACQUIRE placed special emphasis on religious leaders. The project held day-long orientations at the divisional, district, and upazila levels for Muslim religious leaders (imams), supported by the development of the booklet *Family Planning in the Light of Islam* in August 2005. Since then, a total of 5,557 religious leaders received orientation on LAPMs through this program, and 30,000 copies of the booklet were distributed. Orienting religious leaders in this way was very helpful for dispelling misconceptions about FP methods and for overcoming religious leaders’ negative attitudes. After the orientation, although not many imams started to speak in favor of FP publicly, most at least stopped speaking against FP, and a few even became advocates. Unfortunately, the DGFP did not become involved in scaling up the program or in taking it to the mass media.

## **IR 2: Improved Performance of Service Delivery Providers**

IR 2 was designed to improve the performance of service providers. ACQUIRE worked to enhance the government’s capacity to provide training and refresher workshops on LAPMs, counseling, infection prevention, and management of complications. ACQUIRE and the DGFP conducted 98 training of trainer (TOT) sessions; 4,867 providers received technical/clinical training; and 411 supervisors received supportive supervision training. The training sessions focused on FWVs and assistant family welfare officers (earlier called senior family welfare visitors), and a limited number of MOs also received training. The project also provided job aids to support service provision. ACQUIRE used systems strengthening as a key strategy toward quality improvement, working on such systems as supervision, MIS, and monitoring.

## List of Major Interventions

- ◆ Training/refresher on IUCD, NSV, tubectomy, counseling, infection prevention, and complications management
  - ◆ Technical assistance to strengthen implant services
  - ◆ Capacity building of NIPORT for refresher training of FWAs and FPIs
  - ◆ Strengthening of DGFP's supervisory system and development of supportive supervision
  - ◆ Strengthening of DGFP's MIS and monitoring system (including data quality audit)
- (Source: EngenderHealth Bangladesh Country Office, 2004–2008)

## IR 2.1 Improved Provider Support System

### Supervision

Core indicators 9, 10, 14, and 15 related to supervision and were only collected at the endline (see Table 5, page 20). The data show that three-quarters of the providers reported that they had effective supervision. A very high percentage (94%) of facilities used enhanced supervision approaches or tools. However, only about one-third of supervisors coordinated with a supply officer to ensure a steady flow of supplies.

The endline survey collected additional details to round out the assessment of supervision. More than 80% of supervisors reported receiving training on supportive supervision, and more than 90% had worked as a supervisor for four or more years (data not shown).

Off-site supervision did not vary by facility level. Overall, supervisees reported receiving an average of two visits during the past three months from an off-site supervisor. More than 40% of those interviewed reported that their off-site supervisor checked supplies and equipment, reviewed service statistics, or observed service delivery. Far fewer reported that their off-site supervisor worked on the regularity of supplies, reviewed client records, talked with clients or gave feedback on performance, checked infection prevention practices, or organized/provided skill-based training (see Table 6, page 21).

For on-site supervision, interviewees reported that more than 80% of supervisors observed service delivery and that approximately 50% checked supplies/equipment or reviewed service statistics. About 30% of on-site supervisors provided feedback on performance, talked with clients, reviewed client records, or coordinated for regular supply, and even fewer checked infection prevention practices, provided skills training, or organized training or refreshers.

The in-depth interviews revealed that while introducing supportive supervision was not easy, the new style was appreciated:

*After having training on [facilitative supervision] FS, my supervisory style and technique has been positively changed; now I know that during supervision, I will not only identify the gaps, but also provide [technical assistance] to my supervisee to improve their performance.*

—Key informant interview, DGFP

*We found that they were motivated for FS, and this is an achievement. The government sector is not habituated to supervision. We have worked hard to change habit.*

