

PW. ACL-989
109879

Review of Sterilization Services in Bangladesh

14 October to 01 November 2000

**Ministry of Health and Family Welfare
AVSC International**

REVIEW OF STERILIZATION SERVICES
IN
BANGLADESH

October 14 to November 1, 2000

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This publication is made possible, in part, through support provided by the U.S Agency for International Development (USAID) under the terms of cooperative agreement USAID/Dhaka No. 388-A-00-96-90022 and cooperative agreement USAID/Washington HRN-A-00-98-00042-00. The opinions expressed herein are those of the authors and do not necessarily reflect the views of USAID.

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ACRONYMS

ADCC	Assistant Director, Clinical Contraception
AIDS	Acquired immune deficiency syndrome
AITAM	Associates in Training and Management
ARI	Acute respiratory tract infection
AVSC	AVSC International
BAVS	Bangladesh Association for Voluntary Sterilization
BCC	Behavior change communications
BCCP	Bangladesh Center for Communications Program
BDHS	Bangladesh Demographic and Health Survey
BRAC	Bangladesh Rural Advancement Committee
BWHC	Bangladesh Women's Health Coalition
CA	Cooperating agency
CMCH	Chittagong Medical College Hospital.
CMT	Clinical management training
COPE©	Client-Oriented, Provider-Efficient quality improvement tool
CS	Civil Surgeon
CTU	Contraceptive technology update
DC	Deputy Commissioner
DCS	Deputy Civil Surgeon
DDFP	Deputy Director, Family Planning
DFP	Directorate of Family Planning
DHS	Directorate of Health Services
DHS	Demographic and Health Survey
DMCH	Dhaka Medical College Hospital
ESP	Essential Services Package
FP	Family planning
FPAB	Family Planning Association of Bangladesh
FPCSP	Family Planning Clinical Services Project
FPCST	Family Planning Clinical Supervision Team
FP-MCH	Family Planning – Maternal and Child Health.
FP/RH	Family planning and reproductive health
FWA	Family Welfare Assistant
FWC	Family Welfare Center
FWV	Family Welfare Visitor
FWVTI	Family Welfare Visitor Training Institute
GOB	Government of Bangladesh
HIV	Human immunodeficiency virus
HLD	High-level disinfection
HPSP	Health and Population Sector Program
ICDDR,B	International Center for Diarrhoeal Diseases Research, Bangladesh
ICPD	International Conference on Population and Development
IEC	Information, education and communication.
IM	Intramuscular/intra-muscularly
Inj.	Injection
IP	Infection prevention
IPC	Interpersonal communication
IPPF	International Planned Parenthood Federation
IUD	Intra-uterine contraceptive device
MCH	Maternal and child welfare

MCH&FP	Maternal and child health and family planning
MCHTI	Maternal and Child Health Training Institute
MCWC	Maternal and Child Welfare Center
MFSTC	Mohammadpur Fertility Services and Training Centers
MIS	Management information system
MO (Clinic)	Medical Officer Clinic
MO (MCH-FP)	Medical Officer, Maternal Child Health- Family Planning
MO	Medical Officer
MO (CC)	Medical Officer Clinical Contraception.
MR	Menstrual regulation
MSCS	Marie Stopes Clinic Society
MSR	Medical surgical requisites
MWRA	Married women of reproductive age
NGO	Non-governmental organization
NIPHP	National Integrated Population and Health Program
NSV	No-scalpel vasectomy
Ob/Gyn	Obstetrician/Gynecologist
OJT	On-the-job training
OT	Operating theatre
PHC	Primary health care
PRIME II	Improving the Performance of Primary Providers in Reproductive Health Project
PSTC	Population Services and Training Center
QAT	Quality Assurance Team
QIP	Quality Improvement Partnership
RSDP	Rural Service Delivery Partnership
RTI	Reproductive tract infections
SMC	Social Marketing Company
STD	Sexually transmitted disease(s)
STI	Sexually transmitted infection(s)
TFPO	Thana Family Planning Officer
THFPO	Thana Health & Family Planning Officer
THC	Thana Health Complex
Tk.	Taka
TOT	Training of trainers
TRC	Technical Review Committee
UFHP	Urban Family Health Partnership
USAID	United States Agency for International Development
VS	Voluntary sterilization

ACKNOWLEDGEMENTS

The assessment team acknowledges its great debt and appreciation to several institutions and numerous individuals. Their willing assistance made it possible for the team to complete its scope of work.

First, we are most grateful to the Ministry of Health and Family Welfare (MOHFW) for sanctioning this exercise, extending its full cooperation and hospitality, and opening the doors of its facilities around the country to the team. Mr. Dhraj Kumar Nath, Additional Secretary, MOHFW, and Mr. Mohammed Moniruzzaman, Director General, Directorate of Family Planning, MOHFW, provided support and guidance.

USAID/Dhaka initially identified the need for the assessment and provided the funding for much of the assessment activity. The team is particularly grateful to Mr. Jay Anderson and Mr. Neil Woodruff of the USAID/Dhaka HPN Office for their active support and interest.

