

Facility Assessment Report



Family Planning Focusing Adolescent and Youth-Friendly Services (AYFS), PFP, PACFP, Post MR-FP and Gender Responsiveness, Bangladesh

July 2019

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ACRONYMS

ADCC	Assistant Director Clinical Contraceptive
AD Syringe	Auto Disposable Syringe
AFWO	Assistant Family Welfare Officer
ANC	Ante natal Care
ARH	Adolescent Reproductive Health
AYFH	Adolescent and Youth Friendly Health
AUAFP	Accelerating Universal Access to Family Planning
AUFPO	Assistant Upazila Family Planning Officer
BCC	Behavioural Change Communication
BHFS	Bangladesh Health Facility Survey
BP	Blood Pressure
BRAC	Bangladesh Rural Advancement Committee
CC	Community Clinic
CHCP	Community health Care Provider
DGFP	Director General of Family Planning
DGHS	Director General of Health Services
DGNM	Director General of Nursing and Midwives
DH	District Hospital
ECP	Emergency Contraceptive pill
FEFO	First Expired, First Out
FGD	Focus Group Discussion
FP	Family Planning
FPCS-QIT	Family Planning Clinical Services-Quality Improvement Team
FPI	Family Planning Inspector
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
GBV	Gender Base Violence
GOB	Government of Bangladesh
HIV-AIDS	Human Immunodeficiency Virus -Acquired Immune Deficiency Syndrome
HLD	High Level Disinfectant
INGO	International non-Government Organization
IP	Infection Prevention
IPC	Interpersonal Communication
IUD	Intra Uterine Device
KII	Key Informant Interview
LAM	Lactational Amenorrhea Method
LAPM	Long Acting and Permanent Method
LARC	Long Acting Reversible Contraceptives
MA	Medical Assistant
MCH	Maternal and Child Health Services
MCWC	Maternal and Child Welfare Centre
MGBV	Management of Gender Base Violence

MNCHFP	Maternal Neonatal Child health and Family Planning
MO-MCH & FP	Medical Officer-Maternal and Child Health & Family Planning
MO Clinic	Medical Officer-Clinic
MOCC	Medical Officer Clinical Contraceptive
MOH&FW	Ministry of Health and Family Welfare
MoS	Month of Supply
NGO	Non-Government Organization
NSV	Non-Scalpel Vasectomy
NVD	Normal Vaginal Delivery
OB/GYN	Obstetrician and Gynaecologist
OCP	Oral Contraceptive pill
OPD	Outpatient Department
OT	Operation Theatre
PAC-FP	Post Abortion Care Family Planning
PMR-FP	Post Menstrual Regulation Family Planning
PNC	Post Natal Care
POP	Progesterone Only pill
PP-FP	Postpartum Family Planning
PP-IUD	Postpartum Intra Uterine Device
PV	Per Vagina
RH	Reproductive Health
RMO	Resident Medical officer
RTI	Reproductive Tract Infection
SACMO	Sub-Assistant Community Medical Officer
SBCC	Social Behavioural Change Communication
SOP	Standard Operating Procedure
SPs	Service Providers
SRH	Sexual and Reproductive health
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TV	Television
UFPO	Upazila Family Planning Officer
UHC	Upazila Health Complex
UH&FPO	Upazila Health and Family Planning Officer
UH&FWC	Union Health and Family Welfare Centre
USAID	United State Agency for International Development
VIA	Visual Inspection with Acetic Acid
WHO	World Health Organization

EXECUTIVE SUMMARY

Bangladesh, particularly in the last decade, has made considerable progress in improving the health status of its population. This is evidenced by the progress made in Millennium Development Goals (MDGs) 4 and 5, with marked declines in maternal and child mortality¹. Yet, Bangladesh's health service delivery has a long way to go in providing optimum services to its citizens. One of the primary concerns for the healthcare service delivery system has been the universal coverage of family planning services. In this backdrop, USAID has launched the "Shukhi Jibon" project, in order to increase utilization of family planning services through universal health coverage in Bangladesh. Pathfinder International, in partnership with Intra Health International, will implement the project for five years. In partnership with the Ministry of Health and Family Welfare, this project will provide adaptive, needs-driven technical assistance and systems strengthening at national, divisional, district, and upazila levels. The ultimate aim of Accelerating Universal Access to Family Planning (AUAFP), known as Shukhi Jibon in Bangladesh, is to reach those most in need of family planning services and information—districts and divisions with lower modern contraceptive prevalence and populations facing the greatest barriers.

In this context, this Facility Assessment Survey was designed to gather in-depth information on variety of aspects of the existing health facilities and family planning services across 69 health facilities in 6 districts of Bangladesh. The assessment has aggregated comprehensive information on key operational, service details and status of family planning service provision within these facilities. It has also helped garner extensive data to understand the existing model of local health facilities, the infrastructure and technology need gaps, personnel capacity development requirements, local community perspectives and managers' and service providers' experience in health and family planning service provision.

IPE Global and HDRC have been commissioned by Pathfinder International to conduct this study. As part of the assignment, a team of consultants has closely worked together to develop an understanding of the context of family planning services in Bangladesh and also conducted an in-depth desk study based on publicly available secondary information.

The assessment deployed mixed methods including both quantitative and qualitative methods for collection of information and evidence. The facilities were selected purposively in consultation with client. The assessment not only generated evidence through quantitative data points, but also addressed the 'why' and 'how' questions through qualitative findings about the status of facilities focusing on adolescent health services, family planning services using a gender-responsive lens. Questionnaires were provided by the Client, modified by the consulting firm, upon reviewing the GoB approved FP Manual (2017). Primary Data was collated across multiple sources including facility assessment, key informant interviews and focus group discussions. The quantitative data from facility audit was triangulated during KIIs with managers and service providers as well as FGD sessions with young adolescents and opinion leaders.

This report outlines key findings of the assessment, categorized into quantitative analysis and qualitative aspects of facility and community. Given the Client requirements, this report is based on a structure which reflects the quantitative findings from facility audit and the qualitative findings from KII with managers and service providers and FGD with young adolescents and opinion leaders under objectives wise and some suggestions as way forward. The findings will aid Pathfinder International to plan and create need-based solutions, on training and skilling programs, access to affordable equipment and develop a sustainable healthcare delivery model in the coming months.

Facility Assessment Report

Facility inspection revealed inadequacy of staff and presence on the day of survey. There is lack of training on gender and youth and adolescent services in 2 years preceding the survey. There is scarcity of privacy and confidentiality regarding service provision. The basic amenities (any 5) are available in 64% of facilities while basic client services are available in 55% facilities. Moreover, only 33% facility provided all services relevant to general FP services. The surveyed facility (UH&FWC) had necessary equipment for NVD but service provider is not available 24x7. Implant and sterilization is not available in UH&FWCs. There was no reporting of stock out. The availability of consent form coincides with the availability of FP services in different facilities. Infection control is poor in UH&FWCs (23%). Greater number of UHCs have of posters compared to other type of facilities while greater number of UH&FWCs have banners. Only a little more than half of the service providers in UHC and UH&FWC can show job-aids.

All surveyed facilities sent through supervisory visits within 6 months preceding the survey. Data suggest that there is provision of feedback and debriefing based on the supervisory visit. However, only 16% facility reported any action based on supervisory visit.

Findings from the KII with managers and service providers suggest that there is ardent need to provide adequate capacity building trainings, especially on the use and availability of various family planning methods, particularly for newly recruited staff. The Service providers, though, feel the need to receive trainings on PFP, PAC-FP, Post MR-FP, which will help them to increase the use of LARC. Managers also spoke in favor of introducing the practice of mentorship as a supervision mechanism. However, since the concept of mentorship is still very new, managers look forward to receiving associated training on Mentorship. In case of client screening, many of the providers we interviewed do not use the long checklist to the point as they don't have enough time. All managers and providers gladly accept and acknowledge the need for addressing adolescent health with separate focus and providers feel the need to appoint a separate counselor specifically for adolescents, which is currently missing. Some have also emphasized the need to appoint both male and female counselors to address gender-specific issues better.

Our discussion with adolescents reveal that family planning related services are still limited to married women. Most male adolescents, both married and unmarried, do not currently seek out family planning services to a good extent. One of the underlying reasons is the lack of awareness about the importance and availability of family planning services for men. At the same time, several male respondents voiced the lack of initiative from health workers, especially FWAs to reach out to men. They have opined that if a male FWV is appointed, then male clients would feel much more comfortable to approach him for FP services

Based on encouraging findings about the potential of promoting and expanding family planning services in Bangladesh, the report has concluded with a few key recommendations as a way forward. To begin with, a concerted and coordinated effort from the Government and other relevant sectors is essential in addressing the manpower shortage and capacity issue, which is one of the major challenges at present. At the same time, there is scope to strengthen the counseling service regarding FP at the health facilities. A three-days long training on counseling is recommended. Then, there is need and scope to undertake both vertical as well as horizontal expansion of cotton, especially in regions currently lying fallow. Finally, there is a crucial need to undertake awareness raising initiative at a much larger scale in order to increase outreach, break social stigma and eventually improve uptake and utilization of adolescent friendly FP services. If efforts from all these ends are well directed and coordinated, there is indeed a bright future for improved family planning practice in Bangladesh.

Highlights of Few Facility Assessment Survey Results

53% of Service Providers were present on the day of survey

55% of surveyed facilities had all general services

80% of the training in past 2 years were received by service providers in UHCs and UH&FWCs

64% of surveyed facilities had at least 5 basic amenities

97% of surveyed facilities had commodities for temporary short term FP method

33% of surveyed facilities were adequately prepared to provide FP services

48% of surveyed facilities were adequately prepared for Infection control

100% of surveyed facilities had supervisory visits within 6 months

94% of surveyed facilities could not ensure privacy during counselling

87% of surveyed facilities did not have separate seating arrangement for FP service

30% of surveyed facilities had complete records

71% of surveyed facilities had adequate readiness to provide FP services

A. BACKGROUND AND OBJECTIVES

The Accelerating Universal Access to Family Planning project

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

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

The project will operate in the divisions of Dhaka, Mymensingh, Sylhet, and Chottogram through a phased approach, beginning with six pilot districts, providing adaptive, needs-driven technical assistance (TA) and systems strengthening, and it will expand to all districts during the fourth and fifth project years. The project will reach individuals and communities most in need of quality FP services and information through innovative approaches tailored to reach areas with lower Modern Contraceptive Prevalence Rates (MCP) and populations facing the greatest access barriers, such as unmarried adolescents, newlyweds, First-Time Parents (FTPs), and postpartum (PP), Post-Abortion Care (PAC), and Post-Menstrual Regulation (MR) clients.

AUAFP link to USAID/Bangladesh's CDCS

AUAFP is designed to support the GOB's vision of becoming a middle-income country by 2021 while focusing on improving the lives of the poor, as indicated in the GOB's goal statement: "Bangladesh, a knowledge-based, healthy, food secure and climate resilient middle-income democracy."¹ In support of this GOB vision, USAID/Bangladesh developed the CDCS (2011-2016) with four development objectives in its results framework: (DO1) citizen confidence in governance institutions increased, (DO2) food security improved, (DO3) health status improved, and (DO4) responsiveness to climate change improved.

AUAFP Objectives and Intended Result

The overall objective of the AUAFP project is to increase utilization of family planning services through universal health coverage that will contribute to USAID/Bangladesh's CDCS goals and specifically DO3: Health Status Improved.

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

The Assignment

This facility assessment was undertaken in selected locations as part of the preparatory activity of the project. The assignment covered selected locations within project area (detailed in methodology section) in consultation with Pathfinder International. The assignment covered the following components:

Objectives of Conducting the Facility Assessment

As a part of the preparatory activity, the project is planning to conduct a comprehensive facility assessment, covering the following components:

Adolescent health Services

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

Family Planning with Post-partum, Post abortion care, and Post-MR services

- Assess the quality of PFP, PAC-FP and Post MR-FP services at facility level that examines structural barriers to quality services, the availability of contraceptive supplies, logistics, client flow, quality of education and counselling, and follow up, among others.
- Assess the status of PFP, post-MR -FP and PAC FP service delivery to understand the degree of integration of FP with post-partum, post abortion care, and post-MR services and quality improvement.

Gender Responsiveness

- To assess gender responsiveness at facility level.
- To examine integration of gender with family planning services.

B. ASSESSMENT METHODOLOGY

The Assessment methods

The assessment deployed mixed methods including both quantitative and qualitative methods for collection of information and evidence. Primary Data was collated across multiple sources including facility assessment, key informant interviews and focus group discussions. The quantitative method included structured questionnaire for facility assessment through observations as well as face to face interviewing. The structured questionnaire for facility assessment included 13 different sections in line with the objectives. It also provided options to note down any special instances. The facility assessment required face to face conversation with multiple service providers as well as managers. The assessment not only generated evidence through quantitative data points, but also addressed the ‘why’ and ‘how’ questions through semi-structured interviews (KIIs and FGDs) about the status of facilities focusing on adolescent health services, family planning services using a gender-responsive lens. Focus group discussions covered adolescent married as well as unmarried boys and girls and opinion leaders while key informant interviews were conducted with service providers, facility managers, and administrative managers.

The questionnaires

The overall assessment included 5 different types of questionnaires:

1. Structured Questionnaire for Facility Assessment,
2. Focus group discussion guidelines for Adolescents,
3. Focus group discussion guidelines for Opinion leaders,
4. Discussion guidelines for Key informant interview with managers, and
5. Discussion guidelines for Key informant interview with service providers.

The questionnaires were provided by Pathfinder International, translated and modified by the consulting firm. The questionnaires were finalized in consultation with Pathfinder International upon pre-testing and reviewing the GoB approved FP Manual (2017).

Geographical Coverage and Sample Size

The ToR mentioned that the project planned to cover 32 districts across 4 divisions and specified the districts to be covered under the assignment (Dhaka, Chottogram, Rangamati, Mymensingh, Faridpur, and Sylhet). The mentioned districts included 65 upazilas and 59 Upazila health complexes (UHC) of Bangladesh. In discussion with Pathfinder international, the assignment was to cover at least half of the upazilas with UHCs which rounded up to 30 covering 5 from each district. The assignment also covered district hospitals (DH) and maternal and child welfare center (MCWC) in the sadar upazilas.

Table 1: Geographical Coverage of the Assignment

Districts Name	Number of upazila	Sample District Hospital	Sample MCWC	Sample upazila	Sample union
Dhaka	6	1	1	5	5
Faridpur	9	1	1	5	5
Chottogram	15	1	1	5	5
Rangamati	10	1	1	5	5
Mymensingh	12	1	1	5	5
Sylhet	13	1	1	5	5
Total	65	6	6	30	30

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The upazila health complexes and union health and family welfare centers within the districts were selected following the criteria shared by Pathfinder International:

Selection criteria of Upazila Health Complex (UHC)

- ❖ Better transportation facility from district
- ❖ Availability of electricity and internet connection
- ❖ Performance coverage is better compared to other UHCs in same district
- ❖ Presence/posted UFPO and/or MO (MCH-FP) and UFPA (for maintaining service statistics)

Selection criteria of Union Health & Family Welfare Centre (UH&FWC)

- ❖ High performing center within the selected Upazila
- ❖ Posted and presence of FWV within the selected Upazila
- ❖ Availability of electricity within the selected Upazila
- ❖ Better communication within the selected Upazila

A total of 69 facilities (out of 72) were successfully visited for the facility assessments. In addition, 48 Key Informant interviews with managers and healthcare service providers, 12 focus group discussions with adolescents (equally divided among boys and girls, married and unmarried), and 6 focus group discussions with community influencers took place, as detailed in the following table:

Table 2: Result of facility contact, KII & FGD by background characteristics

Type of data collection activity and target participant	Completed	Duplication of position	Respondent not available	Refused	Other	Total percent
Facility type	69	-	2	1	0	96
District, Upazila & union level facilities						
DH	5	-	0	1	0	83
MCWC	6	-	0	0	0	100
UHC	28	-	2	0	0	93
UH&FWC	30	-	0	0	0	100
Key Informant Interview (KII)	48	10	1	1	0	80
Managers (DDFP, ADCC, FPCS-QIT, UFPO)	17	4	1	1	0	73
Service Providers (MOMCH-FP, MOCC, MO Clinic, FWV)	31	6	0	0	0	84
Focus Group Discussion (FGD)	18	-	0	0	0	100
Female Adolescents	6	-	0	0	0	100
Male Adolescents	6	-	0	0	0	100
Opinion Leaders	6	-	0	0	0	100

Data Analysis

Quantitative analysis: The primary unit of analysis of the study were health facilities with result summarized for districts. Data was analyzed using SPSS. Basic tools used for data analysis are distributions/descriptive statistics (numbers, proportions, and percentages), graphical representations, Statistics (mean, median, mode etc.), Cross tabulations. The report includes multiple readiness assessment following BHFS 2014 report.

Qualitative information analysis: The qualitative discussions were written into scripts. Content analysis was performed for to draw conclusion from such information from reporting. Outline of approaches to qualitative data analysis: (1) Documentation; (2) Organization/categorization; (3) Connection between information; (4) Corroboration/legitimization; and (5) reporting the findings.

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

Ethical Clearance

Ethical Clearance was obtained from Institute of Health Economics (IHE), University of Dhaka following appropriate procedure. Based on the application for ethical Clearance, IHE made specific queries. Upon providing successful clarification to the queries, a certificate was issued. The certificate is attached in annex.

Assignment Implementation

Field team Structure: The field team was under close supervision of core team members of the assignment. The selected field personnel had previous experience with similar assignment and were at least graduates. The field team was divided into 06 teams, each containing 03 field enumerators. Each team was assigned to collect information from 01 district. Contact information of each team was circulated among HDRC, IPE Global and Pathfinder official. Each team was also provided with a field plan. These plans were shared with Pathfinder officials prior to field work. Pathfinder, IPE Global and HDRC also moved to different data collection areas for spot checking as a quality measure.

Project Orientation: HDRC along with IPE Global arranged a 4 day long residential orientation at HDRC training room in Dhaka. Core team members (the team leader and consultants) were present to provide greater insights into project activities, targets, and field level actors. Classroom sessions continued for three days. Following this a field practice was arranged at a nearby health facility, to make sure the field personnel had sufficient prior experience of the real field situation and to address any concerns in the questionnaire design and approach. The orientation ensured uniform understanding among survey staffs about the assignment objective, approach, its results, ethical issues, and data verification process.

Quality Control Measures

Supervision and monitoring deployed in all aspects beginning from training of data collectors to data management. It was implemented by IPE global, HDRC and by Pathfinder International team. However, IPE Global and HDRC deployed their own supervision system to minimize the error of training and data collection. Each team for data collection composed one supervisor and two data collectors (one male and one Female). Supervision and quality control had been deployed during training, data collection and data management and analysis.