—Key informant interview, ACQUIRE



**Table 5. Core indicators for Intermediate Result (IR) 2**

Indicator	Baseline		Endline	
	N	%	N	%
<b>IR 2: Improved performance of service delivery providers</b>				
<b>IR 2.1: Improved provider support systems</b>				
9. Percentage of providers with effective onsite supervision <sup>1</sup>	—	—	212	78
10. Percentage of providers that received at least one effective external supervision visit <sup>2</sup> in past 3 months	—	—	115	72
11. Percentage of providers <sup>3</sup> who received in-service FP training (method- and provider-specific) in past 3 years				
FP Counseling	193	9	213	78*
IUCD	126	2	135	95*
Implants	24	33	19	21
Vasectomy	16	44	18	22
Tubectomy	27	33	19	26
12. Percentage of facilities reporting refreshers in FP norms, standards, guidelines or protocols	—	—	121	67
13. Percentage of providers who have used FP Manual within past year	—	—	213	89
14. Percentage of facilities that use facilitative supervision or COPE or other QI tools or have a QI Committee	—	—	121	94
15. Percentage of supervisors who coordinate with a supply officer to ensure regular supply	—	—	31	32
<b>IR 2.2: Improved client-provider interactions</b>				
16. Percentage of clients who got FP brochures from health facility within past year	—	—	314	18
17. Percentage of clients who received adequate information about LAMP services (method-specific) <sup>4</sup>				
IUCD	8	25	40	75*
Implants	2	100	32	56
Vasectomy	15	27	27	78*
Tubectomy	8	13	47	66*
Baseline figures are based on a limited set of critical information				
18. Percentage of providers who include key information on protection against STI/HIV/AIDS in client information <sup>5</sup>	169	50	197	94*
19. Average number of methods that new client's report provider discussed with them Note: Bangladesh information from client-provider interaction	180	1.9	286	2.3*
20. Percentage of clients reporting client-oriented consultation by provider <sup>6</sup>	245	34	314	39
21. Percentage of providers who use didactic materials or models for FP consultation or counseling	—	—	213	97
22. Percentage of facilities with a system for determining client opinion	121	31	121	67*
23. Percentage of clients comfortable and satisfied with services and method received <sup>7</sup>	245	56	314	68*
24. Mean client waiting time to receive LAMP service (in minutes)	243	36	314	66

Note: \*Difference between baseline and endline is statistically significant at  $p < .05$  level.

- Effective on-site supervision** is defined as supervisor observes service delivery and does at least one other task from the following list: check supplies/equipment; check infection prevention practices; review client records; review service statistics; talk to clients; give feedback on performance; or provide skills training.
- Effective external supervision** is defined as supervisor observes service delivery and does at least one other task from the following list: check supplies/equipment; check infection prevention practices; review client records; review service statistics; talk to clients; give feedback on performance; provide/update knowledge/skills; or discuss roles and responsibilities.
- Calculated only for providers of specific methods.
- Adequate information about LAMPs** is defined as: For each of the methods, in case of problems, what action needs to be taken to address the problem? Separately, for each method, the following: For the **IUCD**—action to ensure IUCD is in place; for the **implant**—protection against pregnancy for five years; for **male sterilization**—chance of pregnancy during first three months; and for **female sterilization**—chance of pregnancy.
- Key information on STIs/HIV/AIDS** is defined as: dual protection, risk of infection and presence of STI symptoms.
- Client-oriented consultation** is defined as: examination (if done) was explained prior to examination; consultation had both auditory and visual privacy; and client felt that information given to provider would be kept confidential.
- Clients comfortable and satisfied** is defined as: Waiting time at facility was reasonable; client felt comfortable asking questions of the provider (if there were questions); and client was satisfied with the services and the method received/referred.

**Table 6. Percentage of providers reporting receipt of various types of off-site supervision, by type of provider (endline only)**

Training Content	% of providers		
	UHC/MCWC n=21	FWC n=60	Total N=81
<b>Frequency of supervision</b>			
Average number of visits in past 3 months	2.4	2.2	2.3
<b>Activities carried out by supervisor</b>			
Check supplies/equipment	45.3	43.5	44.1
Coordinate with supply officer to ensure regular provision of supply	28.0	26.8	27.2
Organize refresher training/on-the-job training on clinical procedure	4.0	7.2	6.1
Check infection prevention practices	14.7	10.1	11.7
Review client records	16.0	23.2	20.7
Review service statistics with staff	49.3	48.6	48.8
Observe service delivery	46.7	50.0	48.8
Talk to clients	14.7	21.7	19.2
Give feedback on performance	16.0	21.0	19.2
Provide skills training	9.3	9.4	9.4

**Source:** Provider interview

Supervisors report having mixed feelings about the supervision checklist that ACQUIRE introduced. Some found it useful to have a record of activities that they needed to follow up on, while others found it onerous and preferred not to repeat the same activities at every visit.

### **Training of providers**

Core indicators 11 and 12 deal with training. A high percentage of interviewees received training in FP counseling and IUCD insertion. The improvement between baseline and endline was dramatic. The data do not look as solid for the other LAPM methods (18–19%); however, these methods were not provided at all facilities, so the results may not paint an accurate picture.

An additional question included only at endline asked providers if they had FP teaching aids to use during FP counseling. Almost all providers reported having used these aids.

