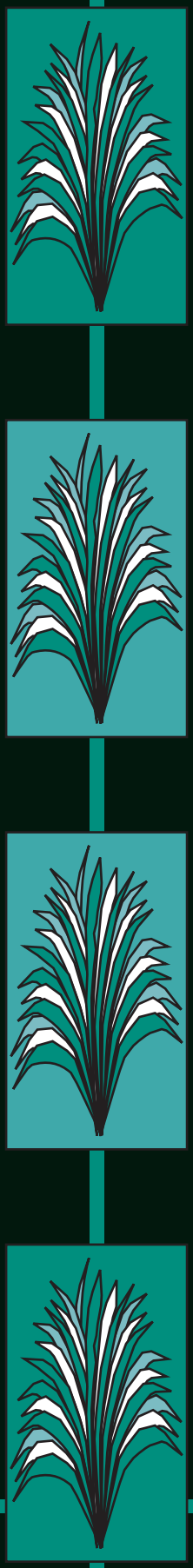

ACQUIRE Evaluation and Research Studies

Strengthening Delivery of Long-Acting and Permanent Family Planning Methods in Bangladesh

Baseline Survey, 2004: Technical Report

E & R Study #3 ◆ April 2006

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ACQUIRE Evaluation and Research Studies

Strengthening Delivery of Long-Acting and Permanent Family Planning Methods in Bangladesh
Baseline Survey, 2004: Technical Report

E & R Study #3 ♦ April 2006

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The authors also acknowledge Dr. Bates Buckner and the Carolina Population Center of MEASURE *Evaluation* for their project collaboration. MEASURE provided the tools and methodology and advice on data collection and analysis. Additionally, this survey report draws heavily on two MEASURE Evaluation publications:

- MEASURE Evaluation. 2002. AMKENI Project: 2001 baseline facility survey: Summary tables and main findings. Chapel Hill, NC: Carolina Population Center. Draft.
- MEASURE Evaluation. 2004. Facility audit of service quality (FASQ): A rapid M&E survey tool. A report of a field test in 6 districts, Coast and Western Provinces, Kenya. Draft.

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This report was edited by Donna Grosso and was formatted by Elkin Konuk; Michael Klitsch managed editorial and production work.

Map of Bangladesh

Acronyms

ACQUIRE	Access, Quality, and Use in Reproductive Health
ADRA	Adventist Development and Relief Agency International
AMKENI	USAID bilateral project in Kenya, led by EngenderHealth
CARE	Cooperative for Assistance and Relief Everywhere
CPI	client-provider interaction
DGFP	Directorate General of Family Planning
E&R	evaluation and research
FP	family planning
FWA	family welfare assistant
FWC	family welfare center
FWV	family welfare visitor
IP	infection prevention
IR	intermediate result
IUD	intrauterine device
LAPM	long-acting and permanent methods
MCWC	mother and child welfare center
MO	medical officer
NSV	no-scalpel vasectomy
SACMO	subassistant community medical officer
UHC	upazila health complex
USAID	U.S. Agency for International Development

Executive Summary

The ACQUIRE Project—which stands for Access, Quality, and Use in Reproductive Health—is a global project funded by the U.S. Agency for International Development (USAID) that works worldwide to advance and support reproductive health and family planning (FP) services, with a focus on facility-based and clinical care. EngenderHealth is the managing partner of ACQUIRE overall[1] and has been working in Bangladesh through the ACQUIRE Project since October 2003 with USAID field and core support to increase access, improve provider performance, and strengthen the environment for FP services.

In Bangladesh, ACQUIRE supports the Directorate General of Family Planning (DGFP) within the Ministry of Health and Family Welfare by strengthening public-sector capacity to manage and deliver quality FP services through interventions in training, supervision, and quality improvement; by coordinating supplies and logistics systems; and by conducting community-based efforts to increase and link demand to service sites. No ACQUIRE or previous EngenderHealth interventions were conducted prior to the survey in any of the facilities described in this report. Because of a sustained and substantial field support commitment from USAID, Bangladesh is a focus country for ACQUIRE.[2] Focus countries are linchpins of New York and field collaboration, in which ACQUIRE develops strategic, data-driven workplans and performance management plans that include targeted evaluations of ACQUIRE global strategies and outcomes and quality monitoring systems.

ACQUIRE conducted this survey from April to July 2004. The baseline data provide a primarily quantitative assessment of the status of FP service delivery in 2004. With continued support from USAID for interventions to achieve project goals, ACQUIRE will conduct an endline survey in 2008 to assess project outcomes.

The ACQUIRE program in Bangladesh is national in scope, with focused, comprehensive interventions in four districts. ACQUIRE will use the baseline data to determine program outcomes of ACQUIRE interventions in the four baseline districts by repeating the survey in 2008 at the same facilities. With this strategy, ACQUIRE and the DGFP expect to advance access and use of long-acting and permanent methods (LAPMs) nationally, while demonstrating the added value of the focused comprehensive approach in four districts. In particular, data from baseline and endline surveys will address the following questions:

1. Are the service providers performing to standard? If below or above, then to what extent?
2. Do facilities have the infrastructure and supplies to provide a full range[3] of FP services?
3. How and to what extent have project interventions supported by ACQUIRE affected:
   a. Quality of services, including client satisfaction?
   b. Availability of services?
   c. Use of services?[4]

---

[1] EngenderHealth manages ACQUIRE in partnership with the Adventist Development and Relief Agency International (ADRA), CARE, IntraHealth International, Inc., Meridian Group International, Inc., SATELLIFE, and the Society for Women and AIDS in Africa (SWAA).

[2] Other focus countries are Bolivia and Tanzania.

[3] A full range is defined as the provision of at least four family planning methods.

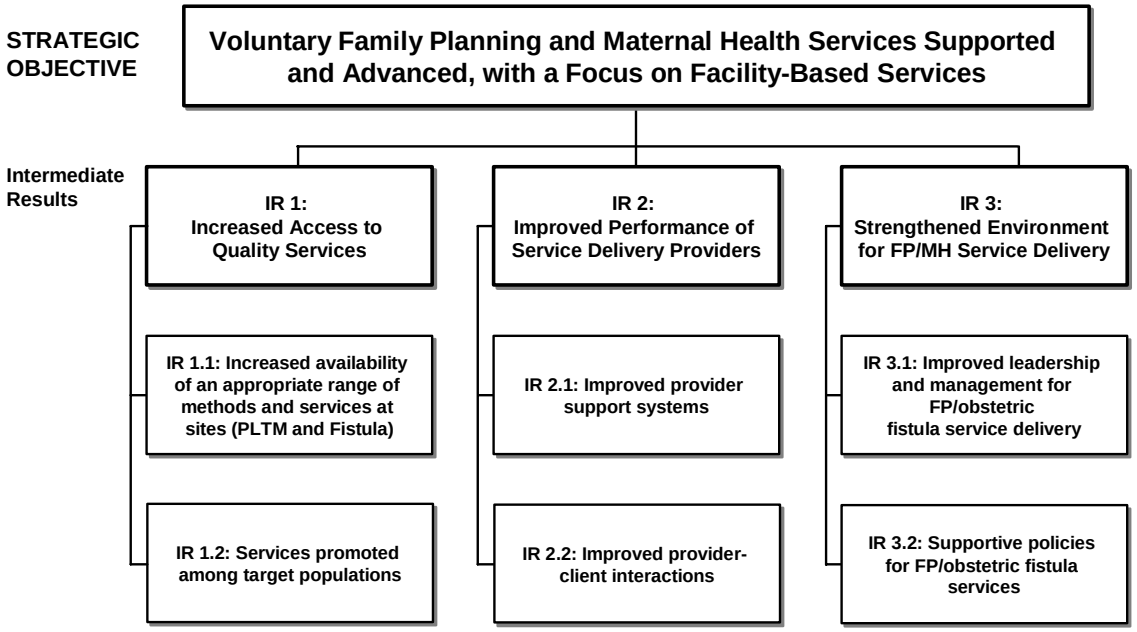
[4] ACQUIRE regularly collects and reports service statistics from the national Management Information System (MIS); these data will be analyzed and used to supplement survey data related to use in 2008.

This baseline is part of an ongoing process for the ACQUIRE Project to support program planning and implementation. Additional qualitative assessments have been undertaken to address major challenges in the baseline and to provide further guidance on the design of interventions. Those other assessments are not reported here but will be incorporated into an end-of-project report along with the endline survey. For example, the preliminary findings were used in October 2004 in discussion with DGFP stakeholders during a performance needs assessment to help determine the direction of the Long-Acting and Permanent Family Planning program for Bangladesh, emphasizing three fundamentals of care: informed choice and decision making, safety in medical procedures, and quality assurance and management. Data were also used to inform a separate performance needs assessment on supervision in 2005, and a training review was conducted in 2005. Key findings from the baseline survey were presented at a national contraceptive seminar in Dhaka in May 2005 that included service providers and high-level policymakers and personnel of DGFP. Copies of the final report will be distributed to all facilities that participated in the survey. ACQUIRE also uses the data to develop program plans for the project period (2003–2008).

The four tools used in this survey include a facility audit, a client-provider observation, a client exit interview, and a provider interview. The sample is purposive and includes 121 facilities in four districts. Site selection was based on levels of contraceptive use and logistics. Within the four districts, there are 29 subdistricts (upazilas). Within these 29 subdistricts, facilities were purposively chosen and divided into two categories—comprehensive and noncomprehensive. At the comprehensive sites, a full set of tools was implemented. In the noncomprehensive sites, only the facility audit was used.

To better meet ACQUIRE's needs for program design and monitoring, key findings in this report are summarized by the ACQUIRE/Bangladesh results framework shown in Figure 1, rather than by survey question.

Figure 1: ACQUIRE/Bangladesh Results Framework



Throughout the report, where relevant, data are presented by facility type, provider category, and client status (new and continuing). The data below provide an overarching perspective, with a summary of key variables by ACQUIRE/Bangladesh intermediate result (IR). The body of the report contains tables of data and discussion, also by result. There are three types of public-sector facilities in Bangladesh: maternal and child welfare centers (MCWCs), upazila health complexes (UHCs), and family welfare centers (FWCs). The MCWC and UHC facilities both provide maternal and child health services and short-term methods and LAPMs.[5]

Major programmatic recommendations include:

- **Emphasize training family welfare visitors (FWVs) in counseling and intrauterine device (IUD) service provision.** FWVs have received less training than other cadres, yet they are an important source of access to FP services. According to national standards, FWVs can provide IUDs, but the majority are neither trained nor equipped to do so. Only 2.3% of all FWVs are trained in IUD insertion and removal services, with just 9.4% trained in FP counseling techniques and 8.6% trained in infection prevention (IP) measures. This cadre of worker misses many opportunities to reach clients who have an unmet need for FP information and services and whose access to services is often limited. The DGFP and partners should make a plan to train FWVs according to the national standards.
- **Support improved access to minilaparotomy at UHC/MCWC facilities.** UHC/MCWC facilities lack the equipment to provide minilaparotomy services for women. The DGFP and partners should provide minilaparotomy kits to UHC/MCWC facilities and incorporate the equipment needs for LAPMs in the procurement procedures and supply chain.
- **Improve compliance with national Family Planning Guidelines.** About three-quarters of UHC/MCWC and about one-half of FWC facilities have a copy of the written national Family Planning Guidelines. Providers need refresher training and/or visits from supervisors in which the DGFP national FP norms and standards are reviewed. Fewer than half of service providers told new injectable and pill clients about initial side effects that may occur and what to do if a client forgets to take the pill or does not get the injection on time.
- **Reduce medical barriers to access to LAPMs.** Although national standards state that no written spousal consent is needed for providing FP methods, providers almost always reported that they require partner consent for method provision, regardless of method type. About 90% to 95% of medical officers (MOs) at UHC/MCWC facilities stated that they require partner consent before providing Norplant implant, IUD, and female and male sterilization services. The DGFP and partners should review these standards with providers and supervisors to reduce this barrier to FP access.
- **Address infrastructural deficiencies to support improved quality of services.** Basic infrastructural deficiencies—such as the lack of piped water and telephones at FWCs for communications and emergencies—hamper the national program's efforts to expand access to quality reproductive health services. The DGFP and its development partners should address these basic structural needs as soon as possible.
- **Allocate resources to support improved IP practices.** UHC/MCWC and FWC facilities are underequipped in the materials needed for IP, such as puncture-resistant containers for sharps, other waste and chloride containers, and facilities for simple waste management. The DGFP and partners should allocate resources for IP supplies for all facilities, and include supplies in the procurement and supply chain.