Team from pathfinder Int. attended training sessions of quantitative and qualitative data collection of data collection teams. Ten percent of all facilities were visited by the Pathfinder International team during data collection and all data collection forms during those visits has been revisited to check the validity and reliability of the information on the spot. Supervisors of these sub-teams looked after the daily collection process to ensure quality of information, after continuously cross checking with IPE and HDRC team of Dhaka for any query. In addition, five percent forms were copied by the pathfinder Int. team to check the consistency and verify the accuracy of data entry during data management.

In case of qualitative interview, a few recording of KII and FGDs were cross checked with the transcripts to understand the accuracy of writing followed by the translations.

Pathfinder Int. team also checked the raw data entry files after having preliminary tables to check the reliability of analysis. It should be mentioned here the all checking and verifying of data were limited into the research team to maintain confidentiality according to the process committed during processing of IRB.

Field Data Collection

Data quality control mechanisms for the Facility Audit were an important issue as the majority of the data for this survey was quantitatively focused. A field protocol was prepared in Bangla (including facilitation techniques for the Facility Audit, KIIs and FGDs) to ensure data quality and consistency. HDRC and IPE Global undertook the following strategies/activities during fieldwork collection for data quality assurance in line with the data quality assurance protocol:

- The core team members were in the field to make sure no serious problems persisted in the data collection process and ensure the process could run properly (e.g. problems with the data collection application).
- The core team members conducted the KIIs with senior level administrative managers.
- Field team supervisors shared respective field updates every day to make sure the data collection was on track. Any notable deviation would have been communicated to the Pathfinder International team immediately.
- Team supervisors consulted the core team for any difficulties regarding tools and identification of respondents (key informants) and HDRC had taken steps immediately to resolve the concerns for smooth execution of data collection.
- HDRC staff maintained field surveying protocols (facilitation techniques for Facility Audit, FGDs and KIIs with consent) at every step of data collection so the data/information collection method remained consistent.
- Revisits were undertaken to selected facilities where data inconsistency or inaccuracy was identified through basic frequency distribution.

Data Quality Control

HDRC took the following steps for assuring quality control during data management, computerization and cleaning:

- Uploaded data was checked for consistency and recoding of 'other' responses to structured questions was done.
- Data was uploaded on a regular basis and inconsistencies were communicated back to field personnel. These were resolved through asking the field enumerator and his/her supervisor for clarification.
- Data cleaning included generating single variable tables for consistency checks.
- Data was cleaned by consistency checks, cross tabulations and cross-checking values with the original questionnaire.

Limitations

- Training information of service providers was collected for the past two years only considering possible recall bias.
- In 20% of cases, managers or service providers were responsible for additional duties/roles within the health facility; as a result, fewer KIIs than anticipated were conducted, as multiple posts were filled by a single manager or provider.
- The selection strategy of facilities was purposive (explained earlier in this section) and may not provide a generalized picture where performance or access is poorer compared to the selected facilities.
- The overall sample size of surveyed facilities is large enough to provide credible estimates in percentages. However, the sample size of tertiary level facilities are very few (District hospital: 5 and MCWC: 6) to provide credible estimates.
- Availability of FP Method Specific Equipment were identified as available and functional on the basis of observation and limitation to counting the set of instruments which might not mirror the actual evidence.

C. FINDINGS

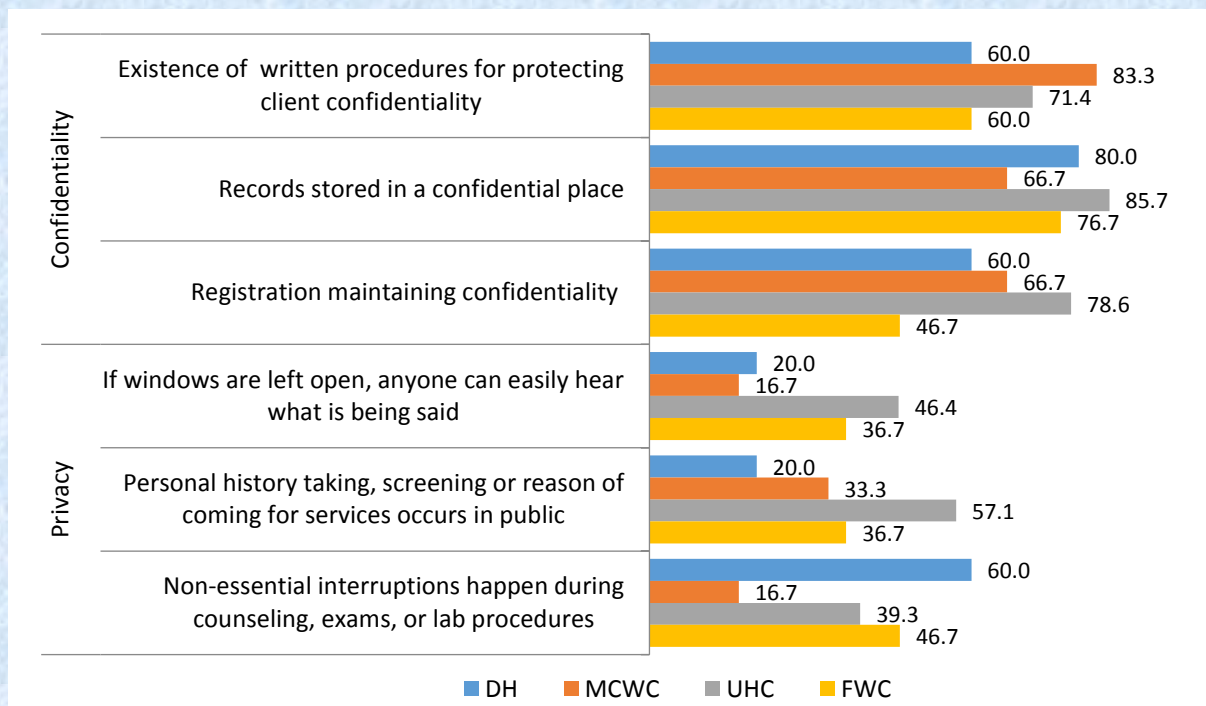
Findings are presented according to the three objectives of the assignment.

C1. Adolescent Health Services

Key concerns relating to adolescent and youth services are confidentiality and privacy. In the section of availability of basic amenities, it was identified that there was a lack of visual and auditory privacy for clients, whether adults or young people, across most of the facilities visited. However, the registration and recordkeeping (confidentiality) show better trend.

In an effort to create spaces that are specifically oriented to young people and to give them more private and comfortable access to health services, the GOB has begun creating “adolescent-friendly corners”. However, this approach is yet to be implemented phase by phase. Only 12 out of 69 inspected facilities (17%) had built adolescent corner providing limited or no services to adolescents by the time the inspection took place. Informants in UHC reveal that they were told to build adolescent corner within UHC.

Figure 1: Confidentiality and privacy status for adolescent and young clients (%)



More than half of the service providers (52%) are not aware of guidelines for service youth. Also 55% service providers think there is a minimum age to provide contraceptive or PAC services which is a misconception (since the guidelines only mentioned about marital status not an age limit) while 87% of the service providers recalled about the necessity of spousal consent. The service delivery guideline is almost uniformly available (99%) and it is reported that it is followed for majority of instances (81%). In reality, the service delivery guideline (FP manual) includes specific instructions to provide services to adolescents and youth. However, only 59% of service providers could recall of such instructions.

Table 3: Service availability and preparedness to provide services to adolescent and youth (%)

Indicators	Type of health facility (%)				Total
	DH	MCWC	UHC	FWC	
Services for adolescents regardless of age and marital status					
Clear written guidelines exist for serving youth	20.0	100.0	42.9	46.7	47.8
Require a minimum age for contraceptive or PAC services	40.0	66.7	39.3	46.7	44.9
Requires spousal consent	60.0	100.0	85.7	90.0	87.0
FP treatment guidelines, procedures and protocols					
Guidelines and SOPs for FP available on site	80.0	100.0	71.4	86.7	81.2
Service delivery procedures for FP services available	100.0	100.0	96.4	100.0	98.6
Service delivery guidelines for serving adolescent clients available	60.0	83.3	53.6	60.0	59.4
The protocols followed routinely	100.0	100.0	82.1	73.3	81.2
PAC treatment guidelines, procedures and protocols exist and are followed	100.0	83.3	78.6	56.7	71.0

The key area of concern is that the service providers themselves are acknowledging that private information such as the personal history, screening, reason of visit takes place in public and non-essential interruptions happen frequently irrespective of facility type. Though there is existence of written procedure of client confidentiality, the infrastructure does not support such confidentiality. However, once the records are written they are stored maintaining confidentiality which is not of much use once others had already listened to those.

It is reflected from the discussion with managers and service providers, young adolescents are able to access the facilities easily. However unmarried adolescents are restricted to receive any FP method as government considers only married couple as eligible recipients of such services. Majority of managers and service providers themselves are not ready to accept the need for family planning methods for unmarried adolescents.

QUOTE: Manager said “Those who are unmarried they are taking the service from the Pharmacy but being a government employee we have to register couple, cannot serve the unmarried. “



All managers and providers gladly accept and acknowledge the need for addressing adolescent health with separate focus and providers feel the need to appoint a separate counsellor specifically for adolescents, which is currently missing. Some have also emphasized the need to appoint both male and female counselors to address gender-specific issues better. Managers have also emphasized on the need to appoint young councilors since they are more at ease at discussing with youth on this topic and open to the idea of providing family planning related counselling to adolescents, while older service providers are often hesitant, shy and resistant to the concept of providing such services to youth and adolescents.

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When asked about accessibility, service providers informed us that adolescents are often hesitant and uncomfortable to come and seek services during peak hours, i.e. 10 AM to 10 PM, and they usually prefer to come at a time where there is not much crowd.

As per Government guidelines, separate youth and adolescent corners are being established in all the health centres. This is being done on a planned phase by phase basis. At the same time, trainings on youth and adolescent friendly health service delivery are also being conducted on a phase by phase basis.

Most Service Providers feel that the previous service delivery timing, from 8:30 to 2:30, was a constraint in reaching adolescents due to overlapping with their school and college hours. In this context, the timing has recently been revised to 9:00 – 3:30. It is expected by both managers and service providers that the service delivery and service uptake rate by adolescents will significantly improve.

The focus of discussion with adolescent groups (male, female, married, unmarried) and opinion leaders revolved around exploring the knowledge and awareness about reproductive health and family planning services that currently exists among young adolescents within the communities. Participants were requested to comment on the following:

- First person to contact for any health-related information.
- Available health services in your community. Source of information of the services.
- Available family planning services in your area.
- Cost of available family planning services in your area.
- The most frequently accessed facility for RH&FP services for family planning services.
- The typical reproductive health / family planning related services people around youth and adolescent age (15-19 years) usually avail from a public health facility.
- Services specifically available related to RH/FP for unmarried adolescents at public health facilities.

Several private and public facilities are available to these communities that provide primary, secondary and tertiary healthcare services. Most adolescents receive health related information from local health facilities, which include Upazila Health Complex (UHC), Family Welfare Centers (FWC) and Community Clinics. When asked about first person to contact for any health-related information, they mentioned the names of NGO (BRAC, Smiling Sun) workers, pharmacy sales person, village doctor, SACMO, CHCP, FWA and FPI as well as local seniors, guardians and family members. For common health ailments like fever, cold etc. they prefer to visit local doctors based in Upazila Health Complex and Family Welfare Centers. For specialized treatment, they prefer to visit district hospitals owing to the affordability factor. With regard to available family planning services, majority of adolescent participants said that while these services are readily available through FWA and UH&FWXs, it is mainly the married women who avail these services. The male adolescents as well as the unmarried female adolescents themselves said that they hardly ever avail these services and most of them feel then these are appropriate for married women.

Most of the adolescent girls, married and unmarried, in the community are fairly educated and are aware about family planning related matters and practices. In terms of health seeking behavior for maternal care, most respondent said that pregnant women are informed and educated about safe pregnancy, nutrition and maternal care. These services are mainly provided by FWAs who visit them on regular basis. As for unmarried young adolescents, they say that they usually visit FWCs to seek services related to lower abdominal pain, menstrual care, white discharge,

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headache, TT, EPI for children, dietary advice as well as services related to physical and mental health issues. All these services are mostly subsidized by government.

Feedback from the adolescent clients however highlight that medicines are mostly not provided to the clients. This shows a great need to address medicine supply issue and find means to improve the supply of adequate medicines in order to better serve the clients.

As mentioned above, it is mostly young married adolescents who currently avail FP services. Social Stigma and fear of losing name often prevent unmarried adolescents to seek out FP services, as stated by the adolescents themselves during the group discussions. At the same time, most young unmarried adolescent girls we interviewed, themselves are of a strong opinion that family planning services are not relevant for them and hence they are hesitant to even discuss on this matter. However, most girls are health-conscious and aware about their bodies. The services that unmarried girls say they do seek out are related to abdominal pain, white discharge, menstrual health, nutritional recommendation, physical and mental health issues etc.

The current service delivery timing from 8:30 AM to 2:30 PM, which overlaps with school timing, has been cited by adolescent participants of FGDs as one of the major hindrances to service uptake by young adolescents. Young adolescents participating in group discussions mentioned that although the timing has been revised recently, this information is yet to be communicated at the field level.

Opinion leaders suggested that Family Planning should be included as separate subject in academic syllabus in schools, madrasa so that adolescents are more aware and less hesitant to avail such services in the future.

C2. Family Planning with Post-partum, Post abortion and MR Services

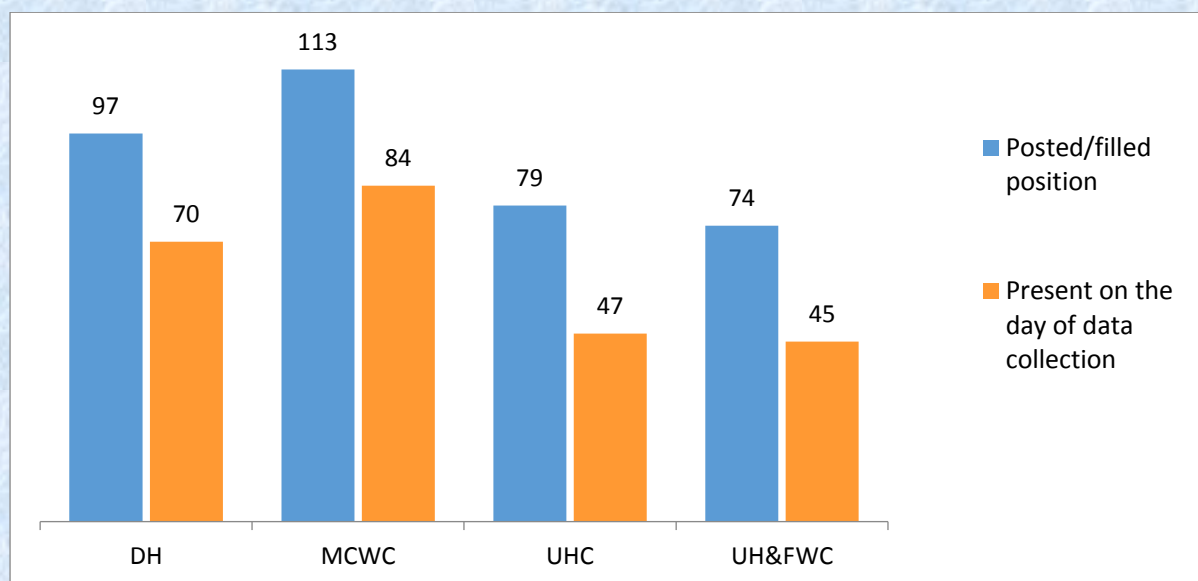
C2.1 Human Resources

The overall availability of human resources compared to sanctioned posts is 83% and the available human resource on the day of survey is 53% compared to the sanctioned posts. This suggests that 64% of available human resources was present on the day of survey. The availability problem is less in cities. It is evident that surveyed district hospitals and mother and child welfare centers there are greater number of service providers available compared to sanctioned posts. The health centers in cities are running with service providers on deputation from upazila and union level while the upazila and union level facilities are struggling with lack of adequate service providers. Absence of posted health service provider is also a key area of concern as the absence of service providers on UHC and UH&FWC on survey date was estimated as 54% and 51% respectively.

Table 4: Availability of human resources and their presence on survey date

Background characteristics	DH			MCWC			UHC			UH&FWC		
	No. of sanctioned post(s)	No. of Provider(s) available (%)	Present on survey date (%)	No. of sanctioned post(s)	No. of Provider(s) available (%)	Present on survey date (%)	No. of sanctioned post(s)	No. of Provider(s) available (%)	Present on survey date (%)	No. of sanctioned post(s)	No. of Provider(s) available (%)	Present on survey date (%)
Provider Type												
OB/GYN	14	114	107	.	.	.	.	.	.	.	.	.
Nurse	10	130	100	.	.	.	.	.	.	.	.	.
Midwife Nurse	19	100	53	10	110	60	.	.	.	.	.	.
MO-Clinic	.	.	.	5	100	80	.	.	.	.	.	.
MO (MCH-FP)	.	.	.	16	100	81	44	84	36	.	.	.
FWV	.	.	.	15	127	93	35	91	74	35	94	80
RMO	.	.	.	.	.	.	22	96	73	.	.	.
UFPO	.	.	.	.	.	.	28	75	39	.	.	.
AUFPO	.	.	.	.	.	.	27	74	33	.	.	.
AFWO (MCH-FP)	.	.	.	.	.	.	27	48	30	.	.	.
MO-FW	.	.	.	.	.	.	.	.	.	25	12	4
SACMO	.	.	.	.	.	.	.	.	.	30	73	57
FPI	.	.	.	.	.	.	.	.	.	30	97	57
FWA	.	.	.	.	.	.	.	.	.	103	77	37
Cleaner/Sweeper	17	59	41	.	.	.	.	.	.	.	.	.
Aya	.	.	.	17	118	94	.	.	.	.	.	.
Total	60	97	70	63	113	84	183	79	47	223	74	45

Figure 2: Availability of human resources and their presence on survey date (%)



C2.2 Training

The most commonly received training within past 2 years were on Supervision followed by PFP, IUD, and FP counseling. Commonly majority of PFP, IUD, and FP counseling were received by FWV/Senior FWV/ AFWO while training on Supervision is received by UFPO and MOMCH-FP.

Across all facilities, FWV/Senior FWV/ AFWO received most number of trainings (87%) followed by MO (MCF-FP) and UFPO/AUFPO while Ob/gyn and RMO received the least number of training. Among type of training, most common was PFP followed by IUD and counseling. The least common training was on gender followed by PAC. . Among all reported trainings, 80% were received by workers in UHC and UH&FWCs while workers in tertiary level facilities receive only 20% training. Most of the training were relevant to FP service provision. The number of training relevant to thematic issues (i.e., gender, adolescent/Youth) and supervision is very few.