Several NGOs and NGO networks collaborated actively throughout the assessment. These are, alphabetically, the Bangladesh Association for Voluntary Sterilization (BAVS), the Family Planning Association of Bangladesh (FPAB), the Marie Stopes Clinic Society (MSCS), the Rural Service Delivery Partnership (RSDP), and the Urban Family Health Partnership (UFHP).

We must also thank members of the special Advisory Committee who oversaw the exercise, helped identify the issues that needed to be reviewed, and checked the reasonableness and feasibility of the preliminary recommendations. Dr. Jahiruddin Ahmed, Line Director, ESP (RH) of the Directorate of Family Planning, MOHFW, chaired the committee and helped to keep the team focused on the important issues. Other members of the committee included, alphabetically, the following: Mrs. Tahera Ahmed, Assistant Resident Representative, UNFPA/Bangladesh; Dr. Mohammed Alauddin, Chief of Party, RSDP; Dr. Mohammed Abdul Baqi, Line Director, ESP, Directorate General of Health Services, MOHFW; Dr. Abu Jamil Faisal, Chief of Party, Quality Improvement Project; Dr. Ahmed Al-Kabir, Chief of Party, UFHP; and Mr. Neil Woodruff, Program Coordinator, PHN Team, Dhaka.

The staff of AVSC's Bangladesh Country Office provided superb logistical support to the team throughout the exercise, accompanied the team during field visits, and helped the exercise to go very smoothly. In particular, Dr. Abu Jamil Faisal spent countless hours before and during the assessment planning and organizing the exercise, ensuring that the needs of the team were attended to, and providing expert background briefings about various aspects of the Bangladesh program.

Finally, we are especially indebted to the numerous clients, community workers, service providers, program managers, women leaders, researchers, and medical specialists throughout the country who were so generous with their knowledge, insights, time, and good humor. We sincerely hope that the findings and recommendations in this report will result in improved sterilization services that better meet the desires and needs of clients as well as improvements in addressing the needs of providers so that they might better serve the needs of clients.

SUMMARY PRINCIPAL FINDINGS AND RECOMMENDATIONS

Introduction

Sterilization performance has fluctuated in Bangladesh in response to program initiatives and changes in client demand. At the peak, nearly 500,000 procedures were performed in 1984/85 during a period of intense promotion of sterilization. However, since the mid-1980s annual performance has steadily declined, as other contraceptive methods became more widely available and as certain problematic practices to increase sterilization performance were phased out. The average annual performance over the past 5 years has been about 60,000 procedures. Sterilization prevalence slowly increased from 9.4% in 1985 to 10.3% in 1991, but since then it has steadily declined to 7.2% in 1999/00. Sterilization prevalence will continue to decline over the next several years as cohorts who were sterilized years ago age and exit their reproductive lives. Meanwhile, after substantial increases in use of modern contraceptive methods over the past two decades, modern use has begun to level off while use of traditional methods has increased in recent years.

With these trends in mind, a comprehensive field review of current availability, quality and use of sterilization services was conducted from October 14 to November 1, 2000 to examine the factors affecting demand for and supply of sterilization services. The exercise was conducted with the support of the Ministry of Health and Family Welfare (MOHFW) and funded by the United States Agency for International Development (USAID). Specific objectives in the scope of work included examining the underlying demand for sterilization services; reviewing the adequacy of sterilization service delivery systems and infrastructure in the public, NGO and private sectors; assessing the quality of sterilization services; identifying the impact of manager and provider attitudes and behavior on the availability of sterilization services; and identifying needs and opportunities for improving communications about sterilization. In addition, the scope of work specifically requested that the impact and desirability of the current system of payments to sterilization clients, referral agents, and providers be examined.

A nine-person team with expertise in program management, clinical services and training, and client perspectives conducted the review. Three sub-teams were formed and they conducted field visits in Dhaka and three other geographic areas visiting and observing services in GOB and NGO hospitals, clinics and training sites. During the visits the team met with and interviewed district and thana government health and family planning managers, service providers, field workers, and clients. In addition, the team reviewed findings from a 1992 assessment of clinical family planning services as well as other assessments, available program documents, service statistics, studies, and research. An Advisory Committee consisting of government, NGO and donors officials who are familiar with the Bangladesh program oversaw the entire exercise. The team presented its draft findings and recommendations to the Advisory Committee and in a de-briefing with a larger group of government, NGO and donor representatives. Their feedback is addressed in this final report.