[5] Short-term family planning methods include the pill, condoms, and injectables. Long-acting and permanent methods include the Norplant implant, the intrauterine device (IUD), and male and female sterilization services.

- **Use problem-solving techniques to address persistent challenges to quality services.** FWC facilities are better able to provide privacy for client counseling and examinations. Using problem-solving techniques such as COPE®, UHC/MCWC sites should find ways to improve client confidentiality and services.
- **Strengthen links between communities and service sites to improve access, quality, and utilization.** While the majority of UHC/MCWC and FWC facilities have a formal system for reviewing management and administrative issues, only a third have a system for determining client opinion about the health facilities or services. Only a quarter have functioning family welfare committees where communities can interact with the health care system. The DGFP and partners should expand community mobilization and participation in health services to better serve their clients.

Summary of Results

IR 1: Increased Access to Quality Services

IR1 is focused on expanding the delivery of quality LAPM services within the context of informed choice in an integrated setting.

Infrastructure

Basic infrastructure was more often in place at UHC/MCWC than at FWC facilities on the day of the survey. All UHC/MCWC facilities had working electricity, compared with 40% of FWC facilities. On-site telephones were present and working at about one of every two UHC/MCWC facilities, but very rarely at FWC facilities. The majority of UHC/MCWC facilities had piped water, compared with about one-third of FWC facilities. Conversely, private counseling and examination rooms were more frequently available at FWC than at UHC/MCWC facilities: Approximately 60% of FWC facilities had a separate room with a door or curtained area for counseling, compared with fewer than one-third of UHC/MCWC facilities.

Supplies and equipment

Supplies and equipment were available universally for short-term methods, including condoms, the pill, and injectables, irrespective of location and facility type. IUD supplies and insertion kits were available at 89–92% of total sites. Other LAPMs, including the Norplant implant and sterilization, were only available at UHC/MCWC facilities, according to national protocols. Norplant implants and no-scalpel vasectomy (NSV) kits for male sterilization were available at 60–70% of UHC/MCWC sites. Fewer than a quarter of sites had working minilaparotomy kits for female sterilization.

Trained service providers

The majority of all facilities have the recommended numbers of service providers outlined in the national standards and protocols. On average, one MO and three to four FWVs and senior FWVs were posted at UHC/MCWC facilities; at FWCs, one subassistant community medical officer and one FWV were posted. Training is focused on higher-level providers. MOs at the UHC/MCWC facilities received more training than FWVs at both facility types. MOs most often reported having been trained in tubectomy (43%), followed by Norplant implant insertion and removal, NSV, and IP (all at 38%). FWVs received the least training, particularly in IUD insertion and removal, which they are required to provide according to national standards and protocols. Of the FWVs posted at UHC/MCWC facilities, only 3% reported training in IUD insertion and removal, 6% reported training in FP counseling, and 10% reported training in IP.

Outreach

FP outreach, defined as regular staff visits within the community to deliver services, is more prevalent from FWC than from UHC/MCWC facilities: Ninety-six percent of FWC and 69% of UHC/MCWC facilities reported having an outreach program. Of the total facilities with an outreach program, 90–100% reported providing short-term methods (condoms, the pill, and injectables). A higher proportion of FWC outreach programs reported referring clients for IUD, Norplant implant, and tubectomy services compared with the UHC/MCWC programs. Conversely, a slightly higher percentage of UHC/MCWC programs reported referring clients for NSV services.

Infection prevention

A greater proportion of UHC/MCWC than FWC facilities consistently reported having better IP measures. Slightly more than 20% of FWC facilities had a puncture-resistant container for sharps; 4.3% had leakproof, lidded waste containers; and only 6.5% had a plastic bucket with a lid for chlorine solution. Just over half of FWC facilities burn their contaminated syringes and bandages in an incinerator. FWV facilities were consistently found to be ill equipped for service provision based on IP findings, while UHC/MCWC facilities were slightly better but did not meet the minimum requirements of IP.

IR 2: Improved Performance of Service-Delivery Providers

This result is focused on improving the performance of service providers by upgrading their knowledge and skills and increasing their motivation to provide quality care.

Clinical observation

During client-provider observations, service providers were judged based on their adherence to key steps by method, as outlined in the DGFP national FP norms and standards. Fewer than half of providers told new injectable and pill clients about initial side effects that may occur, such as nausea, weight gain, or breast tenderness (47.4%), or about what to do if the client forgets to take the pill or does not get the injection on time (43.9%). For injectable clients at both facility types, the majority of providers cleaned the injection site appropriately, while fewer allowed the dose to self-disperse or reconfirmed the method choice for returning clients. Clinical skills are meeting the needs of clients only a little less than half the time.

Client counseling

Comprehensive counseling for new clients includes discussing medical history, current parity, fertility preferences, and method preference; it also addresses FP concerns, method use, warning signs, and side effects. Client-provider observations of new clients at both facility types showed that about 90% of providers asked clients about parity and method preference; fewer than 50% asked about clients' desire to have more children; and about one-third asked about desired timing of next birth or addressed clients' concerns about an FP method. Clients are not getting the information they need, especially in the areas of health or side effect concerns that may affect continuation rates.

Client satisfaction

At both facility types, almost three-quarters of total clients reported that the waiting time was reasonable, and the majority expressed satisfaction with the given services. The majority of all clients (98–100%) reported that they would encourage others to come to the facility for FP services. At both facility types, the majority of new clients perceived that the information they discussed during their visit would be kept confidential. A smaller proportion (39–42%) reported that their privacy was ensured during the discussion. Few differences were reported among continuing clients. Clients are very satisfied with services, although more work is needed to ensure verbal privacy at all facilities.

Method switching

The vast majority of short-term method users switched to another short-term method rather than to an LAPM. Forty-four percent of condom users switched to injectables, 39% to the pill, 7% to NSV, and 5% to either the IUD or tubectomy. Sixty-eight percent of pill users switched to injectables, 16% to condoms, 8% to NSV, 4% to tubectomy, about 3% to the IUD, and less than 1% to the Norplant implant. Forty percent of injectable users switched to the pill, 33% to condoms, 13% to tubectomy, 10% to NSV, and 3% to either the IUD or the Norplant implant.

IR 3: Strengthened Environment for Family Planning and Maternal Health Service Delivery

This result is focused on developing strong leadership and management systems to support service-delivery providers, directly contributing to the sustainability of LAPM programs.

Community mobilization

The majority of both facility types had a system for reviewing management and administrative issues; a much smaller proportion of facilities had a system for community and client involvement. Thirty-one percent of UHC/MCWC facilities had a system for determining client opinion about the health facilities or services, and 28% had functioning Family Welfare Committees. About one-third (32.2%) of FWC facilities had a system for determining client opinion about the health facility, and about one-fifth (23.3%) had functioning Family Welfare Committees. Client input into health service delivery for their community is a weak component in Bangladesh that could benefit from investments in community participation.

National standards and protocols

Facilities were more likely to keep inventory records than to have a copy of the national Family Planning Guidelines. Only half of the FWCs had guidelines on hand, compared with three-quarters of the UHC/MCWC facilities. The majority of UHC/MCWC facilities (86.2%) and FWC facilities (93.5%) kept inventory records for drugs and supplies. The logistics and procurement system benefits from good record keeping. Any improvements in the system will certainly be easier to implement due to access to data. However, the use of standards and guidelines will need to be improved, starting with a new round of dissemination, orientation, and use by supervisors and sites.

Barriers to services

Service providers almost always reported that they require partner consent for method provision, regardless of method type. About 90–95% of MOs at UHC/MCWC facilities stated that they require partner consent before providing Norplant implant, IUD, and female and male sterilization services. Requiring spousal consent is not in compliance with national standards; as noted above, orientation to the standards and implementation by supervisors is a high priority to reduce barriers to service.

Introduction

The ACQUIRE Project[6]—which stands for Access, Quality, and Use in Reproductive Health—is a global project funded by the U.S. Agency for International Development (USAID) that works worldwide to advance and support reproductive health and family planning (FP) services, with a focus on facility-based and clinical care. The ACQUIRE Project in Bangladesh is led by EngenderHealth. The ACQUIRE/Bangladesh portfolio builds on previous EngenderHealth work to strengthen clinical FP methods with a focus on sterilization, in close collaboration with the Directorate General of Family Planning (DGFP) and the Directorate General of Health Services within the Government of Bangladesh's Ministry of Health and Family Welfare.

In October 2003, USAID/Washington awarded ACQUIRE to EngenderHealth and its partners. In that same year, USAID/Bangladesh provided field support funds to ACQUIRE in Bangladesh to strengthen the public sector's capacity to manage and deliver quality services through interventions in training, supervision, and quality improvement; in coordinating supplies and logistic systems; and in conducting community-based efforts to increase and link demand to service sites. In 2004–2005, USAID/Bangladesh provided funding for a major scale-up of activities and services, necessitating this baseline survey.

Bangladesh, with an estimated population of 140 million and a per capita income of U.S. $441, has the highest population density in the world (834 people per km^2). According to the Population Reference Bureau, Bangladesh's population could exceed 250 million by 2050.[7] Over the last two decades, Bangladesh has undergone a remarkable demographic transition. The total fertility rate declined to 3.0 from 6.3 in the early 1970s. Some 58.1% of currently married women are using a contraceptive method, with 10.8% using traditional methods and 47.3% using modern methods. The pill continues to be the most popular FP method, with 26.2% of all currently married women choosing this contraceptive. Other commonly used methods are injectables (9.7%) and female sterilization (5.2%). More than 11.3% of married women have an unmet need for FP services in Bangladesh—5.1% for spacing births and 6.3% for limiting births.[8]

The public sector remains the primary source of FP methods. Fifty-seven percent of current users of modern methods obtain their methods from a public-sector source. Two major health units operate in parallel under the auspices of the Ministry of Health and Family Welfare in Bangladesh. The Directorate General of Health Services advises and supports the medical college hospitals, district hospitals, and upazila health complexes (UHCs) at the subdistrict level. The DGFP oversees the operations of the district-level maternal and child welfare centers (MCWCs) and smaller facilities called family welfare centers (FWCs). The MCWC and UHC facilities both provide maternal and child health services and offer short-term FP methods and long-acting and permanent methods

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[6] EngenderHealth manages ACQUIRE in partnership with the Adventist Development and Relief Agency International (ADRA), CARE, IntraHealth International, Inc., Meridian Group International, Inc., SATELLIFE, and the Society for Women and AIDS in Africa (SWAA).