Table 5: Trainings received by staff for family planning and reproductive health services in the previous 2 years (frequency)

Background characteristics	Medically trained provider						UFPO/AUFPO	FPI	FWA
	Ob/Gyn	RMO	MO (MCH-FP)	MO-Clinic	FWV/Nurse/Midwife/Sr. FWV/AFWO	SACMO/MA			
Training Types									
IUD	0	1	3	0	21	0	0	0	0
PP IUD	0	0	0	1	1	0	0	0	4
PFP	1	0	1	0	24	0	1	1	0
Implant	0	0	7	0	4	0	1	0	0
Vasectomy	0	0	2	0	2	0	0	0	0
Tubectomy	1	0	0	0	2	0	0	0	0
Short-acting FP method	1	0	1	0	4	0	1	0	0
Counseling-FP	0	0	2	0	10	0	4	1	5
PAC	0	0	1	0	3	0	0	0	0
IP	0	1	1	1	6	2	0	0	0
RTIs/STIs	0	0	0	0	3	2	1	0	2
Adolescents & Youth FHS	0	0	2	2	5	3	3	0	2
Gender	0	0	0	0	0	1	0	0	2

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Background characteristics	Medically trained provider						UFPO/ AUFPO	FPI	FWA
	Ob/Gyn	RMO	MO (MCH-FP)	MO-Clinic	FWV/Nurse/ Midwife/Sr. FWV/AFWO	SACMO/ MA			
Supervision	0	1	5	0	2	0	5	3	0
Total	3	3	25	4	87	8	16	5	15

The discussion with the managers and service providers revealed mixed feelings with regard to training provision. Most managers expressed concern over irregularity and gaps in service provision when service providers, who are already short in number, are sent off to trainings on ad-hoc basis. While majority of managers do feel there is a need to provide adequate capacity building trainings, especially on the use and availability of various need-based family planning methods, for newly recruited staff, they do not feel the same is necessary for existing ones since they are already skilled at their jobs. Managers have said that they have a plan to promote the use of LARC among clients in order to prevent unplanned pregnancies, for which it is essential to provide adequate trainings to service providers on the associated methods. The Service providers (MoMCH, FWVs), also feel the need to receive trainings on PFP, PAC-FP, Post MR-FP. The Service providers said that since these trainings on family planning methods includes technical training on the use of LARC, including implant and IUD this will eventually help them to promote and thereby increase the use of LARCs within the community.

It came up during discussion with managers that basic trainings for managers and for FWAs and FWVs have been conducted by NIPORT since long. There is no pre-fixed timelines for these trainings. As per demand, DGFP plans the trainings and ask NIPORT to organize those as per given schedule. Accordingly, NIPORT in turn sends participant lists to relevant facilities. , Managers said that they are not consulted about the timing of training or the selection of participants. Once trainings are scheduled, respective managers' have no choice but agree to let providers at their facilities attend these trainings as per given schedule.

Several managers stressed the importance of inclusion of training on counselling and motivation as part of existing trainings. Although they have also stressed the fact that existing staffs are overburdened with work, leaving them little time for counseling, which they do not necessarily view as an integral part of service provision. Service providers also mentioned that sometimes they organize group counselling on any specific issue when solitary counseling does not provide sufficient time. **QUOTE: Service provider said "Group counselling is provided and there is no separate counsellor"**.

Managers also spoke in favor of introducing the practice of mentorship as a supervision mechanism. However, since the concept of mentorship is still very new, managers look forward to receiving associated training on Mentorship.

C2.3 Basic Services

Availability of Basic Amenities

The facilities were assessed for availability of basic amenities following the Bangladesh Health Facility Survey. **The basic amenities include:** regular electricity, improved water source, privacy during consultation, client latrine, communication equipment, computer with internet access, and availability of emergency transport. Following the BHFS we assessed the facilities with at least basic amenities.

Electricity, Improved water source, and client latrine is available in almost all facilities. Separate latrine for female clients is not available in UH&FWCs. The key concerning issue is privacy while counseling.

Except MCWC, privacy is challenged. The overall availability of basic amenities (at least 5¹) is best in MCWCs followed by UHCs and district hospitals.

Table 6: Availability of basic amenities for client services [%](n)]

Facilities surveyed (n)	Percentage and number of facilities surveyed that had basic amenities available: % (n)									No. of facilities
	Regular electricity	Improved water source	Visual and auditory privacy while counseling	Client latrine	Communication equipment	Computer with internet	Emergency transport	Separate latrine for female clients	Any 5-basic amenity	
Facility type: District, Upazila & union level facilities										
DH	100 (5)	100 (5)	20 (1)	100 (5)	80 (4)	40 (2)	80 (4)	100 (5)	100 (5)	5
MCWC	100 (6)	100 (6)	83 (5)	100 (6)	67 (4)	33 (2)	83 (5)	100 (6)	100 (6)	6
UHC	100 (28)	100 (28)	43 (12)	100 (28)	79 (22)	64 (18)	61 (17)	100 (28)	96 (27)	28
UH&FWC	87 (26)	77 (23)	50 (15)	100 (30)	23 (7)	0 (0)	0 (0)	0 (0)	20 (6)	30
Total	94 (65)	90 (62)	48 (33)	100 (69)	54 (37)	32 (22)	38 (26)	57 (39)	64 (44)	69

Availability of basic client services

The assessment of basic client services is assessed through 8 different services. **The assessment of basic services include:** 1) providing any modern FP methods, 2) MCH services, 3) ANC service, 4) Normal delivery service, 5) PNC services, 6) Adolescent health services, 7) PAC-FP services, and 8) Post MR service. Modern FP methods, MCH services, and ANC service is available in all facilities. PNC services and Adolescent health service is also very commonly available. Family planning services during Post Abortion care is the least commonly available basic client service. All basic client services is available in only 55% of the facilities.

Table 7: Availability of basic client services [%](n)]

Facilities surveyed (n)	Number and percentage of facilities surveyed that had basic client services available: % (n)									No. of facilities
	Any modern FP methods	MCH services	ANC	Normal Delivery	PNC	Adolescent Health	PAC-FP	Post-MR FP	All basic client services	
DH	100 (5)	100 (5)	100 (5)	80 (4)	80 (4)	100 (5)	80 (4)	40 (2)	20 (1)	5
MCWC	100 (6)	100 (6)	100 (6)	100 (6)	100 (6)	100 (6)	100 (6)	83 (5)	83 (5)	6
UHC	100 (28)	100 (28)	100 (28)	100 (28)	100 (28)	93 (26)	75 (21)	89 (25)	68 (19)	28
UH&FWC	100 (30)	100 (30)	100 (30)	70 (21)	100 (30)	93 (28)	63 (19)	80 (24)	43 (13)	30
Total	100 (69)	100 (69)	100 (69)	86 (59)	97 (68)	94 (65)	73 (50)	81 (56)	55 (38)	69

¹ Following the criteria of Bangladesh Health Facility Survey (BHFS)

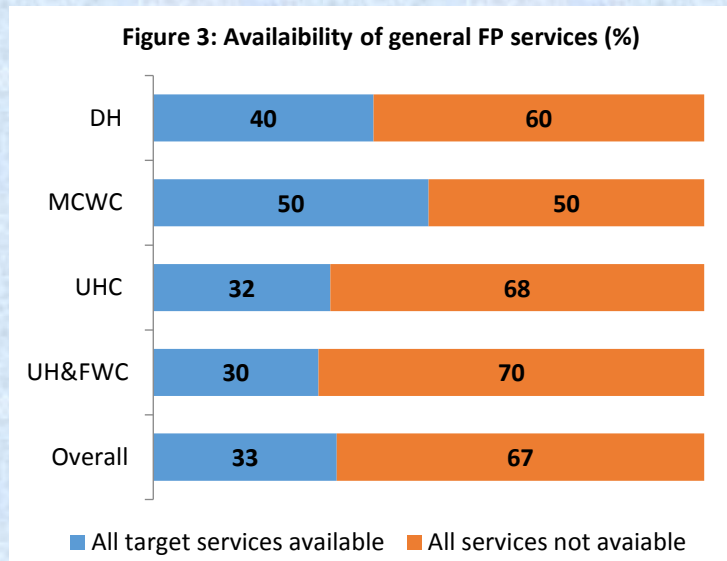
C2.4 Family Planning Services

Availability of General FP Services

The facility assessment asked whether the following categories of FP services were provided at the given facility: 1) Adolescent and Youth Health Services, 2) Counseling for Family Planning, 3) Post Abortion Care-Family Planning, 4) Postpartum Family Planning, 5) Management of Gender Based Violence (MGBV), 6) Family Planning Services, 7) RTI/STI Management, and 8) Maternal and Child Health Services².

Data suggests that most of the services were available in MCWCs with the exception on MGBV services.

MGBV services, among the categories specified in the assessment, was the least available service category. Most of the service providers were unaware of appropriate MGBV services. Also there is possible gap in the conception of MGBV services (Annex 4, Table 1). Counseling and commodity services on family planning as well as ANC and PNC services were available in all surveyed facilities. Interestingly, 70% of UH&FWCs reported availability of normal vaginal delivery (NVD). Further inspection revealed that the centers are ready for NVD but there is lack of 24x7 service provider availability.



Availability of FP Commodities

The availability of FP commodities has been assessed for the modern contraceptive methods: Pill, Condom, IUD, Injectable, Implant and permanent methods. The availability of Emergency contraceptive pill has also been inspected. The responses for short and long acting methods were recorded based on observation while the response for permanent method was recorded based on availability of equipment and qualified provider.

The necessary FP commodities except for implant and permanent method are commonly available. This lack of availability of implant and permanent method is caused by the UH&FWCs as these methods are not commonly provided there. Condom and injectable are the most common FP method available in the facilities followed by Pill. There is hardly reporting of stock out. Sterilization and implant is not performed in UH&FWCs. The MOMCH performs camp for sterilization and implant according to their calendar. The service providers reported availability of those services in UH&FWC based such camps which is a limitation at their part of understanding.

² C-Section delivery service is not available in UH&FWC

Figure 4: Availability of FP commodities (%)

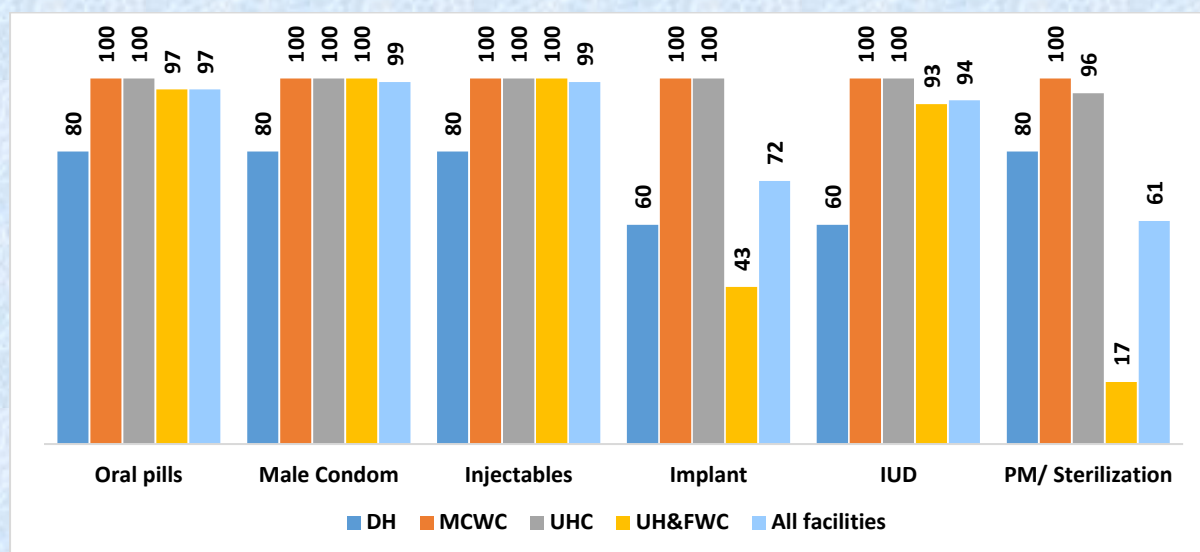


Table 8: Availability of family planning commodities and supplies [%(n)]

Facilities surveyed (n)	Percentage and number of facilities surveyed that had FP commodities and supplies available: % (n)						No. of facilities
	Combined or progestin only oral pills	Male Condom	Progestin-only Injectables	Implant	IUD	PM/ Sterilization	
DH	80 (4)	80 (4)	80 (4)	60 (3)	60 (3)	80 (4)	5
MCWC	100 (6)	100 (6)	100 (6)	100 (6)	100 (6)	100 (6)	6
UHC	100 (28)	100 (28)	100 (28)	100 (28)	100 (28)	96 (27)	28
UH&FWC	97 (29)	100 (30)	100 (30)	43 (13)	93 (28)	17 (5)*	30
Total	97 (67)	99 (68)	99 (68)	72 (50)	94 (65)	61 (42)	69

* Response error

Readiness to Provide General FP Services

The readiness to provide FP services was assessed using a set of six indicators following BHFS 2014: 1) Availability of trained staff (any), 2) Availability of FP guideline provided by GoB, 3) Availability of necessary equipment (BP machine), and 4) Availability of pill, injectable, and condom. Data suggest that all surveyed facilities have trained staff as well as BP machine. In some of the facilities, the service providers could not show the guideline during survey. The section on availability of FP commodities already reveals that condom and injectable was available in all surveyed facilities but one. The key issue hindering the readiness to provide FP services is the lack of availability of OCP. However, discussions with informants reveal that the lack of availability was in fact a unique situation which was the result of recent national election.

Figure 5: Readiness of health facilities to provide FP services (%)

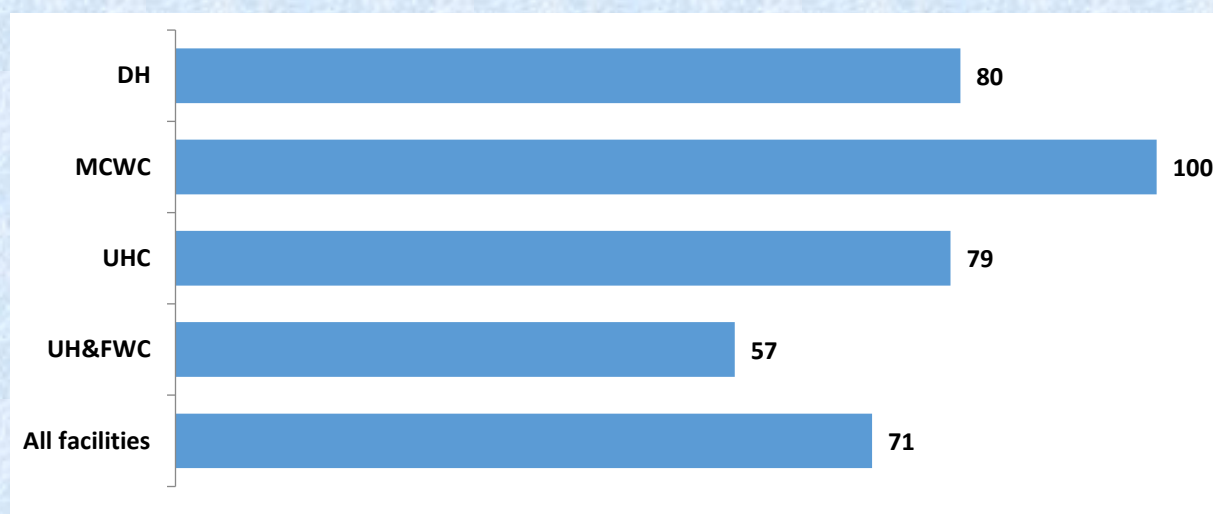


Table 9: Readiness of health facilities to provide family planning services [% (n)]

Facilities surveyed	Percentage and number of facilities surveyed that met each of the SIX OR SEVEN criteria for readiness to provide FP services: % (n)							No. of facilities
	Guidelines on Family planning	Staff trained in family planning any time	Pills	Male condom	Progestin-only Injectables	Blood pressure apparatus	All 6 items available	
Facility type: District, Upazila & union level facilities								
DH	80 (4)	100 (5)	80 (4)	80 (4)	80 (4)	100 (5)	80 (4)	5
MCWC	100 (6)	100 (6)	100 (6)	100 (6)	100 (6)	100 (6)	100 (6)	6
UHC	79 (22)	100 (28)	100 (28)	100 (28)	100 (28)	100 (28)	79 (22)	28
UH&FWC	57 (17)	100 (30)	97 (29)	100 (30)	100 (30)	100 (30)	57 (17)	30
Total	71 (49)	100 (69)	97 (67)	99 (68)	99 (68)	100 (69)	71 (49)	69

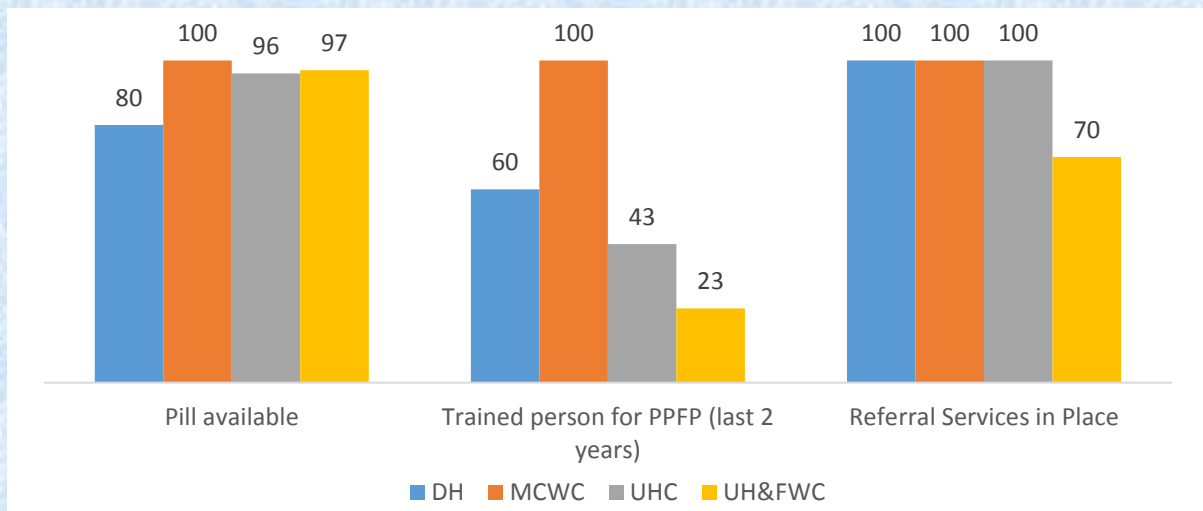
The overall readiness of surveyed facilities is 49% which is higher compared to the national estimates (21%). This is not surprising as the surveyed facilities are not random rather easy to reach facilities.

Readiness to Postpartum FP Services

The readiness to provide PPFp services is assessed through the availability of trained person in PPFp, availability of pill, and existence of referral services in the facility.