## **IR 2.2 Improved Client-Provider Interaction**

The ACQUIRE Project placed emphasis on improving CPIs. Core indicators 16–24 report on the results of CPI-related activities (see Table 7, page 22). Several core indicators showed statistically significant improvements. Between two-thirds and three-quarter of clients indicated that they had received adequate information about the IUCD, vasectomy, and tubectomy; these were all significantly improved from baseline to endline. Clients also reported that providers discussed more methods with them during visits: 2.3, on average, compared with 1.9 at baseline. Ninety-four percent reported receiving information on sexually transmitted infections (STIs) or on HIV and AIDS, also a statistically significant improvement. In additional data collected at endline, 77% of clients reported that providers explained the physical examination before conducting it. While there was a decline in the percentage of clients who would recommend that their relatives/friends come to the health facility for FP services (from 98% at baseline to 74% at endline), client satisfaction remained over 95% at both baseline and endline.

Table 7 provides additional insights into CPI, using information collected only at endline. More than 80% of IUCD clients report being informed by their provider on when to return for follow-up, on side effects, and on warnings signs. Approximately 70% of IUCD clients reported being told by their provider how to check the string to ensure that the IUCD is in place. From CPI observations at endline, all five IUCD clients were told by the provider how to check strings, compared with half at baseline; all clients were told that they might have heavy bleeding or spotting in the time right after insertion, again compared with slightly more than half at baseline.

**Table 7. Percentage of clients report on critical information related to LAPMs that they received from provider and average number of methods discussed with the provider, by type of provider (endline only)**

Information on LAPMs and average no. of FP methods discussed	% of clients		
	UHC/MCWC	FWC	Total
<b>A. IUCD</b>	<i>n</i> =11	<i>n</i> =29	<i>N</i> =40
When to return for follow-up visit	81.8	96.6	92.5
Side effects	81.8	89.7	87.5
Warning signs requiring return to facility	81.8	82.8	82.5
Action to ensure IUCD is in place (check string)	58.8	77.4	70.8
<b>B. Implants</b>	<i>n</i> =28	<i>n</i> =4	<i>N</i> =32
When to return for follow-up visit (7 days after insertion)	10.7	0.0	9.4
Protection against pregnancy for 5 years	100.0	25.0	91.2
Side effects	60.7	25.0	56.3
Warning signs requiring return to facility	53.6	25.0	50.0
<b>C. Vasectomy</b>	<i>n</i> =37	<i>n</i> =5	<i>N</i> =42
Chance of pregnancy during first 3 months	97.3	100.0	97.6
Need for additional contraception	84.6	100.0	85.2
Warning signs requiring return to facility	61.5	0.0	59.3
Signed informed consent form	69.2	0.0	66.7
<b>D. Tubectomy</b>	<i>n</i> =50	<i>n</i> =5	<i>N</i> =55
No chance of pregnancy	94.0	60.0	90.9
Warning signs requiring return to facility	65.9	0.0	61.7
Signed informed consent form	95.5	0.0	89.4

Source: Client exit interview

For the implant, 90% of clients reported being told by their provider that the implant provides protection against pregnancy for five years. Fewer than 10% of implant clients were told when they should return for follow-up, and about 50% of clients were told about side effects and warning signs.

Among vasectomy users, at least 85% were told by providers of the chance of pregnancy within the first three months after having the procedure and about the need for additional contraception for this time period, and 60% were told about warning signs. Only two-thirds of clients reported being asked by the provider if they had signed an informed consent form. From observations of 14 vasectomy procedures at endline, all of the clients were told it is a permanent method, eight were told about slight discomfort at the site of the incision, and 12 were told to use back-up contraception, such as condoms. These results represent an improvement on the baseline observations, when fewer than half were told about incision-site discomfort and only one-quarter were told to use back-up contraception.

For tubectomy users, about 90% were told by the provider about the chance of pregnancy and were asked if they had signed an informed consent form. Approximately 60% of clients were told about warning signs that required returning to the health facility. In observations of 20 tubectomy procedures at endline, 19 clients were told that it is a permanent method and 17 were told about possible discomfort at the incision site. These results were similar to the baseline observations.

Core Indicator 23 shows that two-thirds of clients reported being satisfied with services, a result mirrored by the finding that two-thirds of facilities had a system for determining client opinion. (Both of these results showed statistically significant improvements between baseline and endline.) One area of quality that may have gotten worse is waiting times: Clients reported average waiting times of 66 minutes at endline, compared with 36 minutes at baseline. However, clients reported improvements in auditory and visual privacy during consultation, from about 40% at baseline to approximately 60% at endline. These improvements are mirrored by improvements noted during observation, although the observers reported lower levels: an improvement from 20% to 35% in visual privacy, and from 18% to 25% in auditory privacy.

The in-depth interviews provided several insights into the impact of the IR 2 activities.