[7] United Nations. 2006. *World population prospects: The 2004 revision.* Population database. New York: Department of Economic and Social Affairs. Accessed at http://esa.un.org/unpp/.

[8] Bangladesh Bureau of Statistics (BBS). 2003. *Population census 2001 national report (provisional).* Dhaka: BBS, Planning Division, Ministry of Planning, July; National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ORC Macro. 2005. *Bangladesh Demographic and Health Survey 2004.* Dhaka, Bangladesh, and Calverton, MD.

(LAPMs), while the FWC facilities provide only short-term methods and the intrauterine device (IUD).[9]

There are also three types of FP providers. The first is the medical officer (MO), a physician who graduated from a recognized medical college. The second is the subassistant community medical officer (SACMO), a paramedic who completed a three-year course on general health care and a one-year internship at a government training institute. The third is the family welfare visitor (FWV), a female health service provider who completed at least 10 to 12 years of schooling and 18 months of basic training in FP services.

The MCWC is situated at the district level and employs one physician and 10–12 service providers. The UHC at the upazila level is staffed by one MO who manages 7–8 providers, including FP staff. The FWC is located at the union level and provides maternal and child health and short-term FP methods and IUD services. Each FWC has at least one FWV, one SACMO, and four to nine family welfare assistants (FWAs), depending on the size of the union in each center.

ACQUIRE conducted this survey from April to July 2004 in Bangladesh to gather baseline data as part of its support to the DGFP within the Ministry of Health and Family Welfare in delivering facility-based quality FP services in the public sector to the population of Bangladesh. ACQUIRE will repeat this survey at the same facilities in 2008 to determine programmatic outcomes in the four selected districts. The surveys will address the following questions:

1. Are the providers performing to standard? If below or above, then to what extent?
2. Do facilities have the infrastructure and supplies to provide a full range[10] of FP services?
3. How and to what extent have project interventions supported by ACQUIRE affected:
   a. Quality of services, including client satisfaction?
   b. Availability of services?
   c. Use of services[11]

Key findings are summarized by the ACQUIRE/Bangladesh results framework[12] throughout the report, to aid in program design and planning. Where relevant, data are presented by facility type, provider category, and client status (new and continuing). The ACQUIRE/Bangladesh results are:

1. Increased access to quality services
2. Improved performance of service-delivery providers
3. Strengthened environment for FP and maternal health service delivery

[9] Short-term services include the pill, condoms, and injectables. Long-acting and permanent methods include the Norplant implant, the IUD, and male and female sterilization services.

[10] A full range is defined as the provision of at least four family planning methods.

[11] ACQUIRE regularly collects and reports service statistics from the National Health Management Information System (NHMIS); these data will be analyzed and used to supplement survey data related to use in 2008.

[12] The results framework is an evaluation model based on USAID performance management concepts. ACQUIRE/Bangladesh presents two types of results in its framework—a strategic objective and intermediate results (IR). This model, crucial to programmatic organization, management, and monitoring, will be used by ACQUIRE during the project period (October 2003 to September 2008). Each result has indicators attached to it to demonstrate its achievement.

Methodology

Data Collection Tools

MEASURE Evaluation originally developed the data collection tools and methodology used in this survey for the AMKENI Project, a bilateral USAID project led by EngenderHealth in Kenya. The MEASURE pilot tested these tools for AMKENI in 2002. The tools are based on MEASURE Evaluation's Services Provision Assessment and Quick Investigation of Quality Tools. The four tools used in this survey include:

- Facility audit
- Client-provider observation
- Client exit interview
- Provider interview

Sampling

Districts were purposively selected. During the first phase of selection, to ensure homogeneity, districts were excluded if the capital city or divisional headquarters were located in the district. Districts were also excluded if they previously received any support from EngenderHealth.

During the second phase of selection, districts were purposively selected from the remaining list of districts based on service performance level and intervention schedules.

- Service performance level was judged by service statistics from October 2000 to September 2001 for tubectomy, vasectomy, IUD, and Norplant implant clients
- The intervention schedules were:
  - Group 1: scheduled to receive ACQUIRE interventions from April to June 2004
  - Group 2: scheduled to receive ACQUIRE interventions from July 2004 to June 2005

Based on these criteria, four districts were purposively chosen, as shown in Table 1. All 29 subdistricts (upazilas) were included within the four districts.

Table 1. Sample districts

District	Performance level		Intervention schedule	
	Low	High	Group 1	Group 2
Chandpur		✔	✔	
Dinajpur		✔		✔
Chapai Nawabgonj	✔		✔	
Rajbari	✔			✔

Within the 29 upazilas, 121 facilities were purposively chosen and divided into two categories—comprehensive and noncomprehensive. (These categories are named for the tools that ACQUIRE implemented at the sites, not for the range of services provided there.) At the comprehensive sites, a full set of tools, including the facility audit, client-provider observation, client exit interview, and provider interview, was implemented. At the noncomprehensive sites, only the facility audit was used.

The comprehensive sites included all UHCs and MCWCs.[13] Of the total FWCs within each upazila, 40% were chosen purposively based on logistical variables (e.g., road conditions to the site and availability of service providers at the site). Of this 40%, two were identified as comprehensive sites and the remaining were noncomprehensive sites.[14] Table 2 shows the distribution of facilities by district. (A complete list of facility names by upazila is presented in Appendix 1.)

Table 2. Number of upazilas and facilities

District	Upazila	Facility		
		UHC/MCWC	FWC	Total
Chandpur	7	7	27	34
Dinajpur	13	13	38	51
Chapai Nawabgonj	5	5	12	17
Rajbari	4	4	15	19
Total	**29**	**29**	**92**	**121**

Interviewer Selection and Training

The survey employed six teams, with 3–4 persons per team. Each team included at least one general data collector, a physician, and a field supervisor. In total, there were 18 general data collectors, six physicians, and six supervisors, all of whom were selected based on educational qualifications, relevant experience, willingness to work in hardship areas, and sex. The team attended a one-week data collection training workshop in Dhaka. The training, led by ACQUIRE/Bangladesh, was conducted in Bangla. Each team leader was provided a training guide for each instrument. The questionnaires were translated into Bangla and back-translated into English for accuracy.

Pretesting and Fieldwork

The entire data collection team pilot tested all four instruments for four days following the training and then returned to Dhaka to discuss the results, solve problems, clarify terms and procedures, and make necessary adjustments to the tools. Data collection began immediately following the training in Dhaka in four districts from April 23 to July 7, 2004. Data collection was intermittent, as the teams had to return to Dhaka and then go back out again several times due to competing project priorities and political unrest.

Upon arriving at the facility, the field supervisor conducted the facility audit. During this time, the physician observed a client-provider session. Directly afterward, the interviewer conducted the client exit interview and the physician interviewed the service provider. To reduce nonresponse and reporting biases, interviews were conducted in the service-provision area when no other staff or clients were present. In an effort to maintain confidentiality during the interview, if the service-provision area was unavailable or other staff were in the service-provision area, the interviewer selected another area within the facility (or directly outside the facility) where no one could hear the interview being conducted.

At the comprehensive sites, each team used quota sampling to identify at least three clients to interview (new clients were preferred), and all providers were interviewed. At the UHCs and MCWCs, the service providers included one MO, two FWVs, and one senior FWV. At the FWCs,

[13] There is one UHC per upazila except in Sadar Upazilas, where the MCWC replaces the UHC.
[14] All FWCs in an upazila were included if that upazila had two or fewer facilities.

the providers included one FWV and one SACMO. During the time when the teams were interviewing and observing clients and providers, the field supervisor completed the facility audit and traveled to the nearest noncomprehensive site to conduct one facility audit. The teams stayed at the comprehensive sites for one day and returned to the sites when the required numbers of clients were unavailable during the first day.

Throughout the exercise, "new" and "continuing" FP users were defined as follows:[15]

- A new client was a client who was visiting the facility for the following reasons:
  - To receive, to get a prescription for, or to get a referral for a contraceptive method for the first time ever
  - To switch contraceptive methods (after any length of time)
- A continuing client was a client who had used the facility before and was visiting for the following reasons:
  - To get supplies or have a routine follow-up for a method she or he was already using
  - To discuss a problem with a method she or he was currently using

Data Collection/Interview Status

All data were collected using structured methods and closed-ended questionnaires. Facility audits were completed in each of the 121 facilities. Client-provider interactions (CPIs) were observed for 240 FP clients at 85 facilities. Exit interviews were obtained from 245 FP clients at 85 facilities. Interviews were obtained from 193 service providers at 86 facilities.

Each data collection team included at least one general data collector, a physician, and a field supervisor. Upon arrival at the facility, the field supervisor conducted the facility audit. During this time, the physician observed the client-provider session. Directly following, the interviewer conducted the client exit interview and the physician interviewed the service provider.

Informed consent was obtained from clients and service providers prior to interviews. Consent was carefully documented and stored. To reduce nonresponse and reporting biases, team members conducted interviews in the service-provision area when no other staff or clients were present. To maintain confidentiality during the interview, if the service-provision area was unavailable and other staff were in the service-provision area, the interviewer selected another area within the facility (or directly outside the facility) where no one could hear the interview being conducted.

Facility Questionnaire

Table 3 (page 6) shows that field supervisors interviewed 121 administrators using the facility audit tool, which contained questions related to topics such as general infrastructure, personnel, and supplies and equipment. Nearly half of the facility audits were conducted in Dinajpur because of its larger size relative to the other three districts. The majority of facilities are FWCs, because each upazila has only one UHC but multiple FWCs. In Sadar upazilas,[16] the MCWC replaces the UHC. Therefore, the principal comparisons are between the FWCs and UHC/MCWCs.

[15] This definition was taken directly from: MEASURE Evaluation. 2001. Quick investigation of quality (QIQ): A user's guide for monitoring quality of care in family planning. MEASURE *Evaluation* Manual, Series No. 2. Carolina Population Center: Chapel Hill, NC, pp. 102–103.

[16] There is one Sadar Upazila per district.

Table 3. Number of facility audits conducted, by district and type of facility

District	UHC/ MCWC	FWC	Total
Chandpur	7	27	34
Dinajpur	13	38	51
Chapai Nawabgonj	5	12	17
Rajbari	4	15	19
Total	**29**	**92**	**121**

Data source: Facility audit

Client-Provider Observation

Table 4 shows that physicians observed 240 CPIs using an observation tool. The physician observer sat behind the client and avoided eye contact with the provider, with strict instructions not to intervene in the session or provide any "expert" opinions or advice. Observers collected data on client counseling, clinical procedures, and client FP status for 240 CPIs. New clients were defined as those who had never used FP or who were switching methods on the day of the survey. Continuing clients were defined as those who came to the facilities to get supplies, to have a routine follow-up visit, or to discuss a problem about their current method.[17] There were 240 clients—181 new and 59 continuing.