Survey report suggests that PPFp services were available in the majority of the surveyed facilities. Figure 6 suggests that pill and referral services were available in majority of the facilities. As the survey asked only about training that had been provided in the two years prior to the survey, the overall rates of PPFp training may appear low; it is possible that many service providers received training on PPFp services earlier than 2 years.

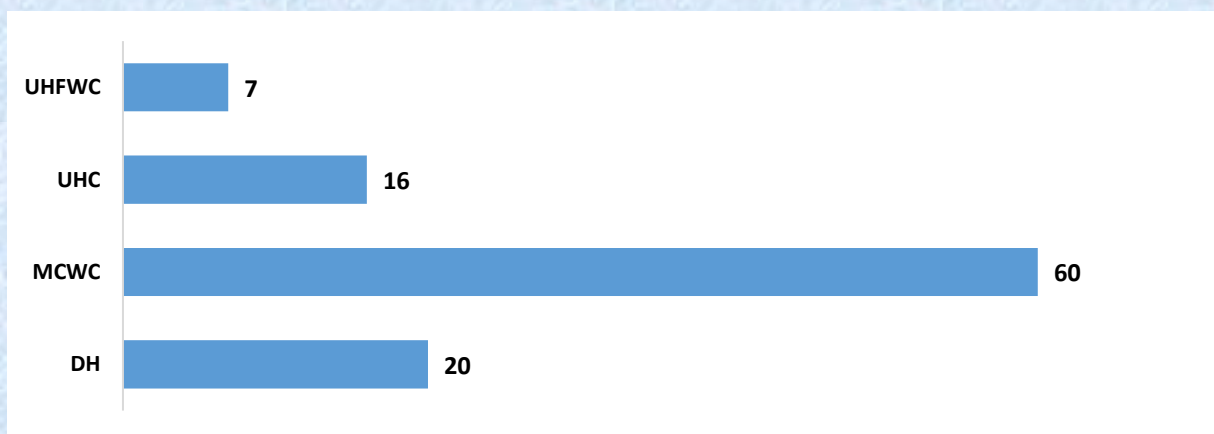
Figure 6: Readiness to Provide PPFP Services (%)



Seating Arrangements for FP Clients and Time to Avail FP Services

Data suggest that there was no distinct seating arrangement available for FP clients in 80% of DHs, 40% of MCWCs, 84% UHCs and 93% UH&FWCs (Figure 7). On average, FP clients had to wait 48 minutes (highest in UHC: 60 minutes and lowest in UH&FWC: 36 minutes) for FP services. The wait time was reported to vary according to the FP method the clients were receiving. Clients for PM reportedly spent nearly 78 minutes to avail services while clients for pill, condom only spend only 12 minutes.

Figure 7: Availability of Separate seating Arrangement (%)



Availability of Informed Consent Form

Informed consent form for IUD is available in most of surveyed facility. DHs show lack of availability of consent forms for NSV. Informed consent is available in majority of facilities where FP service is provided. However, there is large gap in availability of consent form compared to service availability of injectable (consent form available in 45% facility while service provided in 99% facility). We found earlier that permanent method in UH&FWC is done through camps and hence the consent form for PM is less available there.

Table 10: Availability of Informed Consent Form by facility [% (n)]

Facilities surveyed	Percentage and number of facilities surveyed that have IC form available for specific FP services: % (n)					No. of facilities
	IUD	Implant	Tubectomy	NSV	Injectables	
DH	60 (3)	60 (3)	80 (4)	20 (1)	40 (2)	5
MCWC	100 (6)	100 (6)	100 (6)	100 (6)	83 (5)	6
UHC	100 (28)	100 (28)	96 (27)	96 (27)	50 (14)	28
UH&FWC	97 (29)	33 (10)	13 (4)	13 (4)	33 (10)	30
Total	96 (66)	68 (47)	59 (41)	55 (38)	45 (31)	69

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

With regard to client screening for FP methods, many of the providers interviewed said that they do not use the long checklist as they don't have enough time. Some respondents are also of the opinion that since they have been in this profession for a long time, they do not necessarily need to use the checklist and can easily conduct the screening based on their own experience and skill. **QUOTE: Service provider said "Checklist is available but due to shortage of counselling time it is not followed"**.

Moreover in response to the questions regarding the "Citizen Charter", managers view which is a short public display document that lists the names of the available services with corresponding prices, positively. They mentioned that they have executed these according to given guidelines. Managers feel that this is very helpful for clients, as they can easily get a quick overview of the services offered by the facility along with the charge for that particular service, which in turn aid them to decide on the services to avail. Most respondents expressed dissatisfaction about infrastructural arrangements in the facilities where they work. According to them, the allotted space for waiting in most facilities is not enough to accommodate clients along with their attendants.

FP Method Specific Availability of Equipment

Method specific availability of equipment was inspected for long acting (IUD and Implant) and permanent methods. Majority of equipment/supplies for long acting (IUD and implant) is available in facilities down to UHC. But data from UH&FWC reveal some gap in availability. It is notable that there is not much evidence of non-functionality (despite availability) of equipment/supplies.

The UH&FWCs do not have any operation theatre (OT) to perform procedures for permanent method and majority of UHCs share OT with family planning health service providers. Without surprise, all surveyed facilities have equipment for preparatory activities and laboratory equipment. It is to note that, the availability of common equipment for FP method specific service provision is a possible result of purposive selection of health facilities.

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

Readiness to Infection Prevention

The readiness for infection control was assessed following BHFS 2014. Availability of six items were inspected to assess whether the facilities met a minimum threshold for readiness to ensure effective infection control, namely: Four out of five DHs and five out of six MCWCs have all six items for infection prevention. However, only 64% and 23% of UHC and UH&FWC possess all six items for infection prevention. Though 77% of UH&FWCs surveyed had an improved water source, only 57% had running water. Also there is lack of availability of alcohol based hand disinfectant. Though, each individual item does not show much shortage, the condition of readiness is a strict one (where each of the items have to be available) hence the lower readiness in UHC and UH&FWC.

Table 11: Readiness to infection control (%)

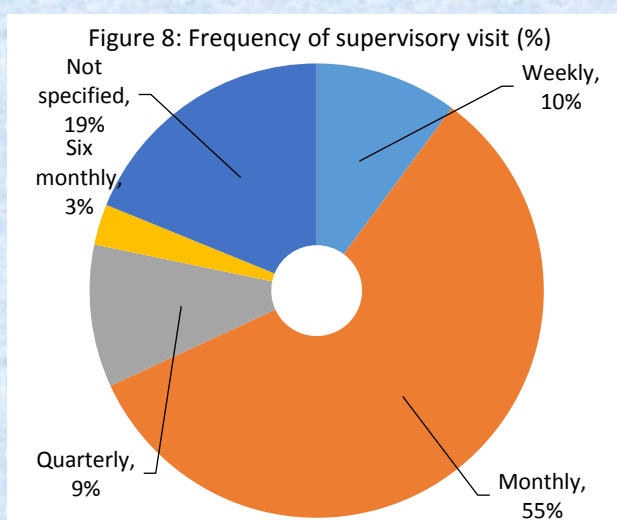
Items for infection control	Facility Type			
	DH (%)	MCWC (%)	UHC (%)	UH&FWC (%)
Soap	80.0	100	100.0	93.3
Running water	80.0	100.0	92.9	56.7
Alcohol based hand disinfectant	80.0	83.3	92.9	56.7
Latex gloves	80.0	100.0	82.1	73.3
Sharps container	80.0	100.0	96.4	73.3
Waste receptacle	80.0	100.0	96.4	80.0
All 6 items available	80.0	83.3	64.3	23.3

Table 12: Present status of infection prevention services (%)

Items for infection prevention	Facility Type			
	DH (%)	MCWC (%)	UHC (%)	UH&FWC (%)
Decontamination	80	100	100	90
Cleaning of Instruments	60	67	46	23
High Level Disinfection (HLD) or Sterilization	40	67	29	7
<i>Boiling</i>	40	67	43	17
<i>Autoclaving</i>	60	83	46	7
Hand Washing	80	100	100	77
Barriers	80	100	93	83
Storage and Disposal	20	33	11	0
Handling Specimens and instruments	80	100	89	80
n	5	6	28	30

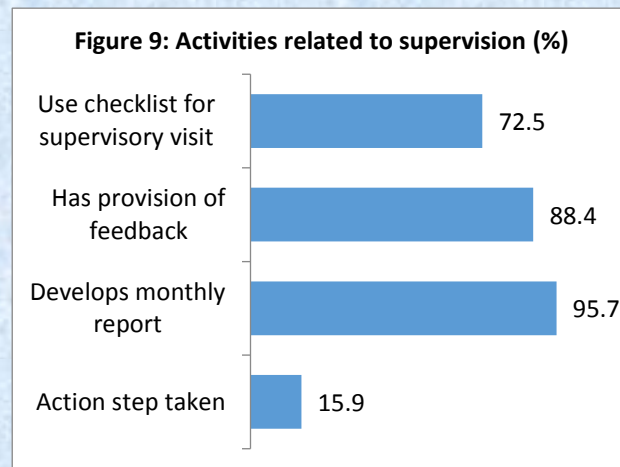
Supervision and Quality Improvement

According to information provided by the service providers, supervisory visits took place in all of the surveyed facilities within 6 months preceding the survey. However, the term 'visit' and 'supervisory visit' is usually considered synonymous in most instances. It is reported that most of the facilities receive supervisory visit on monthly basis (55%). Interestingly, 19% facilities reported that they received visits/supervisory visits without specific time interval. Possible reason of such response is the location of the surveyed facilities. Most of the selected facilities are in easy reachable areas. Hence, in most



instances a visit by GoB official, politically/socially important individuals, donors take place in such easy accessible facilities.

Use of checklist require improvement as more than one-fourth (26%) response suggest lack of checklist use during supervisory visit. Informants suggest that the length of the supervisory checklist discourage supervisors to use them regularly/appropriately. The data suggest that in 95% facilities action plan is developed. The definition of 'action plan' for such instance is simply *the distribution of activities (targets) to service providers for the month during monthly meetings without suggestion or instruction on how to complete the activities (fulfill the targets).*



Furthermore, 84.1% of surveyed facilities have provision of written feedback. The written feedback is in fact a written report in the visitor's book kept in the facility. In most instances, the writing in the visitor's book does not include information on facility improvement. And verbal feedbacks are often forgotten as the follow up in most instances does not take place.

Broadly defined, the role of a "supervisor" is to oversee an individual (or group) engaged in a particular task with the express goal of ensuring that they perform it correctly. Over the years, Mentorship has emerged as an important role in the healthcare arena. Generally speaking, a "mentor" is someone who is more experienced in a particular field and agrees to teach or coach a less experienced mentee. In most cases, this relationship tends to be focused on broader scholarly and career development. However, it can also lead to the formation of a more personal relationship.

In the context of managers based in local healthcare facilities in Bangladesh, the concept is still quite new. The difference between supervision and mentorship is not always clearly understood. All managers interviewed stated that there is a system in place for supervision, although no one was able to describe it in detail. At present, whenever supervisors go for supervision, they write their findings on a supervisory notebook. During follow up visits, they review the previous findings and provide feedback accordingly. Majority of managers stated that they find it quite essential and useful to maintain a level of supervision as it brings discipline to work and that provision of constructive feedback often results in improved performance among their subordinates. Quite a few managers do develop a Supervisory Work plan on a monthly basis and share it centrally. Some have introduced their own supervisory checklist as well. However, no regular practice of giving feedback to the subordinates was found. Service providers also view supervision positively and said that they find it helpful to improve their performance level, based on concrete feedback from their supervisors.

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

Since everyone is overloaded with work, this leaves little time to conduct supervision as per work plan. Majority of managers prefer onsite as opposed to offsite supervision method. However, they feel that offsite method is also effective as a means of complementing the onsite supervision. There is equally divided opinion and preference when it comes to surprise visit and planned visit. Many managers still consider sudden visits as supervisory visits. Those in favor of surprise visits feel that this reveals the real scenario, and hence is more valuable. Some managers prefer planned visits since particularly in remote areas where there is staff scarcity

and hence a planned visit would ensure staff presence during the visit. Other managers prefer planned visits as they feel that these visits will at least trigger the staff to improve their services at that point, which would hopefully result in good practice in the long run

Completion of Records and Arrangements for Reporting Complications

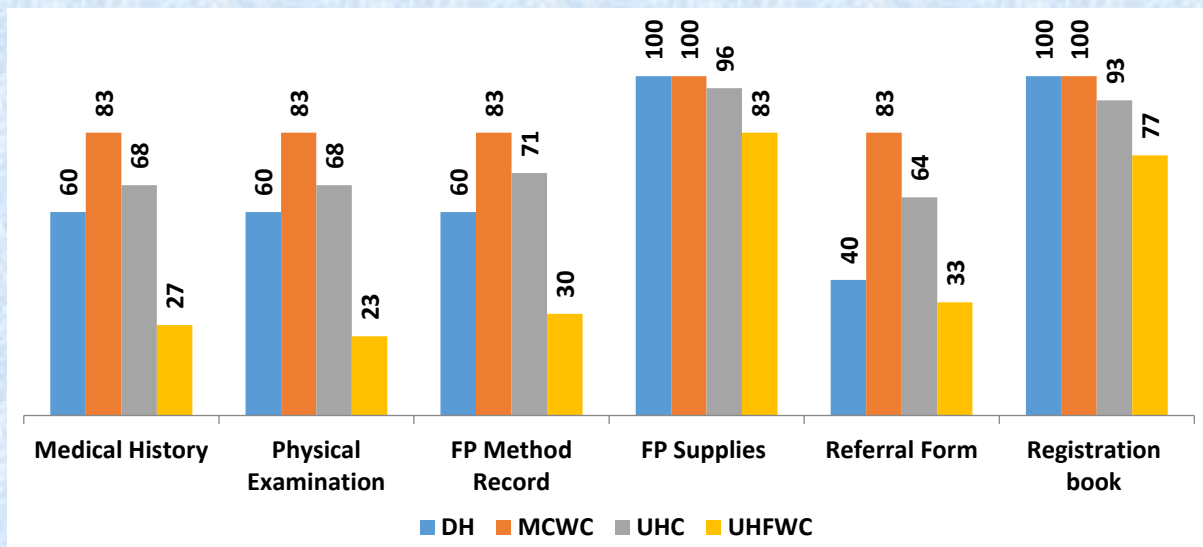
In aggregate, the recording is weakest in UH&FWCs. The records for registration and FP supplies (receiving and distribution) are most well managed while the records for referral are least managed. Similar pattern is identified for record management status for medical history, physical examination history, and FP method use history within specific type of facilities.

Majority of the surveyed facilities have arrangement for reporting as well as recording FP related complications. Almost all facilities with opportunity to report FP related complications have necessary arrangements to deal with the complications. However, the lack of complete recording may create issues in service provision every now and then.

Table 13: Status of record keeping and compilation of records (%)

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

Figure 10: Status of record completion (%)



All managers and service providers stated that reporting system is in place whereby reports are prepared and discussed on a monthly basis, at various level. Targets, specifically to increase the coverage of LARCs, are set per facility and distributed among relevant personnel. According to managers and supervisors, these targets are taken very seriously while judging someone’s performance. Decisions on next steps are taken on the basis of analysis of performance as reflected on monthly reports. **QUOTE: Manager said “We discuss on monthly report. In case of low performance we want explanation why it is low. Because we should fill up the yearly target”.**

However, managers stated that they do not make an extensive use of service statistics to aid decision-making. At community level also, as expressed by managers interviewed, data being collected by health workers needs to be digitized and there is an opportunity to generate more insights and analytics to understand the community health seeking behavior. Managers also suggested that there is a need to focus on process improvement in data collection and driving data analytics for better program monitoring and reporting.

BCC Materials

Physical observations reveal that there was no scarcity of banners and posters. Majority of the surveyed facilities had different type of posters detailing and explaining FP methods. The availability of banner is lower compared to posters. Greater number of UHCs have of posters compared to other type of facilities while greater number of UH&FWCs have banners. However, the placement of banners and posters were not always convenient for the clients to spot. The UHCs and UH&FWCs have limited space for FP services and it should be used wisely to visualize BCC materials such as posters and banners. Else the BCC materials will remain unnoticed and its purpose will not be served.

Few facilities kept booklets/leaflets (UHCs had the larger proportion/percentage) in easily visible places and even fewer allowed clients/visitors to collect them. Overall availability of BCC materials reveal that greater number of BCC material is displayed for long acting methods, followed by permanent methods.

Also a little more than half of the service providers in UHC and UH&FWC can show job-aids (i.e., flipcharts, pictorials) to provide FP services which is of concern. As all service providers are

supposed have the job aids with them. This proportion is a little higher among service providers in DH and MCWC but it still needs a lot of improvement.

Table 14: Availability of BCC materials (%)

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

In response to the question regarding use of tab based IEC materials, managers and service providers both welcomed the introduction of tablet-based IEC materials but they feel that the process of replacing existing IEC materials with tablet-based IEC materials should be gradual and supported with adequate training in order to make the transition effective. The managers said that since most service providers are not technically advanced, it would be wise to provide them training on how to use tablets properly and thereby prepare them gradually to accept the new technology and communication tool.

The focus of discussion with the adolescent group under the theme “SBCC materials” revolved around exploring the status of SBCC materials. Participants were requested to comment on the following:

- Communication materials (such as pamphlets) available at health facilities to take home.

- Experience of electronic devices used during counseling; familiarization with any apps, media etc.

Successful implementation of health SBCC programs depends on the effective distribution, dissemination and use of print, audio-visual and outdoor media.

No one among the respondents has come across communication materials (such as pamphlets) at health facilities to bring back home. Some have noticed a few posters on Family Planning practice on the walls inside and outside the health facilities. However, they could not tell much about the content of these posters. None of the adolescents participating in the FGDs could recall any piece of information they saw written or displayed in any of the SBCC materials. And although they said they are aware about digital devices and social media, none of them are familiar with the use of any electronic devices, any apps, media etc. for promoting family planning methods. No one is aware about the existence of a dedicated health line.

C3. Gender

Gender Responsiveness

Majority of the surveyed facility managers were female (46 out of 69) this was also true for overall management staff. However, males were the greater share of technical staff.

Few of the facilities (5 out of 69) reported security problem with female clients. This compliments the fact in majority of facilities (57 out of 69) female clients shared their story of abuse and violence and some of the facilities (24 of 69) provided some services regarding abuse and violence. Greater proportion of DH and MCWC provided such services compared to UHC and UH&FWC.

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

It is a good indication that women clients generally do not face security problems or difficulties to avail FP services within premises of the surveyed facilities.