Principal Findings

1. Program evolution. Since height of sterilization performance in Bangladesh in the mid-1980s, there have been important developments in the Bangladesh health and family planning program that have an important bearing on current and future sterilization services in Bangladesh. First, during the 1980s Bangladesh made dramatic improvements in making a fuller range of modern contraceptive choices effectively available to couples and in bringing the services closer to clients' doorsteps. Second, the use of

administrative targets for sterilization and intense special campaigns and initiatives to boost sterilization performance were largely abandoned by the end of the 1980s. Third, Bangladeshis everywhere have become more informed and knowledgeable about their contraceptive choices beyond sterilization. Fourth, the long-standing debate over the integration of health and family planning personnel continued over the years. In addition, following recruitment of doctors for the family planning program in 1991, there was conflict between medical and non-medical program officials which resulted in the lack of cooperation of Thana Family Planning Officers (TFPOs) specifically in the clinical contraception program. However, in 1998 the MOHFW decided under the Health and Population Sector Programme (HPSP), 1998 – 2003, to reorganize the MOHFW and unify health and family planning personnel at the thana level and below. The challenges of unification continue to affect the delivery of health services including family planning. Fifth, a HPSP centerpiece is the development of an Essential Service Package (ESP) to be made available to all Bangladeshis. The ESP promotes client-centered and integrated health services. Family planning services, including sterilization, are now to be offered within the context of integrated rather than vertical service delivery. Numerous NGOs, particularly those working under the National Integrated Population and Health Programme (NIPHP) have adopted the ESP. Finally, under HPSP, doorstep health and family planning services will eventually be phased out as clinic-based service delivery is expanded and strengthened. In the future, clients will need to take a more active role in seeking health services including family planning.

2. Demand for sterilization. A critical question is whether the currently low sterilization performance reflects a fall off in client preferences and demand for sterilization as their contraceptive choice. The assessment team examined this issue and concluded, as did the 1992 assessment team, that the increased availability of other contraceptive choices has had a significant impact on sterilization performance. However, we concluded that the historic low levels of sterilization performance should not be attributed solely or perhaps even principally to changes in clients' preferences and demand. There is a dearth of client studies and research that addresses client contraceptive intentions as well as factors affecting client perceptions of, decision-making for, and satisfaction with sterilization. Nevertheless, there is evidence of unmet demand for sterilization services. The 1999/00 Bangladesh Demographic and Health Survey (DHS) reports that 52% of currently married women say they want no more children. In addition, 15% of women, who either want no more children or want to wait two or more years before having another child, are not currently using contraception and are considered to have an unmet need for contraception. Without focused client research, there is no way to accurately gauge how many couples who want no more children would be interested in sterilization but we believe many of them would opt for sterilization if services were better known and more accessible and available. Current sterilization clients must currently overcome significant access barriers and travel long distances for sterilization. The team heard many reports of clients appearing for sterilization but being refused service because the sites were not prepared to serve them.

3. Infrastructure, equipment and supplies for sterilization services. Infrastructure, supplies and equipment do not appear to be limiting factors in the performance of sterilizations. There are sufficient hospitals and clinics with adequate operating theatres and space for pre- and post-operative facilities in both the public and NGO sectors to serve substantially more clients than current levels. There may be a need to improve or reorganize space at particular sites. At many THCs the family planning clinic space is in need of reorganization, and there is not adequate space for counseling and pre-operative examination. At many sites, facilities for sterilization are underutilized as a result of lack of trained personnel or program management problems. In addition, there is a functioning system to routinely provide sites with the essential supplies and drugs needed for services. Disruptions in the supply chain are minimal.

4. Principal factors in low sterilization performance. In addition to the increased availability and preferences for other modern contraceptive methods, the team concluded the following four factors have

contributed to the historic low performance of sterilization in Bangladesh. These are discussed briefly below:

- **Communications and information.** There is a lack of timely and accurate information and communications in the program and in communities for couples about sterilization and its availability. In general, sterilization suffers from a negative public image.
- **Trained personnel.** The number of personnel who are trained to provide sterilization services is inadequate and has been declining over the past decade.
- **District/thana-level management.** There is inadequate leadership and managerial attention and skills at the district and thana levels to organizing and making sterilization services easily available and accessible
- **Quality of care.** There are continuing problems with the quality of care including especially infection prevention, supervision and monitoring, and counseling.

We believe that substantial leadership and program management attention to these areas will significantly enhance the access, availability and use sterilization services in Bangladesh.

5. Behavior change communications and information. Bangladeshi couples do not receive adequate, timely, and consistent information about sterilization through multiple communications channels in order to make them aware of sterilization services and to support them in their contraceptive decision-making. Specifically, sterilization is not addressed in the current behavior change communications (BCC) strategies developed by the government for the public sector and NIPHP for the NGO sector. There are virtually no programs or activities to talk about sterilization in the mass media and clinic-based communications activities (e.g., videos, posters). Interpersonal communications, principally through the work of field workers, who target the poor, are the main source of information about sterilization. Furthermore, there is concern about the quality of information about sterilization that is provided by field workers, in part because of their poor knowledge about sterilization and in part because the payments involved with sterilization may influence their dialogue and counseling of clients. Service providers themselves sometimes have a negative attitude about sterilization and are a barrier to services. There is, thus, a need for accurate and appropriate information about sterilization and its availability through multiple communications channels

6. Image of sterilization. Within the national family planning program, sterilization has been positioned and maintains a widespread image as a contraceptive method for the poor and as an effective method for the country's population limitation goals. This image dominates manager and provider thinking and is an underlying assumption in much of the discussion about how to promote sterilization (e.g., often the first suggestions on how to better promote sterilization relate to altering the payments system rather than conducting innovative communications strategies). Sterilization is not promoted as a contraceptive choice for everyone, regardless of income, education or class, which will allow couples to realize their fertility limitation intentions and protect their health. There is, thus, a need to reposition sterilization as a contraceptive choice for everyone and develop communications strategies that emphasize the personal contraceptive and health advantages of sterilization.