Table 4. Number of service providers and clients observed, by characteristic

Characteristic	UHC/ MCWC	FWC	Total
Service provider			
MO	6	NA	6
Senior FWV/FWV	79	136	215
SACMO	NA	19	19
Total	**85**	**155**	**240**
Client			
New	75	106	181
Continuing	10	49	59
Total	**85**	**155**	**240**

Data source: Observation of client consultation

Client Exit Interview

Table 5 shows that interviewers conducted 245 client interviews[18] using a questionnaire that gathered information about client demographics, FP use and referrals, and client satisfaction. Although the client interviews were not linked to the client observations, the majority were the same clients who were observed. Among these 245 clients, 224 were female and 21 were male.

Table 5. Number of client interviews, by characteristic

Characteristic	UHC/ MCWC	FWC	Total
Client			
New	66	116	182
Continuing	19	44	63
Total	**85**	**160**	**245**

Data source: Client exit interview

[17] Observers were unable to discern whether six clients were new or continuing from observations alone. Analysts were unable to make this distinction from the data, because the observations were not directly linked to the client exit interviews. These six clients were removed from the sample.

[18] Analysts found two interviews with inconsistent data that could not be validated. These two clients were removed from the sample.

Provider Interview

Physicians interviewed 193 service providers[19] on questions related to their demographics, training, service provision, attitudes toward method provision, and clinical practices (Table 6). In total, 91 providers were from UHCs or MCWCs, and 102 were from FWCs. The majority of service providers at the UHC/MCWC facilities were FWVs.

Table 6. Number of service providers interviewed, by characteristic

Characteristic	UHC/ MCWC	FWC	Total
Number of service providers			
MO	21	—	21
Senior FWV/FWV	70	58	128
SACMO	—	44	44
Total	**91**	**102**	**193**

Data source: Service provider interview

Limitations of Baseline Exercise

Because the survey sample was restricted to the four districts, was purposive, and used quota sampling, the results from this data collection exercise may not be representative of all health facilities in all ACQUIRE-supported districts. In addition, data may be skewed: Dinajpur and Chandpur—the two "high-functioning" districts—together account for 70% of the assessed sites, and it is likely that those FWCs chosen for audit in the high-performing districts are also "higher" performing than average, since a major selection factor was their accessibility by road.

The data collection methods were subject to response and recall biases. Self-reported data may reflect the perceived desirability of responses rather than actual knowledge or practices, leading to the potential for response bias. Responses to questions related to events in the past (e.g., training events attended) were subject to recall bias.

The survey lacks control districts due to funding constraints and because all districts are scheduled to receive some type of ACQUIRE support before the end of 2008. Therefore, we chose to use the method described above, whereby facilities will receive interventions at different points in time. In this way, we will replace a case-control analysis with a dose-response analysis at the endline.

The survey did not include the recording of personal identification numbers of interviewed clients, preventing researchers from linking the clients to the observations. In most cases, the data collectors observed and interviewed clients on the same day. Therefore, there was some difficulty in distinguishing between new and continuing clients at the beginning of the provider observation sessions. This became an issue because some sections of the questionnaire were specifically geared toward new clients and did not apply to continuing clients. As the observer was not allowed to intervene in the CPI, she or he was unable to always know the nuances of the client's past FP use, which was crucial to the new client definition. As a result, during analysis, researchers made some judgment calls in data cleaning in cases in which the distinction between new and continuing clients was unclear.

The data collection process took longer than expected because of the need to revisit comprehensive facilities several times, due to a lack of new clients at the centers. In addition, political unrest

[19] Analysts found seven interviews with inconsistent data that could not be validated. These seven providers were removed from the sample.

interrupted data collection by restricting the movements of the data collection teams. Finally, the need to involve physicians in the client-provider observations slowed the data collection process, as their busy schedules sometimes restricted their ability to participate.

The sampling procedure employed purposive quota sampling, requiring a selected number of facilities per upazila and the interviewing of three clients per site. As a result, the sample has a greater proportion of pill, condom, and injectable acceptors and has extremely small numbers (fewer than 30) of Norplant implant, IUD, and sterilization acceptors. This client turnout rate limited our analysis by FP method. The data are presented where possible and are indicated as a "small sample" in a footnote. Where possible, general conclusions were drawn based on the data, to assist managers and policymakers in programmatic decision making.

Respondent Profile

Table 7 shows that a total of 240 CPIs were observed during the data collection exercise. Of these, 85 took place at UHC/MCWC facilities and 155 at FWC facilities. Only 7% of service providers observed at the UHC or MCWC level were MOs (physicians); 93% were FWVs and senior FWVs. The majority (88%) of providers observed at the FWC level were FWVs, and about one in 10 (12%) were SACMOs. All FWVs and senior FWVs are female; therefore, more than 90% of all providers were female.

Table 7. Percentage of service providers who were observed, by position and sex

Characteristic	UHC/MCWC	FWC	Total
Position	**n=85**	**n=155**	**n=240**
MO	7.1	NA	—
SACMO	NA	12.3	—
Senior FWV/FWV	92.9	87.7	89.6
Sex	**n=85**	**n=155**	**n=240**
Female	96.5	91.0	92.9
Male	3.5	9.0	7.1

Data source: Observation of client consultation
NA: Not applicable because this type of provider does not usually practice at this type of facility.

A total of 245 exit interviews were conducted after clients received services. Table 8 (page 10) shows the category of clients who were interviewed. New clients were defined as those who either had never used FP or were switching methods on the day of the survey. Continuing clients were defined as those who came to the facility to get supplies, to have a routine follow-up, or to discuss a problem about their current method.[20] Out of a total of 245 clients who were interviewed, 85 clients received services at UHC/MCWC facilities located at the upazila level and 160 received services from FWC facilities located at the union level. Of those interviewed, three-quarters (74%) were new clients. The majority (91%) were female. All clients were married. The mean age of clients was 29 years, with approximately three living children (average, 2.7 children).

There were 193 provider interviews conducted. Table 9 (page 10) shows that the majority of service providers at UHC/MCWC facilities were FWVs and were female. MOs had been providing FP services for 11 years, on average, FWVs for 22 years, and SACMOs for 18 years. At FWC facilities, slightly more than half of the providers interviewed were FWVs and slightly fewer than half were SACMOs.

[20] Observers were unable to discern whether or not 10 clients were new or continuing from observations alone. Analysts were unable to make this distinction from the data, because the observations were not directly linked to the client exit interviews. These 10 clients were removed from the sample.

Table 8. Percentage of clients who were interviewed, by characteristic

Characteristic	UHC/ MCWC	FWC	All
Category	**n=85**	**n=160**	**n=245**
New	77.6	72.5	74.3
Continuing	22.4	27.5	25.7
Sex	**n=85**	**n=160**	**n=245**
Female	84.7	95.0	91.4
Male	15.3	5.0	8.6
Marital status	**n=85**	**n=160**	**n=245**
Presently married	100.0	100.0	100.0
Education level	**n=52**	**n=97**	**n=149**
Primary	44.2	56.7	52.3
Secondary	42.3	36.1	38.3
Higher	13.5	7.2	9.4
Average years of schooling	6.6	6.0	6.2
Age	**n=85**	**n=159**	**n=244**
Mean age at last birthday (years)	29.0	29.2	29.1
Living children	**n=84**	**n=159**	**n=240**
Mean number of living children	2.7	2.7	2.7

Data source: Client exit interview

Table 9. Percentage and number of service providers who were interviewed, by characteristic, and mean number of years providing services

Characteristic	UHC/MCWC	FWC	Total
	Percentage and number		
Category	**n=91**	**n=102**	**n=193**
MO	23.1	NA	—
SACMO	NA	42.7	—
Senior FWV/FWV	76.9	56.9	66.3
Sex	**n=91**	**n=102**	**n=193**
Female	82.4	57.8	69.4
Male	17.6	42.2	30.6
	Mean no. of years providing services		
Category			
MO	11 (n=21)	NA	—
FWV	26 (n=70)	18 (n=58)	22 (n=128)
SACMO	NA	18 (n=44)	—

Data source: Service provider interview
NA: Not applicable because this type of provider does not usually practice at this type of facility.

Findings

This section presents the baseline data, disaggregated by facility type, client status (new and continuing), and provider type, where possible. Key findings are summarized by the ACQUIRE/Bangladesh results framework throughout the report, to aid in program design and planning. All findings described below follow the expected outcomes (results) of the project interventions. The ACQUIRE/Bangladesh results are:

1. Increased access to quality services
2. Improved performance of service-delivery providers
3. Strengthened environment for FP and maternal health service delivery

IR 1: Increased Access to Quality Services

Intermediate result (IR) 1 is focused on expanding the delivery of quality LAPM services within the context of informed choice in an integrated setting. The result of the interventions will be that clients have better access to the services they need, according to their particular physiological, geographic, financial, social, and cultural contexts. They will better understand the importance of FP and maternal health, the types of services available to them, and where and how to access these services. In this section, data on basic infrastructure, supplies and equipment, provider training, outreach, and infection prevention (IP) practices are presented in the context of two subresults:

- Increased availability of an appropriate range of methods and services at sites (LAPMs)
- Services promoted among targeted populations

IR 1.1: Increased Availability[21] of an Appropriate Range of Methods and Services at Sites (LAPMs)

Under this subresult, the availability and quality of FP services will be increased and integrated in a manner that promotes program sustainability and responsiveness to clients. General infrastructure is included here, as it is necessary to service delivery. General characteristics of facility infrastructure were collected during the facility audit. Table 10 shows that slightly more than half of all facilities had electricity, although the proportion at FWC facilities was only 40%. About half (46%) of all facilities had a piped water supply, although at FWC facilities this proportion was just 33%. Only 48% of UHC/MCWC facilities and no FWC facilities reported having a telephone on-site.

Table 10. Percentage of facilities with available infrastructural amenities

Amenity	UHC/MCWC (n=29)	FWC (n=92)	All (n=121)
Electricity	100.0	40.2	54.5
Piped water	89.7	32.6	46.3
On-site telephone	48.3	0.0	11.6
Separate room with door or curtained area for counseling	27.6	62.0	53.7
Separate room with door for client examination	24.1	62.0	52.9

Data source: Facility audit

[21] Availability includes five components: availability of services, availability of supplies, trained staff, mean number of days per week, and mean levels of staff.

Almost two-thirds (62%) of FWC facilities had a separate room with a door or curtained area for counseling, and the same proportion of FWC facilities had a separate room with a door for client examination. However, only a small proportion (28% and 24%) of UHC/MCWC facilities had a separate room with a door for counseling or examining clients, respectively.

Data on the appearance of each facility are presented in Table 11. General drug supplies and FP supplies can be stored separately; to reflect this, data are presented by single- and multiple-storage areas.

Table 11. Percentage of facilities with selected indicators of storage conditions

Indicator	UHC/MCWC	FWC	All
Single-storage area	**n=18**	**n=70**	**n=88**
Store with supplies away from sunlight	94.4	90.0	90.9
Store with floor swept clean	50.0	58.6	56.8
Double-storage area	**n=11**	**n=19**	**n=30**
Store with supplies away from sunlight	100.0[1]	78.9	86.7
Store with floor swept clean	72.7[1]	78.9	76.7

Data source: Facility audit
[1] Small sample.

In general, regardless of whether the facility contained a single- or double-storage area, supplies were stored away from sunlight at the majority of facilities (91% of single-storage areas and 87% of double-storage areas). At facilities with single-storage areas, floors were observed to be swept clean at about half (57%) of the visited facilities; at facilities with double-storage areas, this proportion was much greater (78%).