Table 15: Gender responsiveness at surveyed facilities (%)

Indicators		Type of health facility				Total
		DH	MCWC	UHC	FWC	
Sex distribution of Facility Manager (#)	Male	1	3	4	15	23
	Female	4	3	24	15	46
N		5	6	28	30	69
Service provision environment of the facility						
Women clients faced security problem to receive service		20	0	4	10	7
Clients shared any story related to physical, psychological or emotional trauma when they come to receive service		100	67	89	77	83

Facility Assessment Report

Indicators		Type of health facility				Total
		DH	MCWC	UHC	FWC	
Woman, victim of gender-based violence received services		60	17	46	23	35
Women faced difficulties in receiving service		0	0	7	10	7
Data collection and reporting						
Facility maintained sex disaggregated service information		60	67	71	43	58
Gender related accomplishments reported in the monthly report		20	33	50	40	42
	N	5	6	28	30	69

Table 16: Gender balance administration and staffing

Administration and staffing	Sex	Type of health facility				Total
		DH	MCWC	UHC	FWC	
Average number of management Staff	Male	2	1	1	1	1
	Female	1	1	3	1	2
Average number of technical Staff	Male	5	9	2	3	3
	Female	2	2	1	0	1
Average number of support Staff	Male	1	3	1	1	1
	Female	0	2	1	1	1

All Managers and Service Providers interviewed stressed that family planning related service is open to all, irrespective of gender. They, however, went on to say that male participation in family planning is limited since most men are of the opinion that family planning is a topic that is relevant to women only. According to managers and service providers were interviewed, male clients remain busy with work during the service hours and have little interest in taking part in family planning discussions or uptake any relevant methods or service. Their lack of participation can also be attributed to the fact that the service providers including FWV and FWA are all women, with whom men do not necessarily feel comfortable to discuss such intimate matters. Managers went on to say that the service providers themselves hardly ever reach out to potential male clients and that there is limited awareness building activities targeted towards men with regard to the importance of family planning practice and available methods. **QUOTE: Manager said “Even male client don’t come to collect condom for themselves, since all our providers are female they don’t feel comfortable”**

The focus of discussion with adolescents and opinion leaders were aimed at exploring the level of gender responsiveness in health facilities under the study locations. Participants were requested to comment on the following:

- Typical experience of a young man who goes to a health facility to seek family planning services.
- Typical experience of a young woman who goes to a health facility to seek family planning services?
- For male participants: Comfort in accessing family planning services.
- For female participants: Comfort in accessing family planning services as young woman.
- Most frequently accessed government run facility for family planning services.

It is evident from the discussions that family planning related services are still limited to married women. Most male adolescents, both married and unmarried, do not currently seek out family planning services to a good extent. At the same time, several male respondents voiced the lack

of initiative from health workers, especially FWAs to reach out to men. They have opined that if a male FWV is appointed, then male clients would feel much more comfortable to approach him for FP services. However, they do receive some family planning related advice from Upazila health complex and FWC. These services are usually free.

Most respondents have reported that there is no separate seating arrangements for boys and girls in health facilities. There is only one toilet for clients in most UH&FWCs. The condition of these toilets have been reported to be very poor and dirty.

According to the opinion leaders, everyone still holds a perception that family planning methods should ideally be adopted by women and not men. Some went on to justify this statement by saying that men need to work long hours to earn a living and since they might become impotent and unproductive as a side effect of adopting family planning methods, it's best they avoid these altogether. **QUOTE: Opinion Leader said "Men will become weak and even impotent as a side effect of taking family planning methods, and hence it's best for men to avoid these as they have to work outside to earn a living."** A few opinion leaders, though, have expressed that FP methods are equally applicable to both genders.

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

C4. WAY FORWARD

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

Advocacy efforts should be extended towards addressing the manpower shortage issue, which is one of the major challenges at present. Areas like training and skill development of service providers if addressed in a comprehensive manner can help ease the workload of healthcare workers as well as address shortage of staff etc. Introduction of staff performance and rewards program could be some of the key steps to improve staff performance and motivation.

It is necessary to strengthen the counselling service regarding FP at the health facilities. A three-days long training on counselling is recommended. There is scope to provide additional support in terms of dedicated counsellor and associated infrastructure. Interpersonal communication skills of service providers need to be improved as well relevant training package can be developed.

There is lack of awareness about the availability of adolescent services at the health centres. While there is dedicated FP service for youth and adolescents, the target group for such services are not much aware about the need and availability of these services. A clear need for strategic awareness building programme to improve visibility of family planning services for young adolescents along with information of service offerings across all facilities are two most important outcomes of the survey. It is important to undertake awareness raising initiative at a much larger scale in order to increase outreach, break social stigma and eventually improve uptake and utilization of adolescent friendly FP services. Wider awareness programs targeting increased male participation should be undertaken at the next phase. It is equally important to educate parents and local opinion leaders on the importance of such service, thereby creating an enabling environment for adolescents to seek FP services and adopt relevant and appropriate practices.

To summarize, the assessment reveals an overall need to galvanize local patients, including youth and adolescents to visit the facilities with the help of community engagement activities. Focus should be placed on strengthening the monitoring of existing operations through revisiting operational strategies and finalize the community engagement strategies to develop a sustainable family planning healthcare model.

During the KII as an evolving issue came out into account that whole family planning department is currently under pressure to meet the target of increasing delivery service at FWC level. Associated challenges to execute which includes the followings:

- There is usually only 1 FWV, 1 SACMO, 1 Pharmacist, 1 Aya and 1 Guard per FWC. This makes it challenging to provide service 24/7.
- All FWCs are not yet ready to serve as delivery centres (Need renovation)
- In many places staffs are not locally based.
- Certain facilities are located in remote and isolates area, which is a concern in terms of security issues, especially newly recruited young staff.

ANNEXURES

Annex-1: Snapshots



Health Facilities

Few Pictures of the Washroom Facilities



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FGD with adolescent boys, girls and opinion leaders

FGD with Adolescent Boys and Girls



FGD with Opinion Leaders

Annex-2: Ethical Clearance



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April 08, 2019

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Title of the Research Project: Facility Assessment of Family Planning Adolescent and Youth-Friendly Services, PFPF, PACFP, Post MR-FP and Gender Responsiveness

Dear Dr. Tasrina

The Institutional Review Board of the Institute of Health Economics (IHE-IRB), which is approved by Federalwide Assurance (FWA), No. FWA00026031, has recently reviewed your responses to the conditions placed upon the ethical approval of the proposal entitled "Facility Assessment of Family Planning Adolescent and Youth-Friendly Services, PFPF, PACFP, Post MR-FP and Gender Responsiveness" Your proposal now meets the requirements and, hence, full ethical approval has been granted.

A handwritten signature in black ink, appearing to read 'Sabur'.

Dr. Muhammad Abdus Sabur
Chair
IRB, IHE

Annex-3: Questionnaires

Data Collection Instruments - 1

Facility Assessment Report

Facility Assessment Tool USAID Shukhi Jibon (AUAFP) project

FACILITY IDENTIFICATION	
NAME OF THE KEY PERSON IN FACILITY: _____	
DIVISION: _____	<input type="checkbox"/>
DISTRICT: _____	<input type="checkbox"/>
UPAZILA: _____	<input type="checkbox"/> <input type="checkbox"/>
UNION/WARD: _____	<input type="checkbox"/> <input type="checkbox"/>
TYPE OF THE FACILITY: _____	<input type="checkbox"/>
1=DH, 2=MCWC, 3=UHC, 4=UHFWC	<input type="checkbox"/>
Facility location: 1 = Urban, 2 = Rural	<input type="checkbox"/>
Facility Managing Authority: 1 = DGFP, 2 = DGHS	<input type="checkbox"/>
Extension of facility service: 1 = Inpatient, 2 = Outpatient, 3 = Both	<input type="checkbox"/>
Number of rooms (dealing with patients) in the facility:	<input type="checkbox"/> <input type="checkbox"/>
How many days in a week does the facility usually remain open?	<input type="checkbox"/>
How many hours does the facility remain open every day (outdoor)?	<input type="checkbox"/> <input type="checkbox"/>

INTERVIEWER VISITS				
	Visit 1	Visit 2	Visit 3	FINAL VISIT
DATE				DAY <input type="checkbox"/> <input type="checkbox"/>
INTERVIEWER'S NAME				MONTH <input type="checkbox"/> <input type="checkbox"/>
				YEAR..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Result Codes:				INTV. CODE <input type="checkbox"/> <input type="checkbox"/>
RESULT CODES: 1 = Completed, 2 = Not Available, 3 = Postponed, 4 = Refused, 5 = Partly Completed, 6 = Other _____ (Specify)				RESULT <input type="checkbox"/>
				TOTAL NO OF VISITS <input type="checkbox"/>
SUPERVISOR	FIELD EDITOR	OFFICE EDITOR		KEYED BY
NAME: <input type="checkbox"/> <input type="checkbox"/>	NAME: <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
DATE: _____	DATE: _____			

Facility Assessment Report

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

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

DISTRICT HOSPITAL (DH)

Provider designation	# of sanctioned Post	# of Provider(s) Availability	# of Provider(s) at Work today
A1. Obstetrician and Gynecologist (OB/GYN)			
A2. Nurse (involved in FP work)			
A3. Midwife Nurse			
A4. Cleaner/Sweeper			

MATERNAL AND CHILD WELFARE CENTRE (MCWC)/Sadar FP Office

Provider designation	# of sanctioned Post	# of Provider(s) availability	# of Provider(s) at Work today
A5. Medical Officer-Clinic(MO-Clinic)			
A6. Medical Officer Maternal and Child health – Family Planning MO (MCH-FP)			
A7. Family Welfare Visitor (FWV)			
A8. Midwife Nurse			
A9. Aya			

UPAZILA HEALTH COMPLEX (UHC)

Provider designation	# of sanctioned Post	# of Provider(s) availability	# of Provider(s) at Work today
A10. Resident Medical Officer (RMO)			
A11. Medical Officer Maternal and Child health –Family Planning (MO-MCH-FP)			
A12. Upazila Family Planning officer (UFPO)			
A13. Assistant Upazila Family Planning officer (AUFPO)			
A14. Assistant Family Welfare Officer – Maternal and Child Health and Family Planning AFWO (MCH-FP)			
A15. Family Welfare Visitor (FWV)			

Facility Assessment Report

UNION HEALTH AND FAMILY WELFARE CENTRE (UHFWC)

Provider designation	# of sanctioned Post	# of Provider(s) availability	# of Provider(s) at Work today
A16. Medical Officer –Family Welfare (MO-FW)			
A17. Sub-Assistant Community Medical Officer (SACMO)			
A18. Family Welfare Visitor (FWV)			
A19. Family Planning Inspector (FPI)			
A20. Family Welfare Assistant (FWA)			

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

Name	Sex	Position/ Title	Training code	Training			Training category code	Training agency	Do you have Smart phone? (Yes – 1 & No – 2)
				Days	Month	Year			

Sex: 1 = Male 2 = Female 3 = 3rd Gender

Position/Title Code: 1 = OB/GYN, 2 = Resident medical officer (RMO), 3 = MO (MCH-FP), 4 = MOCC, 5 = UFPO, 6 = AUFP, 7 = Nurse (involved in FP work), 8 = Midwife/ Nurse, 9 = FWV/Senior FWV/AFWO, 10 = SACMO/MA, 11 = FPI, 12 = FWA (applicable for FWC), 13 = Aya (involved in FP work), 14 = Cleaner/ sweeper (involved in FP work), 15 = Other (Specify)

Training Code: 1 = IUD (Interval), 2 = PP (Postpartum), IUD3 = PPFP, 4 = Implant, 5 = Vasectomy (NSV), 6 = Tubectomy, 7 = Short-acting FP method (oral OCP, condom, inj.), 8 = Counseling-FP, 9 = PAC, 10 = Infection Prevention, 11 = Management of RTIs/STIs, 12 = Adolescent and youth-friendly health services, 13 = Gender, 14 = Supervision, 15 = Other (specify)

Training Category Code: 1 = Pre-service, 2 = In-Service, 3 = On-the-job

Facility Assessment Report

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

Available?: 1 = Yes, 2 = No			
	Services Offered	Available	Comments
	Method: Ask (Facility Manager)		
	General Services		
C1.	Family Planning counseling (except ANC/PNC)		
C2.	Family Planning services		
C3.	Management of Gender-Based Violence (MGBV)		
C4.	Youth and Adolescent Friendly Reproductive Health Services		
C5.	Reproductive Tract Infection/Sexually Transmitted Infection (RTI/STI) services		
C6.	HIV Testing & Counseling services		
C7.	Cervical Cancer screening (VIA test)		
C8.	Post Abortion Care (PAC) – FP services		
C9.	Other Service (Specify)		
	FP services offered		
C10.	Oral Contraceptive pill (OCP)		
C11.	Progestone only pill (POP)		
C12.	Condom		
C13.	Injectable		
C14.	Implant		
C15.	Intra uterine device (IUD)		
C16.	Non Scalpel Vasectomy (NSV)		
C17.	Tubectomy		
C18.	Post-Partum Family Planning (PPFP)		
C19.	Post Abortion Care (PAC-FP)		
C20.	Post Menstrual Regulation- Family Planning (PMR-FP)		
C21.	Lactational Amenorrhea Method (LAM)		
C22.	Emergency Contraceptive pill (ECP)		
	MCH Services		
C23.	Ante natal Care (ANC)		
C24.	Normal Vaginal Delivery (NVD)		
C25.	C-Section Delivery		
C26.	Postnatal Care (PNC)		

Facility Assessment Report

Available?: 1 = Yes, 2 = No			
	Services Offered	Available	Comments
	Management of Gender Based Violence		
C27.	Counseling		
C28.	Post GBV care with ECP		
C29.	Post GBV care with other service (specify)		
C30.	Refer to appropriate facilities		
C31.	What is the standard policy to handle the GBV case?		
	Ante natal Care (ANC)		
C32.	Family Planning counseling		
C33.	Provision of condom for RTI/STI protection, if required		
	Safe Delivery (Normal Vaginal Delivery & C/Section)		
C34.	Family Planning counseling		
C35.	Post-delivery IUD		
	Post natal Care (PNC)		
C36.	Family Planning counseling		
C37.	Contraception/Dual Protection Include		
	Post Abortion Care-Family Planning (PAC-FP)		
C38.	Family Planning counseling		
C39.	Provision of Family Planning methods		

Facility Assessment Report

D. Observation of Physical space, Equipment, and Commodity Storage (Instructions: This section requires observation rather than interaction with the respondent).

a. Facility characteristics

1 = Available and Functional 3 = Not available		2 = Available but not Functional 4 = Not observed	
	Facilities	Status	Comments/ Recommendations
D1.	Are there any signs or directions available in the neighborhood or outside of the facility which help to locate the facility?		
D2.	Does the facility have signboard that is visible?		
	Outdoor facilities	Status	Comments/ Recommendations
Method: Observation (Ask when necessary)			
D3.	Is there any breast-feeding corner?		
D4.	Is there any adolescent corner?		
D5.	Is there any client/visitor waiting room, area, or space in the facility?		
D6.	Is there any visible sign that indicates the waiting room, area, or space?		
D7.	Is there a Citizen Charter displayed in the facility?		
D8.	Is there a price-list of services displayed in the facility?		
D9.	Are performance statistics of the facility displayed?		
	Are comprehensive FP wall-charts/TIHRT chart are displayed in the clients waiting/counseling room?		
D10.	waiting room		
D11.	In counseling room		
D12.	Elsewhere within the facility or on outside walls		
D13.	Do you think this FP wall-chart/TIHRT chart is helpful in providing services to clients?		
D14.	Is there any FP method specific projection chart displayed anywhere in the facility?		
D15.	Is there a box/place where clients/patients can drop notes/letters with their comments/suggestions?		
D16.	Is the box/place easily visible? (placed on way in, way out, in a location where anyone can see it)		
	Method: Ask & Observe		

Facility Assessment Report

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

- b. **Physical space:** Does the clinic have dedicated room for each of the following purposes? If so, rate them according to the following scale. If any of the rooms need renovation, specify the necessary renovations in the "Comments/Recommendations" column of the following chart.

1 = Available and Functional 3 = Not available		2 = Available but not Functional 4 = Not observed	
	Indoor facilities	Status	Comments/ Recommendations
	Method: Observe		
D29.	Separate room for the processing of equipment		
D30.	Toilet for clients (functional)		
D31.	Toilet for clients (clean)		
D32.	Functioning sink		
D33.	Separate room for the processing of equipment (sterilization process)		
D34.	Place for medical waste disposal		
D35.	Separate counseling area maintaining privacy		
D36.	Separate examination room		
D37.	Separate FP service site		
D38.	Specific Recovery area (e.g. PAC & sterilization clients)		
	Waiting area with space for all clients		
D39.	Male		
D40.	Female		

Facility Assessment Report

D41.	Adolescent/youth		
	Outdoor facilities		
	Waiting Room area with seating for client		
D42.	Male		
D43.	Female		
D44.	Adolescent/youth		
D45.	Private counseling		
	Examination area		
D46.	IE&C posters visible		
D47.	FP flip chart available		
	General service readiness		
D48.	Source of water		
D49.	Power supply		
D50.	Waste management (availability of Bin)		
D51.	Tiahrt Chart/FP wall chart		
D52.	Internet connection		

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

	Does the facility/site have:	Status		Comments / Recommendations
		Supply (number)	Functional (number)	
Method: Ask & Observe (Ask to FWV/Store Manager)				
D53.	Stethoscope			
D54.	Thermometer			
D55.	BP Machine			
	Gynecology exam instruments			
D56.	Sim's Speculum			
D57.	Cusco's Speculum			
D58.	Sponge holding forceps			
D59.	Spotlight			
D60.	Kidney tray			
D61.	Gallipot			
D62.	Artery forceps			
	Equipment Supplies for Implant			
D63.	Soap			
D64.	Sterilized Marker			
D65.	Sterilized Gloves			

Facility Assessment Report

	Does the facility/site have:	Status		Comments / Recommendations
		Supply (number)	Functional (number)	
Method: Ask & Observe (Ask to FWV/Store Manager)				
D66.	Sterilized cloths/Surgical drape, Leaky Surgical drape (for Jadelle)			
D67.	Antiseptic solution			
D68.	Gallipot			
D69.	Sponge holding forceps			
D70.	Surgical scalpel blade			
D71.	Sterilized cotton ball (3-5 pcs)			
D72.	Sterilized gauge			
D73.	AD/Disposable syringe			
D74.	Local anesthesia drugs (1% Lidocaine, adrenaline free)			
D75.	hydrocolloid dressing/band aid, general bandage			
D76.	Safety box			
D77.	Mosquito forceps (2 units)			
D78.	U Forceps			
D79.	Implant			
Equipment/Supplies for IUD				
D80.	IUD in sterile packet			
D81.	Cusco's Speculum (Medium size)			
D82.	Tenaculum			
D83.	Uterine Sound			
D84.	Gallipot			
D85.	Artery forceps			
D86.	Scissors			
D87.	Sterilized cotton ball (3-5 pcs)			
D88.	Sterilized Gloves (2 pair)			
D89.	Povidone Iodine solution			
D90.	Spotlight or Torch light			
D91.	Draping sheet			
Physical/infrastructural facilities for the permanent sterilization				
Reception room with facility for counseling and taking history of the patient				
D92.	Chair and table for the counselor			
D93.	Chair or bench for sitting of the client and attendance			