7. Trained personnel. Thousands of doctors have been trained since the early 1970s in sterilizations but are no longer performing sterilizations. One reason is that family planning doctors are lost to the program as a result of lack of career planning. In addition, the absence of adequate in-service and pre-service training capacity for minilaparotomy and no-scalpel vasectomy (NSV) has contributed to the steady decline of the number of trained personnel over the past decade. As a result many service sites have ceased to provide sterilization services due to the lack of trained personnel. There are two initiatives underway to address the backlog and future training needs in the public and NGO sectors. With UNFPA funding, the GOB is currently establishing in-service training capacity for public sector personnel within

the 13 Medical College Hospitals and the MFSTC. Training in the NGO sector is currently served by AITAM, an NGO established with AVSC support in 1991 specifically to address reproductive health training needs in the country. Although these two programs are filling the critical immediate needs for training, as originally noted in the 1992 assessment, Bangladesh does not have a long-term strategy for institutionalizing clinical contraception training in the country that is based on a strategic assessment of long-term needs.

A critical issue that must be addressed immediately to assure successful training by the Medical College Hospitals and AITAM is guaranteeing adequate caseload for practical training. Neither the Medical College Hospitals nor AITAM currently have sufficient caseloads to accommodate the planned training load and must therefore resort to ad hoc arrangements.

8. District- and thana-level organization of services and management. Ensuring the access, availability and delivery of quality family planning services including sterilization services is the responsibility of the health and family planning management teams located at the GOB's district and thana health and family planning offices. The assessment team concluded that a major factor in the decline of sterilization performance in the country is the general lack of leadership and management attention and skills by these personnel. The assessment team observed that there is a general lack of coordination and good relations between health and family planning personnel as a result of their long-standing separation. The current unification of health and family planning under the HPSP at the thana level and below has not yet resolved the coordination issues. Family planning personnel do not have the same opportunities for career advancement as their colleagues on the health side. For this and other reasons, morale is low among family planning personnel. As a result, there appears to be a lack of initiative to organize services, to pro-actively address problems that prevent services from being offered or delivered, to supervise performance and quality of work by service delivery sites and field workers, and to creatively use and orchestrate the community and organizational resources available within their localities. While this is probably not the case everywhere, the team nevertheless believes the problem is serious enough to warrant focused attention.

Many of the observed problems may be resolved as the HPSP proceeds and unification issues are resolved. However, among the local health and family planning teams there is a need for developing modern management skills that will support working together and addressing the needs for proactively organizing family planning service delivery including sterilization. These skills include especially teamwork, problem identification and solving, facilitative supervision, and quality improvement tools and approaches.

9. Quality of care. Considerable progress has been made over the years to improving and maintaining the quality of sterilization services in Bangladesh. Technology, service delivery protocols, and clinical procedures have been standardized to help assure provision of quality services. Medical supervision and monitoring teams periodically visit service sites. However, there are still areas where the quality of services can be improved. The priority areas to be addressed include the following:

- ***Infection prevention (IP).*** The team observed that IP practices varied considerably between and within sites, that accepted international standards for assuring IP in low-resource settings are not followed in most sites, and that the IP knowledge and understanding of clinic personnel is often poor and incorrect. This gap is not only in the clinical family planning and sterilization services, but also with all clinical health services. The problems were observed in all levels of health facilities, e.g., Family Welfare Centres (FWCs), Thana Health Complexes (THCs), medical college hospitals and Model Clinics.
- ***Supervision and monitoring.*** The current GOB supervision and monitoring teams (FPCSTs, QATs) have great potential to assist in maintaining and improving services. However, the teams face

significant challenges to do their jobs effectively. The territory and number of sites under the oversight of each team is very large. Visits are generally short and done by single officers; the addition of a paramedic to the teams could alleviate some of the pressure on the team. The supervision officers need to be trained in facilitative supervision skills and receive regular technical updates. Within the public sector there are no quality improvement systems for local level problem identification and solving.

- **Counseling.** The assessment team confirmed many of the findings that were identified in a 1996 comprehensive review of counseling services and notes that little has been done since then to address the findings and recommendations. In general, there is widespread confusion about the purpose of client counseling in Bangladesh, which is often interpreted as the same thing as 'motivating', 'convincing', or 'converting' clients to accept a particular method such as sterilization. There is thus a need for common and appropriate definition of counseling in Bangladesh. True counseling – to facilitate informed decision-making, choice of contraceptive practice and to provide information that will allow clients to understand and use methods effectively – is not routinely done except in some NGO clinics that may have designated counselors. When done, its quality has often been observed to be quite poor. The quality of provider-client interactions could be improved. Policies about counseling are absent, and responsibility for counseling is not clearly identified. There is not a sustainable counseling training capacity in the country, nor are regular contraceptive technology updates provided for all staff.