According to national policies, UHC/MCWC facilities should provide all FP methods, while FWC facilities should provide all short-term methods and IUD services. Following the national standards of practice from the DGFP, all providers can offer short-term methods. Only MOs (doctors) can provide Norplant implant, NSV, and tubectomy services. MOs and FWVs can provide IUD services, but male SACMOs cannot.

Table 12 shows service providers' responses regarding the availability of FP services. They reported that condom, pill, injectable, and IUD services were almost universally available at all sites (range, 98–100%). Tubectomy and NSV services were reported available at 97% and 72% of UHC/MCWC facilities, respectively.

Table 12. Percentage of facilities offering different FP services

Method	UHC/MCWC (n=29)	FWC (n=92)	All (n=121)
Condom	100.0	97.8	98.3
Pill	100.0	100.0	100.0
Injectable	100.0	100.0	100.0
Norplant implant	65.5	NA	—
IUD	100.0	96.7	97.5
Tubectomy	96.6	NA	—
NSV	72.4	NA	—

Data source: Facility audit
NA: Not applicable because this type of facility does not usually provide this service.

The availability of supplies and equipment was verified during the facility audit, based on observations and interviews with service providers/facility managers on the day of the survey.

According to national policies, UHC/MCWC facilities should provide all FP methods. However, FWC facilities should not provide Norplant implant and male and female sterilization services.

Table 13 shows that supplies and equipment for providing pill and injectable services were available at almost all of the visited facilities, irrespective of location and type (range of availability, 98–100%). Condom supplies were available at 97% of UHC/MCWC facilities and 86% of FWC facilities.

Table 13. Percentage of facilities with available FP supplies and equipment for service delivery

FP method/kit	UHC/MCWC (n=29)	FWC (n=92)	All (n=121)
Condom	96.6	85.9	88.4
Pill	100.0	96.7	97.5
Injectable	100.0	100.0	100.0
IUD	96.6	87.0	89.3
IUD kit	96.6	90.2	91.7
Norplant implant	62.1	NA	—
Minilaparotomy kit	24.1	NA	—
NSV kit	69.0	NA	—

Data source: Facility audit
NA: Not applicable because this type of facility does not usually provide this service. A very small proportion of FWC facilities reported having minilaparotomy and vasectomy kits; however, these data were omitted, as these facilities do not provide these services.

Norplant implant services and supplies were available at 62% of UHC/MCWC facilities. Minilaparotomy kits for tubectomy were available at 24% and NSV kits at 69% of UHC/MCWC facilities, respectively.

Information regarding available medicines for permanent FP services is summarized in Table 14. Interviewers asked if each medication was in stock on the day of the survey and if they could see the medicine for verification, noting whether they observed at least two unexpired units. Data are presented for facilities at which the medicine stocks were verified.

Table 14. Percentage of facilities with available medicines for permanent FP methods[1]

Medicine	UHC/MCWC (n=29)	FWC (n=92)	All (n=121)
Xylocaine (injection)	75.9	NA	—
Pethidine (injection)	93.1	NA	—
Diazepam (tablet)	75.9	NA	—
Phenergan (injection)	69.0	NA	—
Atropine Sulfate (injection)	62.1	NA	—
All indicators	**48.3**	**NA**	**—**

Data source: Facility audit
[1] Availability is defined as the interviewer's observing at least two unexpired units of supplies.
NA: Not applicable because this type of facility does not provide sterilization services. A very small proportion of FWC facilities reported having Xylocaine; however, the data were omitted as these facilities do not provide permanent family planning services.

Five medicines for permanent FP services are required by the national standards: Xylocaine injection, pathidine injection, Phenergan injection, atropine sulfate injection, and diazepam tablets. The survey revealed that 93% of UHC/MCWC facilities had pethidine injection, followed by Xylocaine injection and diazepam tablets (76%), Phenergan injection (69%), and atropine sulfate injection (62%).

Data on key emergency medicines are summarized in Table 15. Interviewers asked if each type of medicine was in stock on the day of the survey and if they could see the medicines for verification, noting whether they observed at least two unexpired units. Emergency medicines include naloxone, dextrose in normal saline (5%), adrenaline, diazepam (injection), sodium bicarbonate, and hydrocortisone. Except for naloxone, fewer than 50% of UHC/MCWC facilities (range, 20–45%) had these medicines available on the day of data collection.

Table 15. Percentage of facilities with available emergency medicines[1]

Emergency medicines	UHC/MCWC (n=29)	FWC (n=92)	All (n=121)
Naloxone	58.6	NA	—
Dextrose in normal saline (5%)	44.8	NA	—
Adrenaline	44.8	NA	—
Diazepam (injection)	34.5	NA	—
Sodium bicarbonate	31.0	NA	—
Hydrocortisone	20.7	NA	—
All indicators	**6.9**	**NA**	—

Data source: Facility audit
[1] Availability is defined as the interviewer's observing at least two unexpired units of supplies.
NA: Not applicable because this type of facility does not provide clinical services. A very small proportion of FWC facilities reported having dextrose in normal saline; however, the data were omitted as these facilities do not provide permanent family planning services.

Clinical contraceptive services require some basic equipment as well as medicine. For example, an autoclave is essential to sterilize clinical equipment for reuse. Similarly, tubectomy operations cannot be performed without an oxygen cylinder. Table 16 shows data gathered on essential supplies necessary for clinical service delivery. Interviewers asked if essential supplies were available and then verified that they were in working condition.

Table 16. Percentage of facilities with essential supplies necessary for service delivery

Essential supply	UHC/MCWC (n=29)	FWC (n=92)	All (n=121)
Stethoscope	89.7	60.9	67.8
Blood pressure machine	86.2	41.3	52.1
High-level disinfectant sterilizing pot	58.6	23.9	32.2
Torch with batteries	55.2	18.5	27.3
Autoclave	96.6	40.2	53.7
Adhesive tape	65.5	5.4	19.8
Oxygen cylinder	93.1	5.6	27.3
Ambu bag	86.2	7.6	26.4
Airway tube	69.0	10.6	24.8
Atraumatic catgut	79.3	3.3	21.5
Suction machine	69.0	5.4	20.7
Foley catheter	41.4	8.7	16.5
I.V. infusion set	44.8	2.2	12.4
Ryle's tube	34.5	4.3	11.6

Data source: Facility audit

All facilities are supposed to be open six days a week. (Friday is a weekly holiday in Bangladesh.) However, method-wise, service provision differs at facilities based on the availability of providers.

Table 17 presents data on the mean number of days that services were provided. Injectable and IUD services were available at UHC/MCWC facilities about six days per week; Norplant implant and sterilization services were available about two days per week. At FWC facilities, IUD and injectable services were available about five days per week.

Table 17. Mean number of days on which facilities offer FP services, by method

FP method	UHC/MCWC	FWC	All
Injectable	5.8 (n=29)	4.9 (n=92)	5.1 (n=121)
IUD	5.9 (n=29)	4.4 (n=89)	4.8 (n=118)
Norplant implant	2.1 (n=19)	NA	—
Tubectomy	1.7 (n=27)	NA	—
NSV	1.9 (n=21)	NA	—

Data source: Facility audit
NA: Not applicable because this type of facility does not usually provide this service.

Table 18 shows the mean availability of service providers. At UHC/MCWC facilities, there are, on average, one MO and three FWV/senior FWVs. FWC facilities, on average, employ one FWV and one SACMO.

Table 18. Mean number of service providers available per facility

Provider	UHC/MCWC (n=29)	FWC (n=92)	All (n=121)
MO	1.0	NA	—
FWV/senior FWV	2.9	1.1	1.5
SACMO	NA	0.8	—

Data source: Facility audit
NA: Not applicable because there is no position for this type of provider at this kind of facility.

Service provider training is an important element of quality services. According to national protocols, MOs provide permanent (tubectomy and NSV), long-acting (IUD and Norplant implant), and short-term (injectable, condom, and pill) FP methods; FWVs provide the IUD and all short-term methods; and SACMOs mainly provide maternal and child health services, though they also provide short-term FP services. Because SACMOs mainly provide maternal and child health services, they are purposely excluded from Table 19 (page 16), which shows the percentage of providers who reported receiving inservice training in the past three years.

MOs received the most training of the three provider types. Training includes preservice and in-service. The largest percentage of MOs reported training in tubectomy, followed equally by Norplant implant insertion and removal, NSV, and IP. MOs least often reported training in IUD insertion and removal (which they should be providing, according to national protocols). At UHC/MCWC facilities, only 3% of FWVs reported training in IUD insertion and removal, even though they should be providing this method, according to national protocols. Just 6% of FWVs reported training in FP counseling, and only 10% reported training in IP.

Table 19. Percentage of service providers reporting having received training in selected services

Training category	UHC/MCWC	FWC	All
MO	**n=21**	**n=0**	**n=21**
Norplant implant insertion and removal	38.1	NA	—
IUD insertion and removal	19.0	NA	—
NSV	38.1	NA	—
Tubectomy	42.9	NA	—
FP counseling	19.0	NA	—
Infection prevention	38.1	NA	—
Complication management	23.8	NA	—
FWV	**n=70**	**n=58**	**n=128**
IUD insertion and removal	2.9	1.7	2.3
FP counseling	5.7	13.8	9.4
Infection prevention	10.0	6.9	8.6

Data source: Service provider interview
NA: Not applicable because there is no position for this type of provider at this kind of facility. One MO was reported at a FWC; these data were added to the UHC/MCWC data.

At the FWC level, the situation was similar. Only 2% of FWVs reported training in IUD insertion and removal; 14% reported training in FP counseling; and 7% reported training in IP. It should be noted that just three out of 193 providers stated that their training had been supported by EngenderHealth, demonstrating that the sites surveyed are baseline sites for the ACQUIRE Project.

IR 1.2: Services Promoted among Targeted Populations

Under this subresult, clients will be informed about and encouraged to access FP services in ways appropriate to their geographic and cultural contexts. In particular, clients will be better informed about the importance of maintaining their own reproductive health, the type of services available to them, and where and how to access FP services.

Table 20 shows the distribution of methods given or referred to new clients.[22] At UHC/MCWC facilities, 40% of all new clients received injectables, followed by the pill (16%) and NSV (15%). At FWC facilities, nearly half of all new clients received injectables, followed equally by the pill and condoms.

Table 20. Percentage of new clients, by methods received or referred for, according to type of facility

Method	UHC/MCWC (n=72)	FWC (n=106)	All (n=178)
New client			
Condom	12.0	24.5	19.3
Pill	16.0	24.5	21.0
Injectable	40.0	43.4	42.0
IUD	8.0	1.9	4.4
Norplant implant	4.0	0.0	1.7
NSV	14.7	2.8	7.7
Tubectomy	8.0	1.9	4.4

Data source: Observation of client consultation

[22] Multiple methods were recorded in the event that more than one method was prescribed. This question was not observed for continuing clients.

Table 21 summarizes data on facilities with an outreach program, defined as regular facility staff visits within the community to deliver services. Staff visits are coordinated by a facility schedule and within a defined catchment area. Services reported included the distribution of condoms, the pill, and injectables.[23] Of all UHC/MCWC facilities, 69% reported having an outreach program, and 96% of all FWC facilities reported having an outreach program. Of all facilities with an outreach program, almost all reported having condom, pill, and injectable services. Referrals from these programs are most prevalent for IUD and tubectomy services.