Facility Assessment Report

	Does the facility/site have:	Status		Comments / Recommendations
		Supply (number)	Functional (number)	
Method: Ask & Observe (Ask to FWV/Store Manager)				
D94.	Method specific client consent form with detail description and other materials and communication aid for counseling			
D95.	Discharge certificate for male and female sterilization			
Laboratory examination facility with physical examination Room				
D96.	Chair and table for the service provider			
D97.	Chair for the client			
D98.	BP instrument with stethoscope			
D99.	Thermometer			
D100.	Weighing machine			
D101.	Spotlight and working torch light with battery			
D102.	Examination table for the client			
D103.	Gloves, speculum, sponge holding forceps, cotton, antiseptic solution (povidon) in a tray for P/V examination			
D104.	Hand washing basin with elbow tap and running water, soap, antiseptic solution (hexisol), and personal towel			
D105.	Urine examination equipment			
D106.	Test-tube/bottle for urine collection and test-tube holder			
D107.	Sugar, albumin and pregnancy test kit			
D108.	Uri-sticks with bottle			
D109.	Blood examination equipment			
D110.	Tallquist book for and disposable lancet			
D111.	Cotton, antiseptic solution in cup/gully pot (rectified spirit/hexisol or povidone iodine)			
Pre-Operative room				
D112.	bed, mattress, bed-cover, pillow, mosquito net and rubber sheet			

Facility Assessment Report

	Does the facility/site have:	Status		Comments / Recommendations
		Supply (number)	Functional (number)	
Method: Ask & Observe (Ask to FWV/Store Manager)				
D113.	water, soap, bucket, towel, bathing facility etc.			
D114.	BP instrument, stethoscope and thermometer			
D115.	Medicine: antibiotic and tablet diazepam			
D116.	Toilet facility			
Operation theater with the facility of dressing, hand-washing and autoclaving or IP space				
D117.	Autoclave, autoclave indicator tape and register			
D118.	Kerosene four-burner pressure stove or gas burner or electric stove or electric connection socket			
D119.	Surgical drum, drum or tray for instrument & gloves			
D120.	Twofold cloth for tray-cover or trolley cover			
D121.	Autoclaving monitoring chart on the autoclaving room's wall			
D122.	Necessary instruments for disinfection: (plastic bucket, sieve, bleaching powder or liquid chlorine or chlorine tablet, stirrer, plastic mug, utility gloves etc.)			
D123.	Basin for washing and wiping of the instrument, detergent powder, brush & towel			
D124.	Table for drying, wrapping and keeping the instrument			
D125.	Hanger/clip for drying the gloves			
Hand washing area attached with operation theater				
D126.	Basin with elbow tap and running water (obviously outside the toilet) or as a substitute water tank or drum with tap can be placed in the wall of table/stand or water filled bucket and mug can be used (in that case an assistant should poured the water)			
D127.	Hand washing soap, antiseptic solution			

Facility Assessment Report

	Does the facility/site have:	Status		Comments / Recommendations
		Supply (number)	Functional (number)	
Method: Ask & Observe (Ask to FWV/Store Manager)				
D128.	Area for undressing the used cloth and wearing OT dress			
D129.	Clean and sterilized musk for all related to the service			
D130.	Boot or sandal for all related person in the OT			
Operation theater				
D131.	Enough light			
D132.	Glass window			
D133.	Netting to prevent insect			
D134.	Air Conditioned			
D135.	wall made of tiles/mosaic up to 7 feet from the floor			
Supplies for the OT				
D136.	OT table with plastic or rubber sheet			
D137.	OT light and to prevent electricity interruption working 3 battery torch or charger light			
D138.	Instrument trolley			
D139.	Small/ Maya trolley for keeping all other instrument for every operation			
D140.	BP instrument and stethoscope			
D141.	Essential instrument for emergency management in working condition			
D142.	Emergency drug for emergency situation			
D143.	For regular tubectomy sufficient amount of instrument set, MSR, and medicine should be available in adequate amount			
D144.	For regular vasectomy sufficient amount of instrument set, MSR, and medicine should be available in adequate amount			
D145.	OT register			
Post- operative room				
D146.	Toilet facility			
D147.	Washing basin			

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	Does the facility/site have:	Status		Comments / Recommendations
		Supply (number)	Functional (number)	
Method: Ask & Observe (Ask to FWV/Store Manager)				
D148.	Bed, mattress, Bed-cover, pillow with cover, mosquito net and rubber sheet, hurricane, vessel, bucket, mug, glass,			
D149.	Stool, table, chair, hand fan			
D150.	BP instrument, stethoscope, Thermometer, 3 battery working torch			
D151.	Medicine – paracetamol, vitamin tablet			
D152.	Emergency medicine			

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

Responses: Available/Yes = 1, Not available/No = 2			
	Are the following systems in place?	Status	Comments/ Recommendations
Method: Ask and observe (Ask to Store Manager)			
D153.	Does this facility store any medicines, or contraceptive commodities?		Please mention how stored
	Are contraceptive commodities generally stored in the service area, or are they stored in a common area with other medicines?		
D154.	Stored in FP service area		
D155.	Stored with other medicines		
D156.	FP commodities not in stocked		
D157.	Inventory of equipment and commodities		
D158.	Storage system according to commodity expiration dates (FEFO) (first to expire, first out)		
D159.	Supplies maintained in required condition (FEFO)		
D160.	Expired contraceptives are destroyed		
D161.	System for ordering/reordering (requisition) supplies		
	Storage facility protected from damage by		
D162.	Rain		
D163.	Sunshine		
D164.	Rats and pests		
D165.	Month of Supply (MoS) board displayed		

D. Transport for emergencies

Responses: Available/Yes = 1, Not available/No = 2			
	Transport facilities Ask and Observe (Ask to Facility manager)	Status	Comments/ Recommendations
E1.	Is there any Emergency Transportation of this facility available? i.e. Ambulance		
E2.	If yes, Is it functional?		
E3.	Area of coverage of transport emergencies	Distance (in km): Area:	
E4.	In case of emergency, do you have any functional referral system for tertiary or higher-level facility including first contact person?		

E. Management Committee

	Management System Ask (Ask to Facility Manager)	Status	Comments/ Recommendations
F1.	Is there any management committee existing for this facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
F2.	Who are the members?		
F3.	How frequently they sit for meeting?	<input type="checkbox"/> Monthly <input type="checkbox"/> Bimonthly <input type="checkbox"/> Quarterly	
F4.	How do they communicate with service providers?		

F. Referral flow from community

	Query to Ask (Ask to FWV)	Response
G1.	Are there any FP client referral system from the community to this facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G2.	If yes, other than the FWA , who are involved with this referral process? (multiple response possible)	<input type="checkbox"/> NGO worker <input type="checkbox"/> Community Volunteer <input type="checkbox"/> NGO Credit Group member <input type="checkbox"/> Opinion leaders <input type="checkbox"/> Public representative <input type="checkbox"/> Private practitioner <input type="checkbox"/> Traditional birth attendants (TBAs) <input type="checkbox"/> Quacks <input type="checkbox"/> Other (specify) <input type="checkbox"/> Satisfied client
G3.	What type of FP client do they (referrer, other than FWA) refer? (multiple response possible)	<input type="checkbox"/> Pill <input type="checkbox"/> Condom <input type="checkbox"/> Injectable <input type="checkbox"/> IUD

Facility Assessment Report

	Query to Ask (Ask to FWV)	Response
		<input type="checkbox"/> Implant <input type="checkbox"/> Vasectomy <input type="checkbox"/> Tubectomy
G4.	Do they refer the following types of clients (referrer, other than FWA) ?	<input type="checkbox"/> PFP <input type="checkbox"/> PAC-FP <input type="checkbox"/> Post MR-FP
G5.	Do they (referrer, other than FWA) refer any adolescent FP client (10-19)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G6.	If yes, what type of services are clients refer for? (multiple response possible)	<input type="checkbox"/> Pill <input type="checkbox"/> Condom <input type="checkbox"/> Injectable <input type="checkbox"/> IUD <input type="checkbox"/> Implant <input type="checkbox"/> Vasectomy <input type="checkbox"/> Tubectomy
G7.	Do any of the referrers, other than FWA , get a referral fee?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G8.	Have any referrers, other than FWA who are involved in referral process received any training?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G9.	Are they (referrer, other than FWA) compensated for their time and work?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G10.	How are they (referrer, other than FWA) compensated for their time and work?	
G11.	Are they (referrer, other than FWA) under any supervision mechanism?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G12.	if yes, who are their (referrer, other than FWA) supervisor?	<input type="checkbox"/> FWA <input type="checkbox"/> FPI <input type="checkbox"/> FWA <input type="checkbox"/> Other (Specify) _____
G13.	Does the facility have standard referral forms that are used? If so, please show	<input type="checkbox"/> Yes <input type="checkbox"/> No
G14.	Are there any referral number tracking system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G15.	What are the strengths and weaknesses of the referral system you just described?	

Facility Assessment Report

G. Observation of Infection Prevention Practices**

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

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

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

Responses: Available/Yes = 1, Not available/No = 2			
	Items	Status	Comments/Recommendations
	Method: Ask & Observe (Ask to Aya /FWV)		
	Decontamination		
H1.	0.5% chlorine solution available (powder or liquid bleach)		
H2.	Instructions for mixing chlorine powder/ preparing chlorine solutions are present & posted on wall		
H3.	Alcohol hand rub available		
H4.	Cap		
H5.	Mask		
H6.	Plastic apron		
H7.	Shoe		
H8.	Gown/mackintosh		
H9.	Spectacles		
H10.	Waste disposal		
H11.	Soap		
H12.	Water tap/running water supply		
H13.	Clean bucket		
H14.	Disposable shoe cover		
H15.	Utility gloves		
H16.	Water measuring pot		
H17.	Bleaching powder container and measuring cup		
H18.	Plastic strainer		
H19.	Wooden nudge stick		
H20.	Watch/timer		
H21.	Cleaning equipment, detergent, & brushes available (List of equipment's)		
H22.	Chlorine solution		
H23.	Bleaching powder		

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	Items	Status	Comments/Recommendations
	Method: Ask & Observe (Ask to Aya /FWV)		
H24.	Chlorine solution keeping bucket		
H25.	Melamine spoon		
H26.	Plastic bucket with green cover for clean water		
	Cleaning of Instruments		
H27.	Basin with running water		
H28.	Plastic bucket		
H29.	Detergent powder		
H30.	Brush		
H31.	Utility gloves		
H32.	Table/ plastic rack		
H33.	Towel		
H34.	Clean clothes		
H35.	Mask/ mackintosh		
	High Level Disinfection (HLD) or Sterilization		
	Boiling		
H36.	Sterilizer or covered steel bucket		
H37.	Timer		
H38.	Lifter		
H39.	Scalpel		
H40.	Blade		
H41.	Scissor		
H42.	Needle		
H43.	Availability of IUD sterilizer		
H44.	Stores equipment in dry HLD container		
	Sterilization		
	Autoclaving		
H45.	Functioning Autoclaving system with appropriate storage of instruments		
H46.	Storage of Lifter and Thermometer		
H47.	Autoclave machine		
H48.	Power source		
H49.	Surgical drum/ tray		
H50.	Timer / watch		
H51.	Supplies of other equipment		
H52.	Glutaraldehyde		
H53.	Autoclave indicator / autoclave tape		
	Hand Washing		

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	Items	Status	Comments/Recommendations
	Method: Ask & Observe (Ask to Aya /FWV)		
H54.	Soap available (Solid/Liquid)		
H55.	Clean towel available, or air dry		
	Barriers		
H56.	Gloves are put on properly		
	Storage and Disposal		
H57.	Antiseptic solutions are labeled		
H58.	Used needles and syringes are immediately disposed of in an appropriate container with no recapping		
H59.	HLD or sterilized equipment is stored in a dry HLD or sterile container		
H60.	Lifter stored in a dry HLD container or sterile container		
H61.	Thermometer is stored in a dry container		
H62.	Black waste disposal bucket		
H63.	White waste disposal bucket		
H64.	Green waste disposal bucket		
H65.	Red waste disposal bucket		
H66.	Blue waste disposal bucket		
H67.	Incinerator		
	Handling Specimens and instruments		
H68.	Utility gloves are available for handling specimens and instruments		

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

Responses: Available/Yes = 1, Not available/No = 2

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

	Activity	Status	Comments/Recommendations
	Method: Ask (Ask to MO)		
	General Record keeping		
I1.	Is there a staff member available to do data entry?		
I2.	Is a client medical record used in the clinic?		
I3.	Is the client given a card to record his/her visits to the facility?		
I4.	Is there a system for filing clients' record and retrieval?		

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15.	Can records be retrieved easily?		
16.	Is the required data entered by the end of each day?		
17.	Do they utilize computer/ mobile/ tablet for record keeping and reporting?		
	Are the following records accurate and complete?		
	Informed Consent Form for:		
18.	IUD		
19.	Implant		
110.	Tubectomy		
111.	Vasectomy		
112.	Injectable		
113.	Medical History		
114.	Physical Examination		
115.	FP Method Chosen		
116.	Number of FP Supplies Given		
117.	Referral Form		
118.	Registration book		
119.	Is the collected data analyzed?		
120.	Who analyzes the data?		
121.	complications related to contraceptive use		
122.	Where are the complications reported and recorded?		
123.	The most recent version of written guidelines and protocols for delivering FP services are available		

H. Management, Supervision and Quality

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

Management

	Query	Response	Answer
	Method: Ask (Ask to Facility Manager)		
J1.	When usually client start coming	Time	
J2.	How long does the client stay at the clinic?	In hours	
J3.	Average waiting time for general client including FP	In minutes	

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	Query	Response	Answer
	Method: Ask (Ask to Facility Manager)		
J4.	Number of clients can be accommodated in waiting area	Number of seats available	
J5.	Does any adolescent/youth client come?	<input type="checkbox"/> Yes <input type="checkbox"/> No (if no, go to I8)	
J6.	Where they usually wait before getting service?	<input type="checkbox"/> Separate arrangement available ----- 01 <input type="checkbox"/> Wait along with other patients ----- 02 <input type="checkbox"/> Other (specify) _____	
J7.	Average waiting time for adolescent/youth client	In minutes	
J8.	Steps to take Services (According to the required service) Client flow chart (Entry to Exit) (Client → Facility → Waiting area → Counselor (if available) → Provider → Pathology → Washing → OT/procedure room → Post-operative → Exit)	Validation of mentioned pathway	<input type="checkbox"/> Yes <input type="checkbox"/> No (deviations: _____ _____ _____
J9.	Does client need any further contact beside above step	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	How much time is required to get the following service:		
J10	NSV	In minutes	
J11	Tubectomy		
J12	Implant		
J13	IUD		
J14	Injectable		
J15	Pill		
J16	Condom		
J17	ECP		
J18	Who manage OT for IUD	Designation of responsible person	
J19	Do manager or provider allow other people who does not involve in any step between client entry to exit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
J20	If yes, what type of people?		

Supervision & Quality Improvement

	Supervision/Quality improvement	Status
J21.	Does your supervisor conduct any supervision visit in this facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
J22.	If yes, how often the supervisor conducts the visit?	<input type="checkbox"/> Weekly 1 <input type="checkbox"/> Monthly 2 <input type="checkbox"/> Quarterly 3

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		<input type="checkbox"/> Six monthly 4 <input type="checkbox"/> More than six month 5 <input type="checkbox"/> Not specified 6 <input type="checkbox"/> Other (Specify) 9
J23.	If supervisory visit is conducted, do they use any checklist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
J24.	Is there any provision of debriefing/feedback/ learning session after completion of the visit of the supervisor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
J25.	If yes, do they use any checklist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
J26.	Is there any provision of written feedback from the supervisor after completion of the visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
J27.	Can you please show any copy of the reports of the supervisory visit? (DETERMINE THIS FROM THE CHECKLIST)	<input type="checkbox"/> Yes (INTERVIEWER: COLLECT ONE SUCH FILLED-IN CHECKLIST FOR YOUR RECORD.) <input type="checkbox"/> No
J28.	Is developing an action plan is part of the feedback system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Quality Assurance	
J29.	Is there any routine visit for quality assurance held by any external supervisor/manager?	<input type="checkbox"/> Yes <input type="checkbox"/> No
J30.	If Yes, who is/are the visitors	<input type="checkbox"/> DGFP-officer/FP Clinical Supervision Team..... .01 <input type="checkbox"/> Other external quality team visits .....02 <input type="checkbox"/> Internal quality team..... .03 <input type="checkbox"/> QIC DQA system .....04 <input type="checkbox"/> QIC visit......05 <input type="checkbox"/> Other (Specify) _____
J31.	If Yes, how often external supervisor/managers conduct visits?	<input type="checkbox"/> Monthly 1 <input type="checkbox"/> Quarterly..... 2 <input type="checkbox"/> Six monthly 3 <input type="checkbox"/> More than six month 4 <input type="checkbox"/> Not specified 5 <input type="checkbox"/> Other (Specify) _____ 9
J32.	Is there any filled-in checklist on the assessment of quality of service for the period of last time?	<input type="checkbox"/> Yes (INTERVIEWER: COLLECT ONE SUCH FILLED-IN CHECKLIST FOR YOUR RECORD.) <input type="checkbox"/> No

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J33.	Did they record the quality assessment information of service on the check list/visit book during the last visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
J34.	Is there any feedback from the supervisor? (DETERMINE THIS FROM THE CHECKLIST)	<input type="checkbox"/> Yes, written feedback 1 <input type="checkbox"/> Yes, verbal feedback 2 <input type="checkbox"/> No 3
J35.	Has any action step taken so far based on the supervision/quality assurance visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No

I. Elements of Youth-Friendly Contraceptive and PAC Services

	Essential Elements Method : Ask (Ask to Counselor/ FWV)	Response Yes=1 No=2	Comments/ Recommendations
	Confidentiality		
K1.	Do written procedures exists for protecting client confidentiality?		
K2.	Are records stored so that confidentiality is ensured?		
K3.	Is registration done in a manner that ensures confidentiality?		
	Adolescents are served regardless of age or marital status		
K4.	Do clear written guidelines for serving youth exists?		
K5.	Is there a minimum age requirement for contraceptive or PAC services?		
K6.	Are spousal consent required?		
	Comprehensive contraceptive counseling offered to all clients		
K7.	Do providers counsel on a range of methods (effectiveness advantages/disadvantages)		
K8.	Do providers allow clients to choose a method, and then provide full information on that method including potential side effects		
K9.	Do providers inform them on follow up visit?		
K10.	Is comprehensive contraceptive counseling offered routinely as post-abortion and postpartum clients?		
	Range of contraceptive methods offered to all clients regardless of age, marital status, and HIV status		
K11.	What contraceptive methods are offered to clients? (multiple response)	<input type="checkbox"/> Pill <input type="checkbox"/> Condom <input type="checkbox"/> Injectable <input type="checkbox"/> IUD	