*After having counseling training, now we know that we can not impose FP methods on clients; it is each client's right to chose an FP method after knowing all information regarding each method.*

—Key informant interview, DGFP

*Before having [infection prevention] training, we did not have a clear idea about proper [infection prevention] practices. Use of chlorine solution was new to me. By using a counseling kit, now I am doing counseling better than before, which has a positive effect on quality services.*

—Key informant interview, DGFP

*IUCD training curriculum [was] acknowledged by the Government as very useful to improve image of IUCD.*

—Key informant interview, ACQUIRE

*Due to quality services, the rate of FP method discontinuation reduced a lot than in past years.*

—Key informant interview, DGFP

Yet the in-depth interviews also highlighted that staff needed more support than simply training. They also needed professional recognition:

*We, as government employees, need appreciation and promotion. I am in the same position for last 18 years, job satisfaction among the FP staff is also important to improve quality of FP services.*

—Key informant interview, DGFP

*Service providers and managers do not like to stay at their working stations. They take deputation [transfer to other areas] and leave their working stations. This is a[n] old problem related to the system.*

—Key informant interview, DGFP

### IR 3: Strengthened Environment for RH/FP Service Delivery

IR 3 focuses on improving the prevailing environment for FP/RH service delivery by strengthening leadership and management and by promoting supportive policies. ACQUIRE worked with the government to revise national FP policies and manuals, which were then made available throughout the country. ACQUIRE and the DGFP also worked to strengthen systems such as monitoring and supervision. Religious leaders are important stakeholders in the FP program. ACQUIRE extensively engaged with religious and community leaders to strengthen their commitment to the government's FP/RH goals: A total of 13,477 religious leaders and 23,602 community leaders received orientations on FP.

#### List of Major Interventions

- ◆ Revise national FP service delivery guidelines
- ◆ Increase advocacy efforts with religious leaders
- ◆ Strengthen monitoring and supervision systems
- ◆ Collaborate with DGFP for research on LAPMs and MIS
- ◆ Contribute to national LAPM BCC campaign to inform community support and generate demand  
(Source: EngenderHealth Bangladesh Country Office, 2004–2008)

#### IR 3.1 Improved Leadership and Management for FP/RH Service Delivery

Table 8 presents the core indicators for IR3. For sub-IR 3.1, Core Indicator 25 shows that the percentage of facilities with formal management systems, such as regular meetings for reviewing management and administrative decisions, was high at baseline (83%) and remained high at endline (87%).

**Table 8. Core indicators for Intermediate Result (IR) 3**

Indicator	Baseline		Endline	
	N	%	N	%
<b>IR 3: Strengthened environment for RH/FP service delivery</b>				
<b>IR 3.1: Improved leadership and management for RH/FP service delivery</b>				
25. Percentage of facilities with a system for reviewing management and administrative issues	121	83	121	87
26. Percentage of facilities where service statistics are used for decision making	—	—	121	55
<b>IR 3.2: Supportive policies for RH/FP services</b>				
27. Percentage of facilities with FP manuals	121	56	121	93*
28. Percentage of facilities with infection prevention guidelines or committees	121	6	121	86*
29. Percentage of providers who provide an FP method exclusive of minimum/maximum age or number of living children				
IUCD	126	0	135	1
Implants	24	0	19	0
Vasectomy	16	0	18	0
Tubectomy	27	0	19	0
30. Percentage of providers who provide FP methods exclusive of partner consent for method				
IUCD	126	8	135	2
Implants	24	8	19	5
Vasectomy	16	6	18	0
Tubectomy	27	4	19	0
31. Percentage of clients reporting favorable attitude of religious leaders toward FP services	—	—	314	87

Note: \*Difference between baseline and endline is statistically significant at  $p < .05$  level.

Core Indicator 26 shows that at endline, more than 50% of health facilities used service statistics for decision making, a practice more common at UHCs/MCWCs. This finding reflects ACQUIRE activities to upgrade data collection and use. Workshops were conducted for more than 1,000 MIS personnel at the district or subdistrict levels. One key informant reported that “MIS workshops have been held throughout the country, leading to a better appreciation and improved availability of MIS reports.” (Key informant interview, ACQUIRE)

### **IR 3.2 Supportive Policies for RH/FP Services**

Core indicators 27–31 address the results for sub-IR3.2. There were statistically significant increases in the percentage of facilities that had FP manuals, from 56% to 93% (Core Indicator 27), and in the percentage with infection prevention guidelines or committees, from 6% to 86% (Core Indicator 28).

#### **Norms and provision of FP methods**

In Bangladesh, the national policy and provider practice may restrict access to LAPMs by couples with certain characteristics. For example, married couples with no children are given the pill or condoms, married couples with one child are given the IUCD, the pill, implants, or condoms, and only couples with two or more children are considered candidates for permanent methods (Stover et al., 2007). The ACQUIRE Project is working with the Government of Bangladesh to revise this policy such that LAPMs are accessible to more eligible couples, based on the World Health Organization (WHO) medical eligibility criteria. For example, a two-child waiver for accepting permanent methods is now being considered by the National Technical Committee.