Table 21. Percentage of facilities with an outreach program

Indicator	UHC/MCWC	FWC	All
Facility	**n=29**	**n=92**	**n=121**
With outreach program	69.0	95.7	89.3
Type of outreach program	**n=20**	**n=88**	**n=108**
Condom	95.0	90.9	91.7
Pill	100.0	95.5	96.3
Injectable	100.0	98.9	99.1
IUD	0.0	0.0	0.0
Referral for IUD	50.0	69.3	65.7
Referral for Norplant implant	40.0	52.3	50.0
Referral for tubectomy	60.0	64.8	63.9
Referral for NSV	50.0	44.3	45.4

Data source: Facility audit

Table 22 shows data for IP measures at the surveyed facilities. At the UHC/MCWC level, the facilities are underequipped in necessary materials for IP. Among all UHC/MCWC facilities, 66% had a puncture-resistant container for sharps, 28% had leakproof, lidded waste containers, and only 21% had a plastic bucket with a lid for chlorine solution. More than half (62%) of the facilities burn their contaminated syringes and bandages in an incinerator.

Table 22. Percentage of facilities following basic infection prevention measures

Measure	UHC/MCWC (n=29)	FWC (n=92)	All (n=121)
Has puncture-resistant container for sharps	65.5	22.8	33.1
Has plastic bucket with lid for chlorine solution	20.7	6.5	9.9
Has leak-proof, lidded waste container	27.6	4.3	9.9
Has IUD sterilizer	86.2	72.8	76.0
Has autoclave	96.6	40.2	53.7
Burns used syringes and bandages in incinerators	62.1	57.6	58.7

Data source: Facility audit

FWC facilities were even less equipped to prevent infection. Of all FWC facilities, 23% had a puncture-resistant container for sharps, 4% had leakproof, lidded waste containers, and only about 7% had a plastic bucket with a lid for chlorine solution. Slightly more than 50% of total facilities burn their contaminated syringes and bandages in an incinerator.[24]

[23] IUDs were also reported as a service included in referrals. These data may be an artifact or may come from a poorly understood question, as this service is not provided outside the facilities. It is also possible that this service is still being provided outside the facilities in a few cases.

[24] According to national standards and protocols, facilities may either burn their waste in incinerators or bury it in a pit. The closed responses only provided the former as a response category, biasing the data somewhat.

IR 2: Improved Performance of Service-Delivery Providers

Intermediate result 2 is focused on improving the performance of service providers by upgrading their knowledge and skills, increasing their motivation to provide quality care, and reinforcing monitoring and feedback systems. In this section, data on clinical observations, client-provider counseling, client satisfaction, and method switching are presented in the context of two subresults:

- Improved provider support system
- Improved CPI

IR 2.1: Improved Provider Support System

Under this subresult, improved performance will be achieved through multiple approaches that address the service provider's skills and knowledge, motivation, and organizational support system. Effective FP programs have providers who are capable of providing facility-based methods, such as the Norplant implant, the IUD, and voluntary sterilization.

Tables 23 and 24 summarize characteristics observed during CPIs. Providers were judged on criteria based on the DGFP national FP norms and standards. The majority of clients chose the pill, injectables, and condoms. Fewer clients were observed for Norplant implant (n=3), IUD (n=8), tubectomy (n=8), and vasectomy (n=13) services. Because the LAPM samples were small, these data are not presented.

Table 23 shows that a total of 114 new female clients were provided the pill or Depo-Provera injections. Providers were most likely to tell clients to take the pill daily or injections quarterly (91%). A smaller proportion told clients about the changes that may occur during menstruation (68%), and fewer than half told clients about initial side effects that may occur, such as nausea, weight gain, or breast tenderness (47%), or about what to do if they forget to take the pill or do not get the injection on time (44%). Comparing UHC/MCWC with FWC facilities, the data show that providers at FWC facilities were more likely to counsel clients on all four components than were their UHC/MCWC counterparts.

Table 23. Percentage of new pill and injectable clients who were counseled about selected issues

Counseling issue	UHC/MCWC	FWC	Total
New client	**n=42**	**n=72**	**n=114**
When to take method	88.1	93.1	91.2
Changes during menstruation	73.8	63.9	67.5
Side effects	50.0	45.8	47.4
What to do if pill or injectable is missed	23.8	55.6	43.9
All indicators	**14.3**	**30.6**	**24.6**

Data source: Observation of client consultation

Table 24 presents data on service providers who performed the required steps outlined in the national standards for injectable clients. In total, 114 injectable observations were reported—74 of new clients and 40 of continuing clients. The number of observations varied by required step, depending on whether the observer was able to assess the characteristic. Four steps are fundamental to care:

1. Reconfirming the method choice
2. Cleaning the injection site and allowing it to air-dry
3. Allowing the dose to self-disperse
4. Disposing of sharps in a puncture-resistant container

Table 24. Percentage of service providers who followed the recommended steps for injectable provision

Recommended step	UHC/MCWC	FWC	All
New client	**n=29**	**n=45**	**n=74**
Reconfirm method choice	51.7	77.8	67.6
Clean and air-dry injection site before injection	93.1	84.1[1]	87.7
Allow dose to self-disperse instead of massaging	62.1	70.5[1]	67.1
Dispose of sharps in puncture-resistant container	17.2	6.7	10.8
All indicators	**0.0**	**6.8**	**4.1**
Continuing client	**n=7**	**n=33**	**n=40**
Reconfirm method choice	71.4[3]	72.7	72.5
Clean and air-dry injection site before injection	85.7[3]	71.9[2]	74.4
Allow dose to self-disperse instead of massaging	14.3[3]	50.0[2]	43.6
Dispose of sharps in puncture-resistant container	0.0[3]	15.2	12.5
All indicators	**0.0**[3]	**6.3**	**5.1**

Data source: Observation of client consultation
[1] n=44. [2] n=32. [3] Small sample.

Data on the last component may misrepresent providers' behavior, since they could have disposed of the sharps following the departure of the observer. At UHC/FWC facilities, the majority of providers cleaned the injection site appropriately, while fewer allowed the dose to self-disperse or reconfirmed the method choice. The same phenomenon was observed at FWC facilities. Although all four components are critical to quality care of both new and continuing clients, the data are disaggregated by client status for consistency.

Table 25 (page 20) summarizes data on service providers who reported checking required contraindications based on national protocols. Responses were unprompted. Data are presented by service provider type and only for LAPMs, because of small or inconsistent sample sizes.

Long-acting methods

Long-acting methods include the IUD and Norplant implant. According to national standards of practice, male SACMOs cannot provide IUD services, and neither SACMOs nor FWVs can provide Norplant implant services. The data show that FWVs were most likely to ask IUD clients about their number of children and to check for infections and were least likely to ask about excessive bleeding. MOs were most likely to check Norplant implant clients' blood pressure and to check for jaundice and were least likely to ask about spotting after intercourse and about weight.

Permanent methods

Permanent FP methods include NSV and tubectomy. According to national standards of practice, only MOs may provide sterilization services. The NSV data show that MOs were most likely to give the client a medical checkup and to ask about the client's number of children; they were least likely to ask about marital status. The tubectomy data show that MOs were most likely to ask about the client's number of children and age of last child. Providers were less likely to do a medical checkup for tubectomy clients than for NSV clients.

Table 25. Percentage of service providers who reported checking certain conditions before providing a service (self-reported)

Method	MO	FWV	SACMO
IUD	**NA**	**n=123**	**NA**
Pregnancy	NA	35.8	NA
Ask about children	NA	73.2	NA
Excessive bleeding during menses	NA	48.0	NA
Excessive bleeding between menses	NA	22.8	NA
Excessive bleeding after intercourse	NA	11.4	NA
Painful menses	NA	41.5	NA
Check for infections	NA	60.2	NA
Check for uterine prolapse	NA	46.2	NA
Norplant implant	**n=19**	**NA**	**NA**
Ask about children	63.2	NA	NA
Pregnancy	57.9	NA	NA
Blood pressure	84.2	NA	NA
Lump in breast	47.4	NA	NA
Jaundice	63.2	NA	NA
Spotting after intercourse	10.5	NA	NA
Weight	5.3	NA	NA
NSV	**n=15**	**NA**	**NA**
Ask about number of children	86.7	NA	NA
Ask about age of last child	53.3	NA	NA
Ask about marital status	20.0	NA	NA
Check/ask about medical status	86.7	NA	NA
Tubectomy	**n=21**	**NA**	**NA**
Ask about number of children	90.5	NA	NA
Ask about age of last child	71.4	NA	NA
Ask about marital status	4.8	NA	NA
Check/ask about medical status	52.4	NA	NA
Check for infection	33.3	NA	NA
Pregnancy	61.9	NA	NA

Data source: Service provider interview
NA: Not applicable because this type of service provider does not usually offer this service.

IR 2.2: Improved CPI

This subresult is focused on improving the style and content of interactions between clients and frontline service providers as key components of quality of care. Service providers are expected to take clients' needs, expectations, and degree of satisfaction into account when providing services. CPIs are even more important in the context of integrated service delivery.

Table 26 shows the average numbers of methods discussed with female new and continuing clients. The variables were similar at UHC/MCWC and FWC facilities. For new clients, approximately half of providers discussed more than one method—two methods on average.

Table 26. Mean number and percentage of FP methods discussed during CPI

Indicator	UHC/MCWC	FWC	All
New client	**n=75**	**n=106**	**n=181**
Mean number of methods discussed	1.9	2.1	2.0
Percentage of observations where providers discussed more than one method	50.7	56.6	54.1
Continuing client	**n=10**	**n=49**	**n=59**
Mean number of methods discussed	1.0[1]	1.6	1.5
Percentage of observations where providers discussed more than one method	10.0[1]	44.9	39.0

Data source: Observation of client consultation
[1] Small sample.

Table 27 summarizes data regarding providers who discussed key client information during counseling sessions. The reported variables were chosen based on national standards and protocols. New male client data are omitted because of sample size. At UHC/MCWC facilities, a higher percentage (89%) of providers asked new female clients about their number of living children than about either their desire to have more children or their desired timing for the next birth; only 3% of providers asked new clients about all information according to national protocols.

Table 27. Percentage of providers discussing necessary information during counseling

Category of Information	UHC/MCWC	FWC	All
New female client	**n=63**	**n=99**	**n=162**
Age of client	63.5	54.5	58.0
No. of living children	88.9	91.9	90.7
History of pregnancy complications	15.9	26.3	22.2
Current pregnancy status	39.7	58.6	51.2
Desire for more children	44.4	50.5	48.1
Desired timing for birth of next child	25.5	31.3	29.0
Regularity of menstrual cycle	79.4	76.8	77.8
All indicators	**12.7**	**19.2**	**16.7**
Continuing female client	**n=9**	**n=49**	**n=58**
Age of client	66.7	28.6	34.5
No. of living children	77.8	51.0	55.2
Age of youngest child	66.7	36.7	41.4
Desire for more children	55.6	28.6	32.8
Desired timing for birth of next child	33.3	14.3	17.2
All	**33.2**	**10.2**	**13.8**

Data source: Observation of client consultation

Table 28 (page 22) presents data on counseling sessions in which client-centered variables were discussed. At UHC/MCWC facilities, about 80% of providers asked new female clients about method preference; 65% discussed the client's preferred method even if it was not prescribed, and about 40% discussed the partner's attitude toward FP or addressed concerns about any method. At FWC facilities, about 90% of providers asked new female clients about method preference; 67% discussed the client's preferred method even if it was not prescribed; and about 30% discussed the partner's attitude toward FP and addressed concerns about any method. It should be noted that

clients generally select a contraceptive method outside the facility during consultations with FWAs in the door-to-door service program. Therefore, the indicator "discussed methods other than the prescribed method" may not be an accurate representation of the quality of client counseling.