10. Opportunities to increase the availability of sterilization services. The team identified three specific areas that represent significant opportunities to increase the availability and use of sterilization services in Bangladesh. These are the introduction of postpartum sterilization services, the development of new models for integrating and offering vasectomy services, and the introduction of sterilization services in the growing private, for-profit health care sector.

- **Postpartum contraception services.** Unlike other countries, immediate postpartum contraception services are not widely available in Bangladesh. Postpartum sterilization and IUD insertion is technically easier, programmatically less expensive, and more convenient for many clients. Significant and growing numbers of deliveries in Bangladesh are now institution-based rather than at home increasing the potential of providing immediate postpartum contraception services for those who choose to limit or delay childbearing after delivery. Increasing numbers of women (and men) are traveling and attending antenatal clinics that provide opportunities to inform couples about their contraceptive choices following delivery, and to counsel and obtain informed consent prior to labor if their choice is sterilization. The number of couples attending antenatal services should increase substantially in the next few years as the ESP becomes more firmly and widely established throughout the country. Thus, we believe that making postpartum sterilization services available in THCs, district hospitals, MCWCs, medical college hospitals, private maternity centers and other sites with significant maternity caseloads would improve access and increase use of female sterilization services.
- **Vasectomy services.** Over the years large numbers of vasectomies have been performed in Bangladesh, but the numbers have fallen to low levels. There are reasons to believe that more Bangladeshi men would request vasectomy if information, communications and services were more routinely and visibly available. However, vasectomy performance in the program has been episodic and has dramatically spiked in response to special campaigns and promotional activities. Today, the majority of vasectomies in Bangladesh are performed by a small handful of NGO clinics that maintain a continuing focus on vasectomy. There is a need to develop new programmatic approaches and models that integrate vasectomy information and services making them routinely available without reliance on special initiatives and campaigns that cannot be sustained. There is a need to identify best practices in vasectomy services from within Bangladesh and other countries which can be used to create new approaches and models for Bangladesh.

- **Private sector services.** Very few sterilizations are performed in private sector facilities in Bangladesh. Nevertheless, the majority of Bangladeshis seek medical services from private sector sources. The private medical care sector is vibrant, entrepreneurial and expanding rapidly throughout urban areas in the country and private clinics, hospitals and maternity centers are expanding at a rapid rate to cater to a growing middle and lower-middle class. Postpartum services can be offered in private maternity centers. Interval minilaparotomy and laparoscopy can be offered in private hospitals. And NSV can be performed in the treatment rooms of private practitioners. In making sterilization services available to the middle and lower-middle class through the private sector it will be essential to revamp sterilization's image as method of the poor.

11. Male involvement. Emphasis on women's health and family planning has resulted in a lack of attention to male involvement in couples' reproductive health practices in general and to men's reproductive and sexual health needs in particular. Attention to men in Bangladesh tends to focus largely on vasectomy and this will continue to be important in the future. There are some GOB and NGO efforts to address male involvement and reproductive health services for men, but the efforts have not yet coalesced into a concerted programmatic commitment and strategy at the national level. There is a need to provide focused attention, leadership and resources to male involvement and male reproductive health needs in Bangladesh.

12. Mobile teams. In recent years, program managers and providers in many areas have turned increasingly to deploying trained mobile teams to static health facilities that do not function as routine sterilization service sites either because of lack of trained personnel at the site or geographic remoteness. While the program's MIS does not keep statistics on mobile and static sterilization services, we believe that the number of mobile team sterilizations has increased substantially and may account for nearly half of nationwide sterilization performance. Use of mobile teams is an appropriate stopgap response to service delivery capacity problems, especially when service delivery and quality guidelines are adhered to. However, they are more expensive and more complex to operate, and tend to be associated with intense mobilization of field workers and use of special programs (see below). Emphasis needs to be placed on re-establishing routine service delivery capacity wherever possible and redirecting the use of mobile teams in more remote areas that cannot retain trained personnel and that cannot sustain routine sterilization services.

13. 'Special programs'. Recently 'special programs' to boost sterilization performance have been organized as collaborative activities between district family planning officials and local clinics of NGOs. In the special programs, the local NGO clinic provides per case payments to field workers who bring clients for sterilization on the scheduled day, and may assist the district officials by transporting and providing food to government mobile teams who provide sterilization services at a site. While the special programs are an example of pro-active government-NGO collaboration, the per case payments to field workers are contrary to government policy. In addition there are allegations that the per case payments are establishing expectations among government and NGO field workers who otherwise do not receive special per case payments. And, some sister NGOs complain that the payments are diverting clients away from their clinics and creating a competitive environment whereby they will eventually also need to provide such payments. The special collaborative GOB-NGO programs should continue but without the per case payments. Funds saved may be redirected to support other needs, such as increased communications activities in the local communities about mobile team visits or for arranging transport of clients to and from clinics.