Core indicators 29–30 provide more details on the results of this work and highlight that this is an ongoing area of concern, particularly translating government policy into revised practice at health facilities. Table 9 (see page 26) provides additional details. In accordance with prevailing national policy, both at baseline and endline, 90–100% of providers check on a client’s number of children prior to prescribing LAPMs. Even though it is not national policy (but an ingrained part of societal culture and unspoken norms), almost all providers require partner consent before LAPMs are provided (especially sterilization). Between 30% and 70% of LAPM providers use the minimum/maximum age as a criterion for the provision of LAPMs. However, for the provision of vasectomy, fewer than 40% of providers use the client’s minimum/maximum age as a criterion.

#### **Role of religious leaders**

Core Indicator 31 shows that 87% of clients that felt their religious leaders were supportive (collected only at endline). In-depth interviews highlighted the importance of the work with religious leaders and the impact that this is slowly starting to show:

*Since orientation of community leaders was not effective and some religious leaders were creating bottlenecks, a strategy to work with religious leaders was chosen.*

—Key informant interview, ACQUIRE

*Religious conservativeness decreased due to ACQUIRE activities, which certainly increased clients’ access to FP services.*

—Key informant interview, DGFP

*The DGFP and line directors are convinced about the involvement of imams and the DGFP has instructed all subdistricts to include imams in local Family Welfare Committees.*

—Key informant interview, ACQUIRE

*In all districts, ACQUIRE has created a resource pool of religious leaders sympathetic to LAPMs.*

—Key informant interview, ACQUIRE

*Advocacy meetings with social and religious leaders also contributed to increased client access to FP/RH services.*

—Key informant interview, DGFP

**Table 9. Percentage of providers reporting using selected criteria for provision of LAPMs, by type of provider**

Criteria	% of providers					
	UHC/MCWC		FWC		Total	
	Baseline n=91	Endline n=75	Baseline n=102	Endline n=138	Baseline N=193	Endline N=213
<b>A. IUCD</b>						
Minimum age	23.1	21.3	39.2	45.7	31.6	37.1
Maximum age	42.9	56.0	57.8	79.7	50.8	71.4
Minimum number of children	95.6	97.3	97.1	98.6	96.4	98.1
Partner consent	94.5	97.3	92.2	96.4	93.3	96.7
<b>B. Implant</b>						
Minimum age	24.2	24.0	40.2	47.1	32.6	39.0
Maximum age	40.7	58.7	54.9	71.7	48.2	67.1
Minimum number of children	91.2	96.0	89.2	92.0	90.2	93.4
Partner consent	93.4	96.0	91.2	90.6	92.2	92.5
<b>C. Vasectomy</b>						
Minimum age	29.7	18.7	44.1	46.4	37.3	36.6
Maximum age	25.3	22.7	37.3	44.9	31.6	37.1
Minimum number of children	96.7	98.7	99.0	96.4	97.9	97.2
Partner consent	95.6	100.0	96.1	94.2	95.9	96.2
<b>D. Tubectomy</b>						
Minimum age	41.8	24.0	53.9	50.7	48.2	41.3
Maximum age	53.8	57.3	69.6	73.9	62.2	68.1
Minimum number of children	98.9	100.0	100.0	96.4	99.5	97.7
Partner consent	97.4	100.0	99.0	94.9	98.4	96.7

Source: Provider interview

### **Other advocacy activities**

ACQUIRE worked on other policy-level activities; for example, staff served on various government boards and committees. These activities were viewed as crucial to the partnership with the government, but key informants also reported that advocacy-level interventions take time to have measurable effect. Nonetheless, respondents reported early signs of several policy changes: 1) more financial resources are being allocated to FP/RH; 2) the approval of a cluster system for providers to partially alleviate the shortage of providers; and 3) approval to conduct a pilot to address shortage of NSV and implant providers:

*At the last meeting of the National Technical Committee (on June 25, 2008), the Committee has finally decided to have a pilot for SACMOs to provide NSV and FWVs to provide implants. Since the NTC is composed of doctors and medical lecturers, this is no small achievement.*

—Key informant interview, ACQUIRE

## Conclusion and Recommendations

The ACQUIRE Project, in collaboration with the DGFP, improved the availability of LAPMs to couples in Bangladesh. Through a systems-strengthening approach, ACQUIRE also made steady improvements in the quality of LAPM services. As a result of this project, of the 21 core indicators with baseline and endline values, 18 showed statistically significant improvements. Engaging religious leaders to address religious misperceptions has been acknowledged as an important contribution to the FP program in Bangladesh. The ACQUIRE Project also contributed to improvements in MIS through training, review, compilation and dissemination of MIS reports related to LAPMs. A significant number of informational booklets, posters, and charts for clients and job aids for providers were developed, which will continue to be used after the end of project. The project also expanded FWVs' training on IUCD insertion and counseling. These successes in LAPM programming occur in parallel with efforts to improve the availability of infection prevention supplies and equipment.