Table 28. Percentage of observations in which selected counseling characteristics were observed

Characteristic	UHC/MCWC	FWC	All
New female client	**n=63**	**n=99**	**n=162**
Discussed partner's attitude to FP	41.3	35.4	37.7
Addressed concerns about any method	41.3	30.3	34.6
Asked about method preference	82.5	89.9	87.0
Discussed client's preferred method even if it was not prescribed	65.2	66.7	60.0
Discussed methods other than the prescribed method	47.6	51.5	50.0
All	**15.9**	**16.2**	**16.0**
Continuing female client	**n=9**	**n=49**	**n=58**
Addressed concerns about current method	55.6[1]	79.6	75.9
Discussed methods other than the prescribed method	22.2[1]	38.8	36.2
All	**22.2**[1]	**34.7**	**32.8**

Data source: Observation of client consultation
[1] Small sample

During client-provider observations, observers determined whether service providers followed important steps in counseling: using visual aids; and discussing warning signs and when to return for a follow-up visit. Table 29 shows steps that providers should follow according to national protocols. New client data are similar for both facility types: Providers were more likely to discuss return visits than they were to talk about warning signs with new clients, and they were less likely to use visual aids. It should be noted that the facility audit did not ask questions about the availability of visual aids, so the data may reflect the lack of these materials on-site. Continuing client data are also similar at both facility types: A very insignificant number of providers discussed warning signs with these clients.

Table 29. Percentage of observations in which provider followed recommended counseling steps

Recommended step	UHC/MCWC	FWC	All
New client	**n=75**	**n=106**	**n=181**
Provider used visual aids	8.0	6.7	7.2
Provider discussed a return visit	69.3	70.8	70.2
Provider discussed warning signs of chosen method	32.0	27.4	29.3
All indicators	**4.0**	**3.8**	**3.9**
Continuing client	**n=10**	**n=49**	**n=59**
Provider discussed a return visit	70.0[1]	63.3	64.4
Provider discussed warning signs of chosen method	0.0[1]	2.0	1.7
All indicators	**0.0**	**2.0**	**1.7**

Data source: Observation of client consultation
[1] Small sample.

Table 30 shows data reported by new clients on aspects of provider counseling. The only overlapping indicator with the observation was similar: About three-quarters of new clients

reported that the provider conveyed information on when to return for a follow-up visit. At UHC/MCWC facilities, about three-quarters of clients reported that the provider explained how to use the method (74%) and when to return for follow-up (78%). Fewer clients (65%) reported that the provider told them about method side effects, and just over half of clients (57%) reported that the provider explained what to do in case of problems with the method.

Table 30. Percentage of clients reporting that provider followed recommended counseling steps

Recommended step	UHC/MCWC	FWC	All
New client			
Provider explained how to use method	74.2 (n=66)	79.3 (n=116)	77.5 (n=182)
Provider talked about possible side effects	65.2 (n=66)	61.2 (n=116)	62.6 (n=182)
Provider explained what to do in case of problems	56.9 (n=65)	61.7 (n=115)	60.0 (n=180)
Provider discussed when to return for a follow-up visit	78.1 (n=64)	69.0 (n=116)	72.2 (n=180)
All indicators	**45.3 (n=64)**	**47.0 (n=115)**	**46.4 (n=179)**

Data source: Client exit interview

At FWC facilities, 79% clients reported that the provider explained how to use the method, and 69% explained when to return for follow-up. Fewer clients reported that the provider discusses method side effects with them (61%) and what to do in case of problems with the method (62%).

Table 31 shows clients' perceptions of services. Almost three-quarters of all clients reported that the waiting time was reasonable. The majority of the clients expressed satisfaction with the services provided. There was little difference reported between clients from UHC/MCWC and FWC facilities.

Table 31. Percentage of clients reporting selected perceptions of the services provided

Perception	UHC/MCWC	FWC	All
New client			
Waiting time was reasonable	73.0 (n=63)	77.3 (n=97)	75.6 (n=160)
Provided method and services were satisfactory	95.9 (n=49)	97.1 (n=105)	96.8 (n=154)
Continuing client			
Waiting time was reasonable	70.6 (n=17)	75.9 (n=29)	73.9 (n=46)
Provided method and services were satisfactory	100.0 (n=14)	97.2 (n=36)	98.0 (n=50)

Data source: Client exit interview

Table 32 (page 24) shows features of client satisfaction with the facility. Clients who received or were referred for a method on the day of the survey were asked whether they were satisfied with the method and services. It should be emphasized that clients generally select a contraceptive method outside the facility during consultations with FWAs in the door-to-door service program.

Table 32. Percentage of clients reporting various perceptions of facilities

Perception	UHC/ MCWC	FWC	All
New client			
Felt that auditory and visual privacy were ensured	39.4 (n=66)	42.2 (n=116)	41.2 (n=182)
Felt that information would be kept confidential	94.4 (n=54)	92.3 (n=104)	93.0 (n=158)
Would encourage others to come	100.0 (n=64)	99.1 (n=115)	99.4 (n=179)
Continuing client			
Felt that auditory and visual privacy were ensured	47.4 (n=19)	43.2 (n=44)	44.4 (n=63)
Felt that information would be kept confidential	69.2 (n=13)	77.1 (n=35)	75.0 (n=48)
Would encourage others to come	100.0 (n=19)	97.7 (n=44)	98.4 (n=63)

Data source: Client exit interview

The majority (97–100%) of all clients reported that they would encourage others to come to the facility for FP services. At UHC/MCWC facilities, the majority of new clients perceived that the information they discussed during their visit would be kept confidential (94%). A smaller proportion (39%) reported that their privacy was ensured during discussion. Very few continuing clients were interviewed on the same aspect; however, when they did respond, their views mirrored those of the new clients.

At FWC facilities, the majority (92%) of new clients also perceived that the information they discussed with the provider would be kept confidential; fewer than half (42%) reported that their privacy was ensured during discussion. Few differences were reported between new and continuing clients.

Table 33 shows method-switching data by current method use. Method switchers were asked what method they were using prior to the day of the survey. These responses were compared with the methods they reported receiving (or were referred for) on the day of the survey. In general, the majority of clients who were using the pill, condoms, or injectables prior to the day of the survey switched to other shorter-term methods on the day of the survey. Specifically, the majority (84%) of pill users switched to injectables or condoms; 83% of condom users switched to injectables or the pill; and 73% of injectable users switched to condoms or the pill.

IR 3: Strengthened Environment for Family Planning and Maternal Health Service Delivery

Intermediate Result 3 is focused on developing strong leadership and management systems to support service-delivery providers, resulting in program sustainability. At all levels, health managers should have access to better information, proven health care practices, and effective management systems.

In this section, data on links to the community, record keeping, the existence of standards and protocols, and barriers to services are presented in the context of two subresults:

- Improved leadership and management for FP service delivery
- Supportive policies promoted for FP services

Table 33. Percentage of clients who switched from one short-term method to another, by current method use

Method	UHC/MCWC	FWC	All
Condom user	**n=20**	**n=21**	**n=41**
Pill	25.0	52.4	39.0
Injectable	40.0	47.6	43.9
IUD	10.0	0.0	4.9
Norplant implant	0.0	0.0	0.0
NSV	15.0	0.0	7.3
Tubectomy	10.0	0.0	4.9
Pill user	**n=43**	**n=70**	**n=113**
Condom	4.7	22.9	15.9
Injectable	62.8	71.4	68.1
IUD	4.7	1.4	2.7
Norplant implant	2.3	0.0	0.9
NSV	14.0	4.3	8.0
Tubectomy	11.6	0.0	4.4
Injectable user	**n=12**	**n=28**	**n=40**
Condom	16.7	39.3	32.5
Pill	25.0	46.4	40.0
IUD	8.3	0.0	2.5
Norplant implant	8.3	0.0	2.5
NSV	16.7	7.1	10.0
Tubectomy	25.0	7.1	12.5

Data source: Client exit interview

IR 3.1:Improved Leadership and Management for Family Planning Service Delivery

The government issues national FP protocols and guidelines to ensure consistency in the service-delivery provision. Facilities are required to follow these guidelines. Stronger management systems will ensure a more efficient use of financial, personnel, and equipment supply resources. Improved health information systems will ensure that data collection and analysis are linked systematically on an ongoing basis for timely decision making.

Table 34 shows that the majority (90%) of UHC/MCWC facilities reported that they have a formal system for reviewing management and administrative issues; 31% have a system for determining client opinion about the health facility or services; and 29% have functioning Family Welfare Committees.

Table 34. Percentage of facilities with systems for reviewing facility management

Indicator	UHC/ MCWC	FWC	All
Has functioning Family Welfare Committee	28.6 (n=28)	23.3 (n=86)	24.6 (n=114)
Has system for determining client opinion about the health facility or services	31.0 (n=29)	32.2 (n=90)	31.9 (n=119)
Has system for reviewing management and administrative issues through formal meeting and discussion	89.7 (n=29)	80.4 (n=92)	82.6 (n=121)

Data source: Facility audit

The majority (80%) of FWC facilities reported that they have a formal system for reviewing management and administrative issues. About one-third (32%) have a system for determining client opinion about the health facility or services, and about one-fifth (23%) have functioning Family Welfare Committees.

IR 3.2: Supportive Policies Promoted for Family Planning Services

Supportive policies are essential to effective programming for measurable public health impact. The project is not expected to address all policy issues, but is expected to focus on specific policies that affect client access to quality FP. Quality of care requires appropriate regulatory networks and systems.

Table 35 summarizes data on facilities that reported having a National Family Planning Manual (which also contains IP protocols). National standards mandate that each facility should have at least one manual. About three-quarters (76%) of UHC/MCWC facilities and about half (55%) of FWC facilities have a copy of the written national Family Planning Guidelines. The majority of UHC/MCWC facilities (86%) and FWC facilities (94%) keep inventory records for drugs and supplies.

Table 35. Percentage of facilities with manual and with inventory records

Indicator	UHC/ MCWC	FWC	All
Has National Family Planning Manual	75.9 (n=29)	55.4 (n=83)	60.7 (n=112)
Keeps inventory records for drugs and supplies	86.2 (n=29)	93.5 (n=92)	91.7 (n=121)

Data source: Facility audit

Service providers were asked if they require partner consent before providing a particular method. Table 36 shows the proportion of service providers who reported that partner consent influences their decision in FP service provision. About 90% of MOs at UHC/MCWC facilities reported that they require partner consent before providing an LAPM; 94% of FWVs reported that they require partner consent before providing IUD services.

Table 36. Percentage of service providers who said they require partner consent before providing method

Method	MO	FWV	SACMO
IUD	NA	93.5 (n=123)	NA
Norplant implant	89.5 (n=19)	NA	NA
Tubectomy	93.5 (n=15)	NA	NA
NSV	95.2 (n=21)	NA	NA

Data source: Service provider interview
NA: Not applicable because this type of provider does not usually offer this service.