14. Payments to clients, providers, and referral agents. As requested, the assessment team examined the current impact of the system of payments to sterilization clients, providers and referral agents. The payments have existed since 1975 with some changes in amounts and rationales. Small payments are also made to IUD and Norplant clients. The payments were deemed necessary to help clients overcome access

to services by compensating for travel, wage loss and food; to help referral agents cover their own travel expenses; and to compensate providers for the additional work they perform. Over their history, the payments have been controversial, have been associated with charges of voluntarism abuse and fraudulent reporting, and have been difficult to efficiently disburse and manage. Problems in providing the funds to service sites in a timely manner are frequently mentioned as a reason for refusing services to clients. Today, some NGOs are providing payments to field workers outside the framework of government policy, and as noted above this is creating problems for the program.

Many providers and managers continue to argue that the payments, especially those to clients and referral agents, are essential and that sterilization performance would further decline if the payments were removed. Others argue that the payments are no longer needed. In fact, the assessment team notes that although the GOB increased client payments and reinstated field agent payments in 1995 after having discontinued the latter for several years, there appears to have been no impact whatsoever on sterilization performance. In fact, sterilization performance has steadily declined over this period suggesting that the demand and supply factors discussed earlier rather than payments are key to sterilization performance. Many providers reported that the small payments (Tk. 20) they receive are not needed and are so small as to constitute an insult.

The team notes that there is a rising chorus of opinion within Bangladesh from representatives of women's groups, NGOs, professionals, donors, and some providers and program managers that the payments should be phased out. They argue that in addition to not having any discernable impact on sterilization performance, they divert attention and financial resources from addressing the difficult underlying challenges of improving training, communications programs, and local organization, management and supervision of services. In addition, the payments continue to treat sterilization as different and apart from other health services and this undermines the principles of integrated service delivery that underlie the HPSP. Some maintain that the policy environment has changed in Bangladesh and the time is now right to take a clear decision to phase out the payment system and to use the resources in more productive ways. While the assessment team itself was unanimous in its conclusion that the payment system should be phased out, team members did not agree about how fast the phase out should occur.

Priority Recommendations

Given the principal findings above, our priority recommendations are summarized below. The detailed report that follows contains numerous specific recommended actions that amplify the priority recommendations below, or that address other issues that are considered important but not critical.

- 1. Behavior change communication and information activities.** (See Section 2.2.) Develop a comprehensive plan to include appropriate messages about male and female sterilization for both clients and providers in the national behavior change communications strategies, dissemination activities, and materials of the MOHFW and NIPHP. The messages should be delivered through multiple channels and geared to improving sterilization's image within a health and individual rights rationale as a contraceptive choice for everyone not merely the poor. The messages should promote informed choice and decision-making for clients and their spouses. AVSC should work with the MOHFW and NIPHP in developing the BCC plan and messages.

An important part of the plan should address on the one hand the negative attitudes and behavior of many service providers against sterilization, and on the other hand inappropriate biases and attitudes among other service providers that result in 'motivating', 'convincing' and pressuring clients for sterilization. BCC materials, training curricula and job aids need to be updated or created with consistent messages. The messages and information should be integrated into all ESP activities.

2. **Counseling.** (See Section 2.2.) Develop and implement a long-term plan to integrate and improve client counseling in both the GOB and NGO service programs. Specifically, implement with AVSC assistance the key recommendations from the comprehensive counseling assessment conducted in 1996, which are still largely valid.
3. **Training.** (See Chapter 4.) Develop and implement a long-term national strategy to institutionalize pre- and in-service training capacity for sterilization and other clinical contraception. The strategy should be based on an assessment of long-term clinical contraception training needs and should be focused on creating sustainable training capacity. The strategy should also address adapting state-of-the-art training approaches for trainee follow-up, on-the-job training, Whole Site Training, and ongoing updates (e.g., CTUs) and linking these with ongoing supervision activities. AVSC should assist in developing the strategy.

In the short term, there is an urgent need to work with each of the current training institutions – the Medical College Hospitals and MFSTC for the public sector and AITAM for the NGO sector – to a) develop model sterilization services at the training sites themselves, and b) create reliable and regular client referral systems that assure caseloads are adequate to ensure high-quality practical training. AVSC is well-positioned to work with the Government to strengthen the public and NGO/private sector sterilization training programs. With USAID support, AVSC can assist in developing strong training capacity at AITAM and possible other NGOs.

4. **District- and thana-level service organization and management.** (See Section 3.7.) District- and thana-level leadership and management of family planning services including sterilization among health and family planning managers and providers must be significantly improved in order to ensure services are well-organized and available. Teamwork, planning, problem solving, and facilitative supervision skills must be improved between district and thana health and family planning personnel.

Concretely, each district health and family planning team should be facilitated to develop and implement a district-level plan to improve the availability and quality of sterilizations in public and NGO sites throughout the district. Development and implementation of the plan should involve simple self-assessment and problem-solving tools and be a team effort involving district and thana health and family planning managers, field supervisors, NGOs, the responsible regional FPCST/QATs, and community representatives. An initial step in the process should be a rapid survey of current capacity and constraints at each of the current and potential service sites in the district. AVSC should provide its technical expertise in systems programming and practical quality improvement (QI) tools and approaches in guiding the development and implementation of the plans.

The above approach may be implemented in a phased manner. In the first phase of approximately 12-18 months, two to three districts should be selected and assisted for developing, field testing, evaluating and refining the approach. AVSC, in collaboration with NIPHP partners, can assist the Government in developing these demonstration districts. Based on the results from this first phase, the program can be extended to other districts in subsequent phases.