The positive results are clear in other ways. The 2007 Demographic and Health Survey and the government's HMIS confirm that the decade-long decline in the use of LAPMs may have been reversed, particularly in the use of IUCDs and vasectomy. Through work with JSI/DELIVER and DGFP, the stock-outs of IUCDs and implants appear to have been overcome, at least for now. Given the country's population momentum, these gains need to be reinforced through high-quality programming to support LAPMs as a good choice for many couples, especially those who have achieved their desired family size.

ACQUIRE's close collaboration with the government has supported the inclusion of LAPMs in all of the DGFP's operational plans, including activities funded by the World Bank, a major funder of the MOHFW. Building on its historical collaboration with the MOHFW, the ACQUIRE Project is well positioned to work on a number of policy issues, such as the use of paramedics to address the shortage of providers of NSV and implants, and to partner with the MOHFW in proposing revision in policy on sterilization.

The core indicators assessed for this evaluation also highlight areas that need further focus.

### Recommendations for Increased Access to Quality Services

- ◆ While continuing to promote informed choice and voluntarism, work with providers to ensure that they offer LAPMs to couples who have reached their desired family size.
- ◆ Continue to work with FWCs on infection prevention (both knowledge of infection prevention and reliable access to needed supplies).
- ◆ Continue to work with providers to enhance their critical knowledge of LAPMs, particularly implants and tubectomy.
- ◆ Continue to develop and distribute information, education, and communications materials, making sure that such materials are available at all health facilities.



## **Recommendations for Improved Performance of Service Delivery Providers**

- ◆ Continue to train providers on LAPMs, particularly implants, vasectomy, and tubectomy.
- ◆ Work with supervisors to enhance the supply chain by establishing mechanisms for communication between supervisors and supply officers.
- ◆ Work with providers to ensure that they convey critical information to clients, both verbally and by providing brochures, particularly for implants and tubectomy.
- ◆ Develop and train providers in better client-oriented counseling techniques.
- ◆ Address patient-flow issues to reduce waiting times.

## **Recommendations for Strengthened Environment for FP/MH Service Delivery**

- ◆ Continue to encourage facilities to use MIS data to assess and enhance their efforts.
- ◆ Continue to work with the DGFP to change regulations regarding minimum/maximum requirements on number of children and on age for LAPM clients, and address informal requirements for spousal consent.

## References

- Directorate General of Family Planning (DGFP). 2005. *Health, nutrition, and population program proposal*. Dhaka: Ministry of Health and Family Welfare (MOHFW).
- DGFP. 2006a. *Bangladesh demographic data sheet*. Dhaka: DGFP, MOHFW.
- DGFP. 2006b. *Countrywide FP service outlets and institutions*. Accessed at: [www.dgfp.gov.bd/countrywide\\_Fp.htm](http://www.dgfp.gov.bd/countrywide_Fp.htm).
- EngenderHealth Bangladesh Country Office. 2004–2008. Strengthening service delivery of permanent and long term methods: Annual work plans. Dhaka.
- Goldberg, R., Durán, R., Monterrey, J., et al. 2006. Bolivia baseline survey, 2005: Technical report. *E&R Study No. 2*. New York: The ACQUIRE Project/EngenderHealth.
- Jain, A., Makawia, A., Schlecht, J., et al. 2006. Tanzania baseline survey report 2004–2005: Technical report. *E&R Study No. 4*. New York: The ACQUIRE Project/EngenderHealth.
- Mahboob-E-Alam, Searing, H., Jain, A., et al. 2006. Strengthening delivery of long-acting and permanent family planning methods in Bangladesh. Baseline Survey, 2004: Technical Report. *E&R Study No. 3*. New York: The ACQUIRE Project/EngenderHealth.
- Mahboob-E-Alam, Bradley, J., and Shabnam, F. 2007. IUD use and discontinuation in Bangladesh. *E&R Study No. 8*. New York: The ACQUIRE Project/EngenderHealth.
- Ministry of Health and Family Welfare (MOHFW). 2008. National Health Policy—Draft for Consultation. Dhaka.
- MOHFW. 2006. *Health policy of Bangladesh*. Dhaka. Accessed at: [www.mohfw.gov.bd/health\\_policy.htm](http://www.mohfw.gov.bd/health_policy.htm), Sept. 16, 2008.
- National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ORC Macro. 2008. *Bangladesh Demographic and Health Survey 2007: Preliminary Report*. Dhaka and Calverton, MD, USA: NIPORT/Ministry of Health/Government of Bangladesh and ORC Macro.
- NIPORT, Mitra and Associates, and ORC Macro. 2005. *Bangladesh Demographic and Health Survey 2004*. Dhaka and Calverton, MD, USA: NIPORT/Ministry of Health/Government of Bangladesh and ORC Macro.
- Population Reference Bureau (PRB). 2008. Datafinder (online tool). Accessed at: [www.prb.org/Datafinder/Geography/Summary.aspx?region=140&region\\_type=2](http://www.prb.org/Datafinder/Geography/Summary.aspx?region=140&region_type=2).
- Stover, C., et al. 2007. *Long-term and permanent methods of family planning in Bangladesh*. Washington, DC: Global Health Technology Assistance Project.