Conclusions

ACQUIRE conducted this baseline survey from April to July 2004 to inform program decision making, to measure changes in quality and availability of services at endline in 2008, and to better design and monitor its program. The data in this report are presented according to the ACQUIRE/Bangladesh results framework. Key data are listed below. Summary data are also included in the Executive Summary, along with major recommendations.

IR 1: Increased Access to Quality Services

This result is focused on expanding the delivery of quality LAPM services within the context of informed choice in an integrated setting. Access is contingent on the availability of trained service providers, methods, equipment and supplies, as well as an infrastructure that effectively supports the provision of methods and services.

The majority of service providers had not received training in FP method provision, counseling, IP, or complications management in many years. MOs received the most training of the three provider types. The largest percentage of MOs reported training in tubectomy, followed equally by Norplant implant insertion and removal, NSV, and IP. Only 3% of FWVs reported training in IUD insertion and removal, even though they should be providing this method according to national protocols. Additionally, only 6% of FWVs reported training in FP counseling, and 10% reported training in IP.

Availability of a range of FP methods is essential to quality FP service provision. The majority of UHC/MCWC facilities reported offering short-term methods almost every day of the week. However, clinical procedures like Norplant implant insertion and voluntary sterilization were only available an average of two days per week, which limits access for those interested in such methods. Most of the new clients were served with short-term methods at both UHC/MCWC and FWC facilities; injectables were the method most often chosen.

Every health facility must have a solid foundation on which to build quality services—for instance, the absence of piped running water may inhibit good IP practices. In this survey sample, the data indicate that facilities were ill equipped to provide quality FP services, although overall the infrastructure of UHC/MCWC facilities was better than that of FWC facilities. For example, piped running water, electricity, and separate rooms for counseling and medical examination were much more prevalent at UHC/MCWC facilities.

IP practices must be followed completely and at all times. However, provider compliance was less than ideal, and necessary equipment was in short supply. Very few of the facilities had proper containers for discarding medical waste or sharps. Sterilization and decontamination practices were not uniformly practiced, contributing to potential risks for both clients and providers.

IR 2: Improved Performance of Service-Delivery Providers

This result is focused on improving the performance of service providers by upgrading their knowledge and skills and increasing their motivation to provide quality care. Improved performance is predicated on the existence of and compliance with the fundamentals of facility-based care: informed choice and decision making, facilitated through appropriate counseling, medical safety in

all service delivery, and quality assurance and management. Quality assurance, supervision, and management variables were not a focus of this study, but these are addressed elsewhere in two internal ACQUIRE performance improvement needs assessment reports.[25]

Informed and voluntary decision making refers to the process by which an individual arrives at a decision based on options, information, and understanding. Although providers asked clients about information key to decision making (e.g., number of children, age of last child, and desire for more children), they failed to use this information to aid client decision making. Instead, the majority discussed an average of two methods with clients, although the facilities had all methods available on-site or through referral. It may be that the gap between providers' knowledge of and counseling on LAPMs is systemic rather than individualized. Additionally, providers deviated from the recommended steps for clinical procedures. For example, many omitted a check of the client's current health status.

In fewer than half of observations, providers omitted information on side effects during family planning counseling sessions. Additionally, providers often failed to convey information on method use, including the warning signs that should trigger a return visit.

Most of the clients reported that they were respectfully greeted, were treated in a friendly way by the service providers, were satisfied with the services received, and would recommend the services to others. However, client response may reflect a lack of understanding about clients' rights and protocols or may be attributable to low expectations or courtesy biases.

IR 3: Strengthened Environment for Family Planning and Maternal Health Service Delivery

This result is focused on developing strong leadership and management systems to support service-delivery providers, directly contributing to the sustainability of LAPM programs.

Ensuring quality services is a continuous process that requires policies, guidelines and norms, and management systems and methodologies that create a positive enabling environment in which services are carried out.

The majority of UHC/MCWC and FWC facilities had a formal system for reviewing management and administrative issues; about one-third had a system for determining client opinion. Functioning Family Welfare Committees were reported more often at UHC/MCWC than at FWC facilities (28% vs. 23%). About three-quarters of UHC/MCWC facilities and about one-half of FWC facilities have a copy of the written national Family Planning Guidelines. The majority of both facility types keep inventory records for drugs and supplies.

[25] The ACQUIRE Project. Strengthening the fundamentals of care for family planning service delivery in Bangladesh: Performance improvement needs assessment report (draft); The ACQUIRE Project. Results of the performance improvement needs assessment (PINA-2) to strengthen the supervision system report (draft).

Appendix 1: Sites and Facilities

Upazila	Facility name	Type	Noncomprehensive	Comprehensive
Chandpur district				
Matlab	Matlab	UHC		✔
	Farazikandi	FWC	✔	
	Fatehpur East	FWC		✔
	Matlab South	FWC		✔
	Narayanpur	FWC	✔	
	Sultanabad	FWC	✔	
	Nayergaon (North)	FWC		✔
	Khadergaon	FWC	✔	
Sadar	Sadar	MCWC		✔
	Maishadi	FWC		✔
	Rampur	FWC		✔
	Sakua	FWC	✔	
Haimchar	Haimchar	UHC		✔
	Algi Durgapur South	FWC		✔
	Algi Durgapur North	FWC		✔
Faridgonj	Faridgonj	UHC		✔
	Gobindapur	FWC		✔
	Gupti East	FWC		✔
	Gupti West	FWC	✔	
Kachua	Kachua	UHC		✔
	Bitara	FWC		✔
	Gohat South	FWC	✔	
	Paurashava	FWC	✔	
	Shahadevpur West	FWC		✔
Hazigonj	Hazigonj	UHC		✔
	Paurashava	FWC		✔
	Razargaon South	FWC		✔
	Hazigonj	FWC	✔	
	Kalacho FWC	FWC	✔	
Shaharasthi	Shaharasthi	UHC		✔
	Royshree North	FWC		✔
	Meher	FWC	✔	
	Suchipara North	FWC		✔
	Tamta	FWC	✔	

Upazila	Facility name	Type	Noncomprehensive	Comprehensive
Rajbari district				
Sadar	Sadar	MCWC		✔
	Alipur	FWC	✔	
	Khankhanapur	FWC		✔
	Mizanpur	FWC		✔
	Pachuria	FWC	✔	
	Ramkantapur	FWC	✔	
Pangsha	Pangsha	UHC		✔
	Boalia	FWC	✔	
	Kalimohor	FWC	✔	
	Machpara	FWC		✔
	Modapur	FWC		✔
	Mourat	FWC	✔	
	Sharisha	FWC	✔	
Goalanda	Goalanda	UHC		✔
	Chotobakla	FWC		✔
	Daulatdia	FWC		✔
Baliakandi	Baliakandi	UHC		✔
	Jamalpur	FWC		✔
	Narua	FWC		✔
Chapai Nawabgonj district				
Sadar	Sadar	MCWC		✔
	Jhilim	FWC		✔
	Khamar	FWC		✔
	Ranihat	FWC	✔	
Shibgonj	Shibgonj	UHC		✔
	Daipukuria	FWC		✔
	Ghorapakhia	FWC	✔	
	Nayalabhangya	FWC		✔
	Shampur	FWC	✔	
Nachole	Nachole	UHC		✔
	Kasba	FWC		✔
	Nizampur	FWC		✔
Gomostapur	Gomostapur	UHC		✔
	Boalia	FWC		✔
	Radhanagar	FWC		✔
Volahat	Volahat	UHC		✔
	Jambaria	FWC		✔

Upazila	Facility name	Type	Noncomprehensive	Comprehensive
Dinajpur district				
Sadar	Sadar	MCWC		✔
	Auliapur	FWC	✔	
	Shashara	FWC		✔
	Sheikhpura	FWC	✔	
	Uthrail	FWC		✔
Birampur	Birampur	UHC		✔
	Dior	FWC	✔	
	Katla	FWC		✔
	Khanpur	FWC		✔
Fulbari	Fulbari	UHC		✔
	Betdoghi	FWC		✔
	Khaerbari	FWC		✔
Nawabgonj	Nawabgonj	UHC		✔
	Joypur	FWC		✔
	Vaduria	FWC		✔
	Daudpur	FWC	✔	
Parbatipur	Chandipur	FWC		✔
	Mominpur	FWC		✔
	Parbatipur	UHC		✔
	Rampur	FWC	✔	
	Paurashava	FWC	✔	
Birole	Birole	UHC		✔
	Azimpur	FWC	✔	
	Dhamoir	FWC		✔
	Madhabbati	FWC		✔
Chirirbandar	Chirirbandar	UHC		✔
	Amarpur	FWC		✔
	Auliapukur	FWC		✔
	Nasratpur	FWC	✔	
	Saitara	FWC	✔	
Bochagonj	Bochagonj	UHC		✔
	Ranagaon	FWC	✔	
	Nafanagar	FWC		✔
	Atgaon	FWC		✔
Kaharol	Kaharol	UHC		✔
	Dabor	FWC		✔
	Sundarpur	FWC		✔

Upazila	Facility name	Type	Noncomprehensive	Comprehensive
Birgonj	Birgonj	UHC		✔
	Satagram	FWC		✔
	Voghnagar	FWC	✔	
	Maricha	FWC		✔
	Nizpara	FWC	✔	
Hakimpur	Hakimpur	UHC		✔
	Boaldar	FWC		✔
	Khattamadhabpur	FWC		✔
Ghoraghat	Ghoraghat	UHC		✔
	Bolakipur	FWC		✔
	Shingra	FWC		✔
Khanshama	Khanshama	UHC		✔
	Alokdihi	FWC		✔
	Goaldihi	FWC		✔

Appendix 2: Personnel Involved in Data Collection

Name	Position
Dr. Abu Jamil Faisel	Team leader
Dr. Sukanta Sarker	Technical support
Dr. Mizanur Rahman	Coordinator
Dr. Rozina Afroz Rana	Physician observer
Dr. Samir Kumar Howlader	Physician observer
Dr. Alamgir Hossain	Physician observer
Dr. Apurba Chakraverty	Physician observer
Dr. Sanjida Hasan	Physician observer
Dr. Fatema Shabnam	Physician observer
Dr. Mansur Alam	Physician observer
Dr. Dayal Chandra Debnath	Physician observer
Dr. Shariful Islam	Physician observer
Dr. S. M. Nizamul Haque	Physician observer
Liaquat Ali	Observer
Mahboob-E-Alam	Observer
Nishat Sultana	Observer
Aparna Jain	Observer
Hannah Searing	Observer
Abdus Sobur Khan	Field facilitator
Anwaruzzaman	Field facilitator
Baharuddin	Field facilitator
Masud Rana	Field facilitator
Matiur Rahman	Field facilitator
Touhida Akter	Field facilitator
Ayesha Nasrin	Interviewer
Bilkis Akhter	Interviewer
Farida Pervin	Interviewer
Mahbuba Akhter	Interviewer
Monira Easmin	Interviewer
Rupali Parvin	Interviewer
Sabina Afroze	Interviewer
Sharmin Akhter	Interviewer
Sumona Sharmin	Interviewer
Taslima Akter	Interviewer
Anwarul Haq	Data entry
Anwarul Islam	Data entry
Mahbuba Sharmin	Data entry
Rafiqul Islam	Data entry
Repon Chandra Pal	Data entry
A. K. M. Warefuzzaman	Data entry