Facility Assessment Report

	Essential Elements Method : Ask (Ask to Counselor/ FWV)	Response Yes=1 No=2	Comments/ Recommendations
		<input type="checkbox"/> Implant <input type="checkbox"/> Vasectomy <input type="checkbox"/> Tubectomy	
K12.	Are there any contraceptive methods that youth cannot receive?		
K13.	Is there a minimum age requirement to receive certain methods?		
K14.	Are any FP method provided to unmarried youth?		
K15.	Are there any methods that are not offered to HIV positive clients?		
	Privacy during FP counselling		
K16.	Are there doors and are they shut during consultation?		
K17.	Are there curtains in the window?		
K18.	If windows are left open, can anyone easily hear what is being said?		
K19.	Are privacy screens used?		
K20.	Does personal history taking, screening or asking why the client has come for services occur in public?		
K21.	Are there any non-essential interruptions during counseling, exams, or lab procedures?		
	FP treatment guidelines, procedures and protocols		
K22.	Are there guidelines and SOPs for FP available on site?		
K23.	Are there service delivery procedures for FP services (including treatment, counseling, and referrals) available?		
K24.	Are there service delivery guidelines for serving adolescent clients available?		
K25.	Are the protocols routinely followed?		
K26.	PAC treatment guidelines, procedures and protocols exist and are followed		

J. Gender responsiveness of services

	Query Method: Ask (Ask to Facility Manager specify)			
	Administration and staffing	Female	Male	Total
L1.	Management Staff			

Facility Assessment Report

Query Method: Ask (Ask to Facility Manager specify)			
L2.	Technical Staff		
L3.	Support Staff		
L4.	Facility Manager	<input type="checkbox"/> Female <input type="checkbox"/> Male	
Quarry Method: Ask (Ask to Facility Manager specify)		Response Yes=1 No=2	Comments
Program environment- a. Physical safety, Psychological/emotional safety, trauma-informed, holistic and culturally competent practices			
L5.	Do women clients face any security problem to receive service from this facility?		
L6.	Did any client share any story related to physical, psychological or emotional trauma when they come to receive service from this facility?		
L7.	Did any woman who victim of gender-based violence receive services from this facility?		
L8.	Is there any difficulties for women to receive service from this facility?		
Service provisions			
L9.	Who are the service recipients from this facility?	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Both <input type="checkbox"/> Third gender	
L10.	Did any staff receive any training/orientation on gender?		
L11.	Are there any gender related agenda include in any meeting?		
L12.	Does any supervisor discuss about gender when they visit the facility?		
Data collection and reporting			
L13.	Do this facility maintain any sex disaggregated service information?		
L14.	Is there any gender related accomplishments in the monthly report?		

Facility Assessment Report

BCC materials Availability

1 = Yes, 2 = No

#	Question Method: Observation	IUD	Implants	Tubectomy	NSV	Inj.	Pill	Condom	More than one method in one material
01	Are there any billboard(s)/ banner(s) in the premise of the facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
02	Are there any posters at the facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
03	Are there any leaflets/booklets are kept in easily visible places?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
04	Are the clients/visitors allowed to take the leaflets/booklets with them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
05	Are there any job-aids which are used by the service provider?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
06	Circle the job-aid that you observed. (Devices or tools (such as instruction cards, memory joggers, wall charts) that allow an individual to quickly access the information he or she needs to perform a task.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Data Collection Instruments – 2

Focus Group Discussion (FGD) Guide: Opinion leaders

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

Identifying leaders

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

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

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

Informed Consent

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

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

Facility Assessment Report

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

If you do not have any question, do I have your permission to continue?

Yes 1 No 2

Moderator's name: _____

Signature of Moderator _____ Date _____

Part A: Background Information

1. FGD Code: _____ 2. Facilitator name: _____

3. Date: ____/____/____ 4. Start Time: _____ 5. End time: _____

6. Location: Division: _____ District: _____

Upazila: _____ Union: _____ 7. # of participants: _____

8. Description of Setting (Surroundings, general atmosphere, weather, observations before starting FGD)	----- ----- ----- ----- -----
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Part A Continued: Participant Information

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

Field	Participant Code	Sex	Age	Occupation/ Role in Community	Spouse’s occupation	Years of Schooling
9.1						
9.2						
9.3						
9.4						
9.5						
9.6						
9.7						
9.8						
9.9						
9.10						
9.11						
9.12						

Part B: Opening Scripts

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

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

Part C: Guiding Questions

Theme: Perception about health and FP services

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

Theme: Gender

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

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

2. Possible involvement of local leaders with health service delivery in this area.

Probe: forming committees, increase providers accountability, periodic visits, generating funds from community, functional community referral, support facility readiness, advocacy for improving health seeking behavior etc.

3. Gender as a barrier to avail MCH and FP services. If so, possible mitigation strategy.

Theme: Youth and Adolescents

1. Most popular health and family planning service provisions. Reason of popularity.

Probe: provider is skilled and available, Facility is nearby, cheap, one stop service, influenced by other satisfied user, FWA influence for that, confidentiality to get the commodity or services etc.

2. Availing services by young people irrespective of age/sex and marital status. If yes, describe.

Probe: provider is skilled and available, Facility is nearby, cheap, one stop service, separate service for young people, compassionate, privacy and confidentiality, age specific counseling etc.

3. Family planning services for adolescents and young people. If special services required, please describe.

Probe: PAC, counseling, other services etc.

Theme: Community engagement

1. Possible engagement of community leaders to enhance family planning services. If possible, please describe. If not possible, please share the barriers.

Probe: supporting facilities through management committee, linking local elites for financial support, involving local govt' etc.

2. Please tell us about the Community support group and community management committee of community clinic. Involvement of community with public health facility. If involved, please describe. If not, please share the barriers.

Probe: familiar about any member of that group; their role; any involvement of yourself; any example etc.

Theme: SBCC

1. Source of knowledge about any MNH and FP services. *(Please probe to have a hierarchical list)*

Probe: please mention any message you can remember of family planning

2. Please share your thoughts about existing SBCC activities (please explain...) in your area. Please share your thoughts on reaching community people more effectively.

Probe: visual, audio, audiovisual etc.

3. Please suggest media (electronic, print) best to be informed on Family Planning messages. Please share the reason of your preference. Please share your thought about internet based information for MNH and FP services.

Probe: familiar with SBCC materials; Tiaht poster; popular; accessible; women can reach etc.; Any electronic device used; familiar with any apps, media etc.; what are those?

Theme: referral

1. Please share us the health service seeking behavior.

Probe: whether they visited community level facility to district level tertiary level facility for getting any particular service by referral mechanism.

2. Please describe of any existing social mechanism to help poor to reach public health facilities. If exists, please describe.

Probe: How local elites can help, financial support, giving fair, arrange vehicle, help them contact with FWA, HA, NGO volunteers etc.

3. Please share us the first point of contact in your locality for health services.

Probe: How she/he helps?

Suggestion/Recommendation

Please share your recommendations to increase community involvements in MNCHFP services?

(Please do not probe)

Data Collection Instruments – 3

Tool for KII

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

Identification of respondents

Name of Facility		Code* -	
Division*-	District*-	Upazila*-	Union*-
Designation of provider: Service provider-2)		Code-	(Manager-1,
DNO- (Facility code+Division code+district code+Upazila code+Union Code+desination code)			

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

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

Consent form

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

Introduction of the study and this interview:

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

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

Why you are being asked to participate:

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

Procedures:

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

Risks/discomforts

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

Protecting data confidentiality

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

Benefits

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

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

Name of provider: _____	
Designation of provider: _____	
What is the highest academic degree you have completed?	
1 = Bachelor	
2 = Masters	
3 = Postgraduate Diploma	
4 = Medical Doctor	
At what year did you begin your service/job?	
Location:	Type of facility:
<input type="checkbox"/> Division	<input type="checkbox"/> District Hospital
<input type="checkbox"/> District	<input type="checkbox"/> Upazila Health Complex
<input type="checkbox"/> Upazila	<input type="checkbox"/> UH&FWC
<input type="checkbox"/> Union	

Policies and guidelines:

1. Do all policies and guidelines issued by the government of Bangladesh reach to your districts immediately (within 1-2 weeks) after publication/revision?
2. How do you check on the most recent policies and guidelines in your facility?
3. Have you ever worked as a member of technical committee for developing guidelines? If yes, what guidelines did this technical committee work on?

Probe: (FP manual, any FP training guidelines, etc.)

4. What do you think of the current policies and guidelines in place and the process of how they are currently revised?

Probe: (any feedback based on facing any issues at field for policy formulation)

- involvement in implementation of any approved policy;
 - challenges faced in implementing policies;
 - proactiveness among providers, staff to implement new or existing policies
5. When a new staff member is hired, does the staff member immediately get foundation training? Why or why not?
 6. How do you disseminate new policy/ guideline to providers/staff? Do your staff/ providers practice up to date policy/ guidelines for providing services or client screening? If no, why?

Training of providers

1. What do you think about skills of providers for providing FP services in different facilities in your district?

Probe: at DH, MCWC, UHC and UH&FWC etc.

2. What kind of training have most service providers working in the facilities received with respect to family planning?
 - a. Can you describe what these trainings usually involve? Do you think they provide sufficient knowledge?

3. What are the major staffing challenges that service providers face in offering FP services to clients?

Probe: Transfer, Lack of service providers and support staff, Lack of field workers, lack of trained staff

4. What are the commodity and other logistic supply related challenges that you are facing that hamper service provision?

Probe: Lack of FP commodities, lack of imprest fund, lack of other logistics supply.

- Structural barriers (insufficient counseling space, IUD insertion space, waiting area, adolescent corner),
 - Working hours,
 - Problems with referrals from community/ field, including low numbers of referrals
 - Poor client screening at the field level,
 - Low numbers of service providers at facility at times (due to leave/ training/ meeting)
 - Stigma
5. What kind of training and/or support would help service providers perform better in this facility?
 - a. What do you think about providing mentorship and supportive supervision for continuous learning and skill development?
 - b. What do you think about showing IEC materials to the clients in Tablets?

Responsiveness of FP services

1. Can you describe a typical FP/RH counselling session between a service provider and a client? What are the steps in the counselling process?

Probe: Place where counselling takes place, use of materials, privacy, respect, informed choice, etc.

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

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

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

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

Probe: visibility, language, appropriateness with services etc.

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

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

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

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

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

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

Probe: accessibility, appropriateness, age specific training etc.)

2. Does your facility offer family planning services to adolescents (ages 11-19)?
 - a. Are these services generally accessible to young people?
 - b. Do the facility's operating hours match the times of day when adolescents, especially students, can typically come into the facility?
3. In what ways do you think that FP services in your district/upazila could be improved to meet the needs of adolescents?
4. What do you think about the qualifications of the service providers in your facility to provide FP services for adolescents?
 - a. What age and sex are the service providers who provide FP services for young people? Do you think this is appropriate and meets young people's needs?
 - b. Do you think the providers at your facility have the appropriate training to provide FP services to adolescents? How so?
 - c. Do you think the providers at your facility have the appropriate skills to provide FP services to adolescents? How so?

Management/ role of GOB

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

Supervision and accountability

1. Is there any system to check progress of provider performance? If so, provide a brief description
2. *Only for DGFP providers:* What do you think about the supervision system of FP service providers and managers in DGFP?

Probe: way of supervision (distant vs. in person), supportiveness/sympathetic, frequency, methods, tools etc.)

- a. How could the supervision system for FP service providers and managers in DGFP be improved?
3. *Only for DGHS providers:* What do you think about the supervision system of FP service providers and managers in DGHS?

Probe: way of supervision (distant vs. in person), supportiveness/sympathetic, frequency, method, tools etc.)

- a. How could the supervision system for FP service providers and managers in DGHS be improved?
4. What are the major challenges of supervision for FP services at DGFP?

Probe for different providers and services, administrative, clinical, hands on coaching, general service or performance related, FP compliance

5. What are the major challenges of supervision for FP services at DGHS?

Probe for different providers and services, administrative, clinical, hands on coaching, general service or performance related, FP compliance

6. How is supervision data is used?
 - a. Please share instances where supervision data was used for improving quality of services, facility readiness, FP compliance etc.
7. What do you think about the dynamics of the supervision of FP services in terms of gender?
 - a. Have you ever encountered instances in which a male supervisor interacts differently with a male service provider than with a female service provider? Can you describe this? What happened? If a problem: How can this be improved?

- b. Have you ever encountered instances in which a female supervisor interacts differently when a male service provider than with a female service provider? Can you describe this? What happened? If a problem:
- c. Have you encountered instances in which a supervisor interacts differently when a younger or older age provider? Can you describe this? What happened?
- d. How this can be improved?
8. What do you think of effectiveness of supervision by on-site and off-site supervisors? How do they differ? Which are more effective? Why?
9. What is the major supervision needs for FP services provision?

Probe: skills (clinical skills, record keeping, client screening skill, counseling skill, follow up skill, logistical management, etc.), management, client interactions, interpersonal interactions, etc.

10. How frequently do service providers conduct follow up for FP service receivers?
 - a. What could be the standard time period (each specific method) for client follow up?
11. In the case of any clinical or management related issue/ emergency, whom do you asking for support or consult to solve any problem related to clinical knowledge and skill (method specific)? Why?

Probe: Do you think he or she has mastery in specific clinical field/ method or management related knowledge and skill?

Mentorship

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

Gender responsiveness

1. Are women and men who come to this facility equally able to access FP services at this health facility?
 - b. Why/why not?
 - c. What barriers might women face in accessing FP services at this facility?

Probe: extent of privacy, feeling uncomfortable, pressure or bias from others at the facility (family, other patients, providers), male provider etc.

- d. What barriers might men face in accessing FP services at this facility?

Probe: extent of privacy, feeling uncomfortable, pressure or bias from others at the facility (family, other patients, providers), female provider etc.

Facility Assessment Report

2. When you counsel women about their FP options, are they usually by themselves or with their husbands?
 - a. What is the role that men play when it comes to women accessing FP services?

Probe: Do they make the final decision about whether to use FP/which method to choose? Do they consult with their wives and the decision is made jointly? Do the men talk with the provider, too?

- b. What do you think about the male participation in FP services (supporting in taking decision by partner)?
3. Are there any differences in how you interact with female patients than with male patients who come to talk to you about their FP options?

Probe: Inquiring about marital status or permission before going forward with recommending options

4. What can be done to improve FP services for women?
 - a. What can be done to improve FP services for men?
5. Do you think FP services at your facilities are responsive to youth and adolescent? How? How this can be improved?

Use of service statistics for making decisions

1. How is performance data currently captured and utilized?
 - a. Is performance data shared with providers?
 - b. Is this data shared in a performance report?
 - c. If yes, is the performance report easy to read and understand? How so?
2. What do you think about the existing performance monitoring system?
3. Do you think DGFP MIS system is enough to support your monitoring system in your management area? Probe: Do you feel confident to use that data? Sometimes people from outside raise question about the data quality. Sometimes, DGHS and private facility data are not captured in DGFP MIS, especially PFP service information.
 - a. Why or why not?
4. How can the use of performance data can be improved in your district/upazila?
5. Do you have any scope to take decision from existing performance monitoring system? If yes where and how?
6. Have you ever used the DGFP MIS data for planning of you district? If yes, what are those?

Probe: stock data, FWV reports etc.

7. Where are the scopes to use data for quick decision making and planning?
8. Have you ever used age and sex-disaggregated data for FP services during district/upazila planning (probe-)?

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

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

Use of electronic devices

1. Do providers use smart devices (i.e., smartphone, tablets) for work?
 - a. If yes, how? what are the common applications used for work?

Probe: Facebook, Facebook messenger, WhatsApp, IMO, Viber, emails etc.)

Data Collection Instruments – 4

Tool for KII

Service provider

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

Identification of respondents

Name of Facility		Code*-	
Division*-	District*-	Upazila*-	Union*-
Designation of provider: Service provider-2)		Code-	(Manager-1,
IDNO # (Facility code+Division code+district code+Upazila code+Union Code+designation code)			

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

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

Consent form

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

Introduction of the study and this interview:

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

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

Why you are being asked to participate:

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

Procedures:

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

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

Protecting data confidentiality

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

Benefits

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

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

Name of provider: _____

Designation of provider: _____

What is the highest academic degree you have completed?

1 = Bachelor

2 = Masters

3 = Postgraduate Diploma

4 = Medical Doctor

At what year did you begin your service/job?

Location:

Division

District

Upazila

Union

Type of facility:

District Hospital

Upazila Health Complex

UH&FWC

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

Providers Capacity:

1. What do you think about the clinical skills of service providers for providing FP services at your facility?

Probe: (Considering all providers of your facility who are supposed to provide specific FP services)

2. Please describe about the training on different issues for service providers.

(Probe: trainee selection process; training management & quality; enough scope to deal real client in practicum; sharing sufficient training material; any strength or weakness; organizational barrier; individual barriers; whether interactive; major challenges; trainee follow-up).

3. What do you think about the interpersonal skill of service providers at your facility?

Probe: (patience; empathy to client; attentiveness; knowledge about services; time management; understand the client's needs; client screening, follow up services).

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

Probe:

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

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

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

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

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

Responsiveness

7. How service providers generally do counselling?

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

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

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

9. Do school/college student can come to the facility due to contradiction with school hours? How?

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

Probe: (visibility; language; appropriateness with services etc.)

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

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

12. What are the challenges of counselling here?

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

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

14. How frequent service provider conduct follow up for FP service receivers? What could be the standard for client follow up mechanism?

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

Probe: (related to clinical knowledge and method specific skill)

Youth and adolescent FP services:

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

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

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

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

18. Do any young boys and girls have provision of access in your facility? If yes, why; when; from where? (generally, /most of the time)

Facility Assessment Report

19. Do any school students come to your facility who referred from school health program? If yes, what is the frequency? If no, why?
20. What do you think about age; sex and skill appropriateness of providers for adolescents FP services in your facility?
21. Do you think providers of this facility act differently for FP clients those are young? If yes; how?

Probe: (maintain confidentiality; involve different SP; follow different methods and materials; time etc.)

Supervision and Mentoring:

22. Is there any supervision and monitoring system to check progress of SP performance? If so; provide a brief description
23. What do you think about the supervision system of this facility?

Probe: (way of supervision distant/close; on-site/ off-site; supervisor-supervisee interaction process; facilitative; frequency, what issues considered during supervision i.e., administrative, hands on coaching, other etc.)