United Nations. 2007. *World population prospects: The 2006 revision*. New York: United Nations Department of Economic and Social Affairs. Accessed at: <http://esa.un.org/unpp>, Sept. 12, 2008.

United Nations Economic and Social Commission for Asia and Pacific (UNESCAP). 2002. *Fifth Asian and Pacific Population Conference: Bangladesh country report*. Bangkok.

World Health Organization/Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP) , INFO Project. 2007. *Family planning: A global handbook for providers*. Baltimore and Geneva: CCP and WHO.

World Health Organization (WHO) Regional Office for South-East Asia (SEARO). 2004. *Bangladesh and family planning: An overview*. New Delhi.

WHO SEARO. 2007. *Country health system profile: Bangladesh*. Dhaka. Accessed at [www.searo.who.int/en/Section313/Section1515.htm](http://www.searo.who.int/en/Section313/Section1515.htm), Sept. 16, 2008.

## Appendix I: Number and Characteristics of Providers and Clients Interviewed or Observed

**Table A1: Number of providers and clients interviewed or observed**

Description	No. of providers/clients					
	UHC/MCWC		FWC		Total	
	Baseline	Endline	Baseline	Endline	Baseline	Endline
<b>A. Provider Interviews</b>						
MO	21	18	—	—	21	18
Asst. FW Officer/FWV	70	57	58	77	128	134
SACMO	—	—	44	61	44	61
<b>Total</b>	<b>91</b>	<b>75</b>	<b>102</b>	<b>138</b>	<b>193</b>	<b>213</b>
<b>B. Client Interviews</b>						
	<b>85</b>	<b>142</b>	<b>160</b>	<b>172</b>	<b>245</b>	<b>314</b>
<b>C. Observation of CPI</b>						
MO	6	46	—	—	6	46
Asst. FW Officer/FWV	79	4	136	2	215	6
SACMO	—	—	19	—	19	—
<b>Total</b>	<b>85</b>	<b>50</b>	<b>155</b>	<b>2</b>	<b>240</b>	<b>52</b>

**Sources:** Provider interview, client exit interview, and observation of CPI.

**Table A2. Characteristics of providers and clients interviewed**

Description	% of providers/clients					
	UHC/MCWC		FWC		Total	
	Baseline	Endline	Baseline	Endline	Baseline	Endline
<b>A. Providers</b>	<i>n=91</i>	<i>n=75</i>	<i>n=102</i>	<i>n=138</i>	<i>N=193</i>	<i>N=213</i>
Women	82.4	81.3	57.8	63.0	69.4	69.5
Men	17.6	18.7	42.2	37.0	30.6	30.5
Mean no. of years of service	22.8	24.9	17.7	21.3	20.7	22.6
Median no. of years of service	26.0	28.0	18.0	21.0	21.0	24.0
<b>B. Clients</b>	<i>n=85</i>	<i>n=142</i>	<i>n=160</i>	<i>n=172</i>	<i>N=245</i>	<i>N=314</i>
Women	84.7	83.1	95.0	98.8	91.4	91.7
Men	15.3	16.9	5.0	1.2	8.6	8.3
Currently married	100.0	100.0	100.0	100.0	100.0	100.0
Mean age at last birthday	28.5	29.3	29.1	28.0	28.9	28.6
Mean no. of living children	2.6	2.8	2.7	2.3	2.7	2.6