5. **Infection prevention.** (See Section 5.1.) The widespread deficiencies in IP practices are not limited to sterilization and other clinical family planning services but rather apply to nearly all health services in Bangladesh. Thus, addressing the problem only for clinical family planning services will not be sufficient. The MOHFW should form a task force to review this sector-wide problem and develop and oversee implementation of a focused action plan to systematically address the deficiencies at all GOB and NGO health care facilities. The task force may include representatives from the health and family planning wing, NGOs, the FPCST/QATs, medical schools, and training institutions, as these

are the groups best positioned to address the problem. AVSC has extensive expertise developing IP systems in low-resource setting around the world and should serve as a technical resource to the task force. At a minimum, the action plan needs to address the following:

- Revision/reaffirmation and dissemination of the national IP guidelines/standards;
- updating the IP components in all pre- and in-service training activities;
- refresher training/re-orientation for trainers and the FPCST/QATs;
- identification and clear communication of IP responsibilities at each type/level of health service site;
- assisting individual service sites through Whole Site Training and OJT approaches to correct IP deficiencies; and
- improvement of on-site facilitative and problem-solving supervision of IP by the FPCST/QATs.

6. Postpartum clinical contraception. (See Section 3.3.) Develop and implement a phased plan to make postpartum clinical contraception (i.e., sterilization and IUD) widely available as national program methods. In the first phase, introduce postpartum sterilization and IUD services in a small number of selected public sector, NGO and private sites over the next two years. Use the practical experience and lessons learned to develop a scale-up strategy. The plan for the scale-up phase should address, at a minimum, the following:

- development and dissemination of service delivery, counseling and informed consent guidelines;
- identification of and development of systems for any special resource and logistics requirements;
- basic orientation (e.g., via CTUs) of field managers, providers, and field workers about the new program methods;
- adaptation of training curricula and programs to include postpartum sterilization and IUDs;
- provision of in-service training to surgical teams at sites with good potential for providing postpartum clinical contraception services; and
- incorporation of appropriate information about postpartum clinical contraception in BCC programs and activities.

7. Vasectomy. (See Section 3.2.) Develop and standardize new models for making quality vasectomy services routinely available, integrated, sustainable, and used. The models would be based on best practices in Bangladesh and other countries, not require special campaigns or payments to generate clients, be well integrated with the ESP, address the specific needs of male clients and their spouses, and be cast within a broader male health and involvement framework. AVSC should assist in developing the new models.

The new models may be developed and tested first in a small number of BAVS, MSCS, and NIPHP NGO clinics, and in the public sector in two or three well-selected districts where local health and family planning managers demonstrate interest in and commitment to the program.

8. Male involvement and reproductive health services. (See Section 2.4.) To address the lack of focused leadership and attention to male involvement and male reproductive health needs, the MOHFW should consider forming a multi-disciplinary GOB-NGO task group. AVSC should assist the task force to:

- define the scope of male involvement and reproductive health services in Bangladesh;
- identify and use lessons learned and best practices from within Bangladesh and elsewhere;
- develop a strategy/action plan for improving the involvement of men and establishing male reproductive health services (beyond vasectomy); and

- adapting communications and information strategies and content for communities, clients, field workers, providers, and managers.
9. **Private sector.** (See Section 3.1.) Working with local organizations, AVSC should conduct a two-year market-testing program to assess the potential for expanding sterilization services in the private sector without compensation payments and on a fee-for-service basis. This market-testing program should include, at a minimum, a) introducing sterilization services in a small number of well-selected private clinics, hospitals, and maternity centers to test private services and to identify the program issues and constraints that would need to be addressed in any scale up in the private sector, and b) conducting a systematic market analysis to determine market size, customer preferences, provider interests, and pricing structures for alternative sterilization service packages.
 10. **Mobile teams.** (See Section 3.4.) As a temporary, stopgap measure, the GOB and NGOs should continue to deploy mobile surgical teams to suitable static facilities to remote areas and to sites that currently do not have trained personnel to help meet the unmet demand for sterilization services. Wherever possible, the mobile teams should pursue the short-term goal of assisting sites to (re) establish routine, regular services provided by trained local service providers.
 11. **Payments.** (See Section 2.6.) In the immediate short-term, the GOB should issue and enforce standard guidelines concerning payments to clients and field agents for all service organizations providing sterilization services in the country. In particular, the practice of some NGOs of providing per case payments to field workers at levels substantially above payments given to reimburse GOB field workers travel expenses should be stopped immediately.

In addition, the GOB should give serious consideration to developing, communicating and implementing a long-term strategy to phase out all payments to clients, providers and field agents. This phase-out strategy may be implemented incrementally by eliminating those payments that do not have a solid rationale. For instance, the small provider payments are no longer perceived as necessary and may be eliminated immediately. Also, there is not a strong justification for the vasectomy transport payments for referral agents and these may also be eliminated. Consideration should be given to gradually reducing the client payments or, at the very least, not increasing the amount of payments further and allowing the value to depreciate over time with inflation.