24. Does the service provider of this facility face any supervision? If yes, how? How can this be improved?

Probe: (any supervision schedule informed to supervisees; checklist used; formal sharing process; sharing through technology or using social media like Facebook, WhatsApp, etc. challenges)

25. How do providers implement recommended actions received by supervision system?
26. Please share an example how supervision helped resolve an issue about FP services provision?
27. Is there any practice of mentorship in your facility?

Instruction for Interviewer: (please read out the definition: Mentoring is a positive developmental partnership; where an experienced; proficient and empathetic person (a mentor) teaches and coaches another individual (mentee) or group of individuals (mentees); in person and/or virtually; to ensure competent workplace performance and provide ongoing professional development).

28. If no, how would you like to see, if Mentorship is introduced to FP services?

Probe: (who could be prospective mentors; mentee; matching; location of mentor; priority skill areas etc.)

29. Do you think sex status of a supervisor can affect supervision? If yes; how? How can this be mitigated?
30. Do you think position/ years of experience can affect supervision?
31. Do you think sex status of a supervisee can affect supervision? If yes; how? How can this be mitigated?
32. What are the major challenges of supervision and mentorship here?

Gender

33. Are there any types of people whom the facility does not provide services to?

Probe: (refugees/internally displaced persons; male; transgenders; disables etc.)

34. Does the facility require approval/consent for any kind of services a patient receives? If yes; why; from whom?

35. Are there any barriers, which prevents women / men (specific age / marital status) accessing to the facility? If Yes; what are those?

Probe: (distance; timing; gender; age and availability of providers etc.)

36. Did any client share any story related to physical, psychological or emotional trauma when they come to receive service from this facility?

Use of data/information

37. Who is mainly responsible to keep information about performance of your facility? Do you ever look at your performance? If yes; how and why describe briefly

38. Do you think; record keeping is helpful for enhance your performance? If no; why? if yes; how

39. Are age and sex-disaggregated data for FP is available in your facility? If yes; do you ever use this? If yes; why?

Use of electronic devices

40. Do providers use smart devices i.e. smartphone; tablets? If yes; how? what are the common purposes?

41. Do providers use smart devices for work? If yes; how? what are the common applications used for work?

Probe: (Facebook messenger; WhatsApp; IMO; Viber; emails etc.)

Data Collection instruments – 5

Focus Group Discussion (FGD) Guide:

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

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

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

Please adhere to the following instructions when facilitating this FGD:

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

Informed Consent

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

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

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responses, which they will utilize to prepare the report. All the data will be stored in a locked and secured place.

You may ask any questions or clarifications before giving your consent for FGD, during or after the FGD. You can leave anytime if you disagree with anything of this discussion. You may also contact Md. Liaquat Ali (01711354106) for any questions after the FGD.

If you do not have any question, do I have your permission to continue?

Yes 1 No 2

Moderator's name: _____

Signature of Moderator _____ Date _____

Part A: Background Information

1. FGD Code: _____ 2. Facilitator name: _____

3. Date: ____/____/____ 4. Start Time: _____ 5. End time: _____

6. Location: Division: _____ District: _____

Upazila: _____ Union: _____ 7. # of participants: _____

8. Description of Setting (Surroundings, general atmosphere, weather, observations before starting FGD)	----- ----- ----- ----- -----
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Part A Continued: Participant Information

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

Field	Participant Code	Sex	Age	Marital status	Years you are living in this community	Other demographic variable (specify)
8.1						
8.2						
8.3						
8.4						
8.5						
8.6						
8.7						
8.8						
8.9						
8.10						
8.11						
8.12						

Part B: Opening Scripts

Opening script—Group interview. Read aloud: Good morning/afternoon, I would like to thank you for giving the time to speak with us in this discussion in which we would like to learn more from you about your experiences with health and family planning services available in your area.

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

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

Part C: Guiding Themes and Questions

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

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

Theme: Gender responsiveness in health facility

1. For male participants: Please describe a typical experience of a young man who goes to a health facility to seek family planning services.

For female participants: Please describe a typical experience of a young woman of your age who goes to a health facility to seek family planning services?

2. For male participants: Comfort in accessing family planning services. If not comfortable, please state reason.

For female participants: Comfort in accessing family planning services as young woman. If not comfortable, please state reason.

3. Please tell us about the most frequently accessed government run facility for family planning services. Please describe the facility to you maximum possible extent.

Theme: Provision of FP services availability and accessibility

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

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

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

Theme: SBCC materials

1. Communication materials (such as pamphlets) available at health facilities to take home. Please share us the usefulness of the communication materials
2. Experience of electronic devices used during counseling; familiarization with any apps, media etc.

(Interviewer's Instruction: In some areas, FWAs provide information and education on FP and RH by using electronic devices, which are very useful. Is there anything exist in this locality?)

Theme: Accessibility of health and FP service information

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

Theme: Barriers to access FP services at community and facility

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

Theme: Scopes to access FP services at community and facility

1. What can health facilities and health providers do to make it easier and better for young people such as yourselves to access health and family planning services?

(Possible action points by health facilities, possible action points by health providers)

Annex-4: Data Tables

Table 1: Overall availability of client services [%]

Services	Facilities			
	DH %(n)	MCWC %(n)	UHC %(n)	UH&FWC %(n)
AYHS	100 (5)	100 (6)	92.9 (26)	93.3 (28)
FP counseling	100 (5)	100 (6)	100 (28)	100 (30)
PAC-FP	80 (4)	100 (6)	75 (21)	63.3 (19)
MGBV	40 (2)	50 (3)	35.7 (10)	60.0 (18)
PPFP	60 (3)	100 (6)	96.4 (27)	86.7 (26)
FP services	100 (5)	100 (6)	100 (28)	100 (30)
RTI/STI	80 (4)	100 (6)	96.4 (27)	90 (27)
MCH services				
Ante natal Care (ANC)	100 (5)	100 (6)	100 (28)	100 (30)
Normal Vaginal Delivery (NVD)	80 (4)	100 (6)	100 (28)	70 (21)
C-Section Delivery	80 (4)	100 (6)	28.6 (8)	0 (0)
Postnatal Care (PNC)	80 (4)	100 (6)	100 (28)	100 (30)
All services	40 (2)	50 (3)	32.1(9)	30.0 (9)

Table 2: Training in 2 years preceding the survey (frequency)

Facility Type	Position/Title	No. of training provided													
		IUD (Interval)	PP IUD (Postpartum)	PPFP	Implant	Vasectomy (NSV)	Tubectomy	Short-acting FP method	Counseling-FP	PAC	Infection Prevention	Management of RTIs/STIs	Supervision	Adolescent and youth-friendly health services	Gender Issues
District Hospital (DH)	OB/GYN	0	0	1	0	0	1	1	0	0	0	0	0	0	0
	Nurse	0	0	0	2	1	1	0	1	0	0	0	0	0	0
	Midwife-Nurse	0	0	0	0	0	0	0	0	0	0	1	0	0	0
	FWV/Senior FWV/ AFWO	2	0	2	0	0	0	0	1	1	1	1	0	0	0
MCWC	MO (MCH-FP)	0	0	0	1	0	0	0	0	0	0	0	0	1	0
	MOCC	0	1	0	0	0	0	0	0	0	1	0	0	2	0
	Nurse	0	0	0	0	0	0	0	0	0	1	0	0	0	0
	Midwife-Nurse	0	0	0	0	0	0	1	0	0	0	0	0	0	0
	FWV/Senior FWV/ AFWO	4	0	6	0	0	0	1	0	0	1	0	0	0	0
UHC	RMO	1	0	0	0	0	0	0	0	0	1	0	1	0	0
	MO (MCH-FP)	3	0	1	4	2	0	1	2	1	1	0	5	0	0
	UFPO	0	0	0	1	0	0	1	2	0	0	1	3	2	0

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Facility Type	Position/Title	No. of training provided													
		IUD (Interval)	PP IUD (Postpartum)	PPFP	Implant	Vasectomy (NSV)	Tubectomy	Short-acting FP method	Counseling-FP	PAC	Infection Prevention	Management of RTIs/STIs	Supervision	Adolescent and youth-friendly health services	Gender Issues
	AUFPO	0	0	1	0	0	0	0	2	0	0	0	2	1	0
	FWV/Senior FWV/ AFWO	7	1	10	0	1	0	1	7	2	1	0	0	2	0
	FMA	1	0	0	0	0	0	0	0	0	0	0	4	0	0
	UFPA	0	0	0	0	0	0	0	0	0	0	0	9	0	0
	Office Assistant	0	0	0	0	0	0	0	0	0	0	0	1	0	0
	FPC	0	0	0	0	0	0	0	1	0	0	0	0	0	0
UHFWC	MO (MCH-FP)	0	0	0	2	0	0	0	0	0	0	0	0	1	0
	FWV/Senior FWV/ AFWO	8	0	6	2	0	1	1	1	0	3	1	1	3	0
	SACMO/MA	0	0	0	0	0	0	0	0	0	2	2	0	3	1
	FPI	0	0	1	0	0	0	0	1	0	0	0	3	0	0
	FWA	0	4	0	0	0	0	0	5	0	0	2	0	2	2

Table 3: Overall availability of service providers

Facilities	Providers of respective facilities	Status		
		Sanctioned	Available	Present
DH	OB/GYN, Nurse, Midwife, Cleaner	60	96.7	74.1
MCWC	MO-Clinic, MOMCH, FWV, Midwife, Aya	68	105.9	68.4
UHC	RMO, MOMCH-FP, UFPO, AUFPO, FWV	261	81.2	85.8
UH&FWC	MO-FW, SACMO, FWV, FPI, FWA	270	70.4	73.2

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Table 4: Availability of basic amenities for client services [n(%)]

Facility type	Regular electricity% (n)	Improved water source % (n)	Visual and auditory privacy while counseling % (n)	Client latrine % (n)	Communication equipment % (n)	Computer with internet % (n)	Emergency transport % (n)	Separate latrine for female clients	Any 5 basic amenity
DH	100 (5)	100 (5)	20 (1)	100 (5)	80 (4)	40 (2)	80 (4)	100 (5)	80 (4)
MCWC	100 (6)	100 (6)	83.3 (5)	100 (6)	66.7 (4)	33.3 (2)	100 (6)	100 (6)	100 (6)
UHC	100 (28)	100 (28)	42.9 (12)	96.4 (27)	78.6 (22)	64.3 (18)	60.7 (17)	96.4 (27)	60.7 (26)
UH&FWC	86.7 (26)	76.7 (23)	50 (15)	93.3 (28)	23.3 (7)	0 (0)	0 (0)	0 (0)	20 (6)

Table 5: Availability of FGP service commodities (frequency)

Facility type	FP services (frequency)						
	OCP	POP	injectable	LARC	PM/sterilization	PPFP	ECP
DH	2	4	4	4	4	3	0
MCWC	4	6	6	6	6	6	6
UHC	8	27	28	28	27	27	23
UH&FWC	9	29	30	29	5	26	22

Table 6: Readiness to provide FP services (frequency)

Facility type	Readiness (frequency)			
	Trained staff	Guideline	Equipment	Commodities
DH	5	4	5	4
MCWC	6	6	6	6
UHC	28	22	28	28
UH&FWC	30	17	30	29
Total	69	49	69	67

Table 7: Readiness to infection prevention (frequency)

Facility type	Soap	Running water	Soap and running water	Alcohol based hand disinfectant	Soap and running water or else alcohol based disinfectant	Latex gloves	Sharps container	Waste receptacle	All 6 items available
DH	4	4	4	4	4	4	4	4	4
MCWC	6	6	6	5	5	6	6	6	5
UHC	28	26	26	26	24	23	27	27	18
UH&FWC	28	17	17	17	9	22	22	24	7

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Table 8: Record keeping and Treatment Protocols (%)

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

Table 9: Availability of youth-friendly contraceptive and PAC service instruments (%)

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

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Table 10: Privacy during FP counseling (%)

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

Table 11: Method specific availability of FP equipment (Implant) (%)

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

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Table 12: Method specific availability of FP equipment (IUD) (%)

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

Table 13: Method specific availability of FP equipment (Permanent Method: Preparation and Examination) (%)

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

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Tallquist book for and disposable lancet	0.0	20.0	0.0	0.0	0.0	7.1	0.0	43.3
Cotton, antiseptic solution in cup/ gully pot (rectified spirit/hexisol or povidone iodine)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	33.3

Table 14: Method specific availability of FP equipment (Permanent Method: Operation Theatre) (%)

Equipment	DH		MCWC		UHC		UHFWC	
	Available not functional	Not available	Available not functional	Not available	Available not functional	Not available	Available not functional	Not available
Pre-Operative room								
bed, mattress, bed-cover, pillow, mosquito net and rubber sheet	0.0	40.0	0.0	16.7	0.0	42.9	3.3	60.0
water, soap, bucket, towel, bathing facility etc.	0.0	60.0	0.0	16.7	0.0	35.7	0.0	53.3
BP instrument, stethoscope and thermometer	0.0	40.0	0.0	16.7	0.0	35.7	0.0	46.7
Medicine: antibiotic and tablet diazepam	0.0	40.0	0.0	16.7	3.6	35.7	0.0	53.3
Toilet facility	0.0	40.0	0.0	16.7	0.0	46.4	0.0	50.0
Operation theater with the facility of dressing, hand-washing and autoclaving or IP space								
Autoclave, autoclave indicator tape and register	0.0	20.0	0.0	0.0	0.0	0.0	6.7	70.0
Kerosene four-burner pressure stove or gas burner or electric stove or electric connection socket	0.0	40.0	0.0	0.0	0.0	10.7	0.0	16.7
Surgical drum, drum or tray for instrument & gloves	0.0	20.0	0.0	0.0	0.0	0.0	3.3	26.7
Twofold cloth for tray-cover or trolley cover	0.0	20.0	0.0	0.0	0.0	3.6	0.0	63.3
Autoclaving monitoring chart on the autoclaving room's wall	0.0	80.0	0.0	33.3	0.0	39.3	0.0	90.0
Necessary instruments for disinfection: (plastic bucket, sieve, bleaching powder or liquid chlorine or chlorine tablet, stirrer, plastic mug, utility gloves etc.)	0.0	20.0	0.0	0.0	0.0	3.6	3.3	20.0
Basin for washing and wiping of the instrument, detergent powder, brush & towel	0.0	20.0	0.0	0.0	0.0	3.6	0.0	16.7
Table for drying, wrapping and keeping the instrument	0.0	20.0	0.0	0.0	0.0	10.7	3.3	26.7
Hanger/clip for drying the gloves	0.0	20.0	0.0	16.7	0.0	35.7	0.0	53.3
Hand washing area attached with operation theater								
Basin with elbow tap and running water (obviously outside the toilet) or as a substitute water tank or drum with tap can be placed in the wall of table/stand or water filled bucket and mug can be used (in that case an assistant should poured the water)	0.0	20.0	0.0	0.0	0.0	3.6	0.0	46.7
Hand washing soap, antiseptic solution	0.0	20.0	0.0	0.0	0.0	3.6	0.0	20.0
Area for undressing the used cloth and wearing OT dress	0.0	60.0	0.0	33.3	0.0	39.3	0.0	80.0
Clean and sterilized musk for all related to the service	0.0	20.0	0.0	0.0	0.0	10.7	3.3	50.0
Boot or sandal for all related person in the OT	0.0	20.0	0.0	16.7	0.0	25.0	0.0	73.3
Operation theater								
Enough light	0.0	20.0	0.0	0.0	0.0	3.6	0.0	26.7

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Glass window	0.0	20.0	0.0	0.0	7.1	14.3	0.0	50.0
Netting to prevent insect	0.0	80.0	0.0	0.0	0.0	35.7	3.3	80.0
Air Conditioned	20.0	60.0	0.0	16.7	7.1	50.0	0.0	93.3
wall made of tiles/mosaic up to 7 feet from the floor	0.0	20.0	0.0	0.0	0.0	28.6	0.0	76.7
Supplies for the OT								
OT table with plastic or rubber sheet	0.0	20.0	0.0	0.0	0.0	7.1	0.0	40.0
OT light and to prevent electricity interruption working 3 battery torch or charger light	0.0	20.0	0.0	0.0	0.0	17.9	0.0	46.7
Instrument trolley	0.0	20.0	0.0	0.0	0.0	7.1	0.0	66.7
Small/ maya trolley for keeping all other instrument for every operation	0.0	20.0	0.0	0.0	0.0	32.1	0.0	86.7
BP instrument and stethoscope	0.0	20.0	0.0	0.0	0.0	3.6	0.0	33.3
Essential instrument for emergency management in working condition	0.0	20.0	0.0	0.0	0.0	10.7	0.0	43.3
Emergency drug for emergency situation	0.0	20.0	0.0	0.0	0.0	7.1	0.0	46.7
For regular tubectomy sufficient amount of instrument set, MSR, and medicine should be available in adequate amount	0.0	20.0	0.0	0.0	0.0	7.1	0.0	90.0
For regular vasectomy sufficient amount of instrument set, MSR, and medicine should be available in adequate amount	20.0	60.0	0.0	0.0	0.0	7.1	0.0	93.3
OT register	0.0	40.0	0.0	0.0	0.0	3.6	0.0	86.7
Post- operative room								
Toilet facility	20.0	40.0	0.0	16.7	7.1	35.7	3.3	73.3
Washing basin	20.0	60.0	0.0	16.7	36.0	32.1	0.0	73.3
Bed, mattress, Bed-cover, pillow with cover, mosquito net and rubber sheet, hurricane, vessel, bucket, mug, glass,	20.0	40.0	16.7	16.7	0.0	46.3	3.3	53.3
Stool, table, chair, hand fan	20.0	40.0	0.0	33.3	0.0	50.0	0.0	66.7
BP instrument, stethoscope, Thermometer, 3 battery working torch	0.0	40.0	0.0	16.7	3.6	28.6	0.0	63.3
Medicine – paracetamol, vitamin tablet	0.0	40.0	0.0	16.7	0.0	35.7	0.0	63.3
Emergency medicine	0.0	40.0	0.0	16.7	0.0	32.1	0.0	70.0

Table 15: Availability and functionality of Gynecology exam Equipment (frequency)

Equipment	Status	DH	MCWC	UHC	UHFWC	Total
Sim's Speculum	Available	4	6	28	16	54
	Functional	4	6	28	16	54
CUSCO's Speculum	Available	4	6	27	25	62
	Functional	4	6	27	25	62
Sponge holding forceps	Available	4	6	28	26	64
	Functional	4	6	28	26	64
Spot light	Available	4	6	25	15	50
	Functional	4	6	22	12	44
Kidney tray	Available	4	6	27	25	62
	Functional	4	6	27	25	62
Gallipot	Available	4	6	28	25	63
	Functional	4	6	28	25	63
Artery forceps	Available	4	6	27	25	62
	Functional	4	6	27	25	62
	n	5	6	28	30	69

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Table 16: Management of health facility

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

Table 17: Supervision system for quality improvement (%)

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

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Table 18: Routine visit to quality improvement (%)

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