**Sources:** Provider interview and client exit interview



## Appendix 2: Project Outputs

Indicator	Achievement
	ACQUIRE Project Period
	ACQUIRE Total
<b>FP &amp; RH SERVICES</b>	
<i>National LAPM service statistics</i>	
Tubectomy	401,419
Vasectomy	329,702
<b>Total sterilizations</b>	<b>731,121</b>
IUD	1,074,697
Implant	429,893
<i>LAPM service statistics by supported sites</i>	
Number of supported sites	6,702
Tubectomy	156,833
Vasectomy	137,961
<b>Total sterilizations</b>	<b>294,794</b>
IUD	435,585
Implant	210,429
<b>TRAININGS/ORIENTATIONS</b>	<b>82,827</b>
<b>Technical/Clinical Training</b>	<b>5,217</b>
Skills-based sterilization training program	27
Women	3
Men	24
IUD, IP, & C for FWVs (5 days)	3,533
Women	3,522
Men	11
TOT—IUD, IP, & C for physicians and trainers (5 days)	115
Women	115
Men	-
Complications management training (3 & 2 days)	133
Implant training course (5 days)	18
Women	12
Men	6
FWC intervention (2 days)	1,334
Infection prevention training (2 days)	57
Women	34
Men	23
Training on PP TL and PP IUCD (5 days)	12
Women	10
Men	2

Indicator	Achievement
	ACQUIRE Project Period
	ACQUIRE Total
<b>Program Management/Technical Assistance</b>	<b>4,382</b>
Facilitative supervision training for FP managers (5 days)	177
Women	56
Men	121
District planning meeting	1,582
District review meeting	1,396
Divisional workshop	875
Future Search Conferences	60
Facilitative supervision training for Sr. FWVs	244
Women	244
Men	—
Counseling training TOT (5 days)/orientation (2 days)	142
Women	88
Men	54
TOT course—generic (5 days)	48
Women	22
Men	26
Higher-level management meeting	52
<b>Monitoring and Evaluation/Research</b>	<b>2,344</b>
IUD discontinuation study	30
Young married couples baseline survey	22
LAPM baseline survey	—
Male-friendly assessment	2
MIS orientation	1,145
Women	153
Men	992
LAPM endline survey	—
DQA/compliance visit/orientation	465
Women	182
Men	283
Reality Check model	20
Women	9
Men	11
<b>BCC/Advocacy—Religious</b>	<b>15,137</b>
National-level FP orientation for religious leaders (1 day)	150
Divisional-level FP orientation for religious leaders (1 day)	521
District-level FP orientation for religious leaders (1 day)	3,714
FP orientation in the Local Outreach Initiative (LOI)—Upazila (1 day)	6,802
Women	155
Men	4,762
FP orientation for female religious leaders (1 day)	626
FP orientation for Qwami group religious leaders (1 day)	566

Indicator	Achievement
	ACQUIRE Project Period
	ACQUIRE Total
FP orientation in the LOI for religious leaders (1 day)	2,695
Experience-sharing/curriculum review (1 day)	63
<b>BCC/Advocacy—General</b>	<b>25,084</b>
Union advocacy meeting for community leaders (1 day)	2,810
Upazila/Zonal BCC/advocacy meeting (1 day)	19,638
Community awareness raising meeting (1 day)	1,318
Women	436
Men	882
Stakeholders' meeting	—
<b>Staff Orientation</b>	<b>17,517</b>
Upazila/zonal FP workers' orientation & planning meeting (1 day)	16,966
Orientation on RH services of young married couples (1 day)	81
Counseling training for FWAs/FPs (1 day)	155
Women	59
Men	96
MRH orientation for field staff/provider (1 day)	160
Women	115
Men	45
IP & C orientation for NGO staff	
<b>LOGISTICS INFORMATION</b>	<b>2,531,850</b>
No. of leaflets distributed	2,264,374
No. of festoons distributed	10,587
No. of Jogagog distributed	36,555
No. of signboards distributed	-
No. of IP, IUD, & C handouts (trainers) distributed	72
No. of IP, IUD, & C handouts (Participant) distributed	3,000
No. of consent forms distributed	5,784
No. of laminated clinical method cards distributed	21,892
No. of handout copies distributed	30,967
No. of circulars distributed	10,893
No. of Tiaht chart posters distributed	6,487
No. of penile models distributed	167
No. of pelvic models distributed	303
No. of counseling kit boxes distributed	2,835
No. of book ( <i>FP in the Light of Islam</i> ) distributed	30,056
No. of folders ( <i>FP in the Light of Islam</i> ) distributed	2,479
No. of notepads ( <i>FP in the Light of Islam</i> ) distributed	4,567
No. of festoons ( <i>FP in the light of Islam</i> ) distributed	640
No. of FP booklets ( <i>FP in the Light of Islam—English version</i> ) distributed	86
No. of FS reporting books distributed	104
No. of NSV campaign posters distributed	100,000
No. of NSV TV commercial spots (30 seconds)	2