Finally, consideration should be given to testing the performance of sterilization without payments in selected GOB, NGO and private sector sites. This must be done with careful planning. The prerequisites for such a test would include ensuring that there is good local leadership and management of the organization services, assurance of the quality of care, proper preparation and orientation of field workers, providers and the community, and implementation of a systematic communications and information strategy. The communications and information activities should make clients aware of the availability of services, communicate the advantages of sterilization from a personal contraceptive and health perspective, and address any issues regarding client perceptions concerning sterilization. This test should be done in conjunction with implementing other recommendations (e.g., postpartum sterilization, vasectomy, district- and thana-level management improvements, etc.) AVSC should work with the MOHFW and NIPHP in designing field tests of sterilization services without payments.

12. **Implementation.** The GOB, NIPHP, and donors should consider and discuss the findings and recommendations in this report and develop concrete implementation plans identifying actions to be taken, resources needed, institutions and units that are responsible, and timeframes for completing the activities. A process should be clearly identified for routine monitoring of the implementation of the recommendations in this report and the detailed action plans that are developed. Technical assistance

resources should be identified. Given its long and specialized experience in expanding sterilization services worldwide and in Bangladesh, AVSC International can assist the GOB, NGOs and donors in developing the action plans, monitoring implementation, and providing technical assistance.

1. INTRODUCTION

1.1. Purpose of the Assessment

The overall purpose of the assessment was to review the status of sterilization services in Bangladesh and identify the demand and supply factors that underlie the current level of sterilization performance in the country. Annex A provides the complete Scope of Work for the assessment exercise. Specific objectives included the following:

- To assess the potential of the existing service delivery system (including but not limited to management, training, and supervision) to increase the availability, quality and use of sterilization (minilaparotomy and vasectomy) in Bangladesh.
- To examine the attitudes and behavior of service providers, NGO leaders and local and national government officials and determine how their planning and decisions have affected the current service provision capacity and client use of sterilization services.
- To examine the desirability of continuing the current provision of payments by the GOB and NGOs to providers, clients and referral agents.
- To make specific recommendations to USAID, the GOB, and other interested donors on effective means to expand the availability of sterilization services, while maintaining a high level of medical quality and ensuring complete voluntarism in the program.
- To provide specific recommendations on means to improve behavioral change communication (BCC) activities for sterilization programs and incorporate these recommendations into the new NIPHP BCC strategy.

1.2. Overview of sterilization performance

Sterilization has been a prominent contraceptive method within the national family planning program since the 1960s. Sterilization services were emphasized when the national family planning program was revived following the liberation war in the early 1970s. From the mid-1970s through the mid-1980s, the GOB and donors invested considerable resources in expanding sterilization services. The GOB organized special initiatives to promote and make sterilization services available, introduced a system of payments to assist sterilization clients overcome barriers to services, improved operating theatres and provided surgical equipment in government hospitals, and established stores and a logistics systems for expendable supplies needed for sterilization services. In this effort it was assisted by NGOs, most notably, the Bangladesh Association for Voluntary Sterilization (BAVS), which was established in 1974. BAVS played an important critical role for the next decade and a half in demonstrating the acceptability of sterilization services, helping to introduce new technology including minilaparotomy under local anesthesia and no-scalpel vasectomy, training hundreds of GOB and NGO surgical teams to perform sterilization, and serving a substantial portion of the national sterilization caseload through a network of 24 clinics throughout the country.

As a result of these and other program interventions, sterilization performance increased quite dramatically throughout the late 1970s and early 1980s reaching a high of nearly 500,000 procedures in 1984/85. Unfortunately, the rising performance of sterilization during this period was associated with relatively high morbidity and mortality and reports of voluntarism abuse. As a result of the problems, the

GOB instituted a number of pioneering reforms in its national program. These included the establishment of Family Planning Clinical Surveillance Teams (FPCSTs), the development and periodic updating of service delivery guidelines for sterilization services, the elimination of administrative sterilization performance targets, and the elimination of targets and per case payments to field workers for referral of sterilization clients.

Figure 1.1 depicts the trends in male and female sterilization performance in Bangladesh from the mid-1970s to the present. The graph shows that following the mid-1980s peak, sterilization performance has gradually fallen to historic low levels. In 1998/99, the most recent year for which GOB MIS data is available, 61,720 sterilizations were reported performed (16,500 vasectomies, 45,220 tubectomies).

Table 1.1 provides DHS prevalence data from 1975 to the present. Sterilization prevalence increased through the 1980s, but has begun to decline since 1991 following the decline in sterilization performance. We can anticipate that given the persistent low levels of sterilization performance in recent years, sterilization prevalence will continue to decline for the next several years as the cohorts of those who were sterilized years ago age and leave their reproductive lives. Table 1.1 also shows that while sterilization prevalence has been declining, use of other modern methods, especially pills and injectables has been increasing as the national program has worked to make temporary methods more available. Figure 1.2 takes the DHS prevalence data and shows sterilization's declining share of total contraceptive use as other modern methods use has increased.

Figure 1.1: Trends in Sterilization Performance, 1974-99

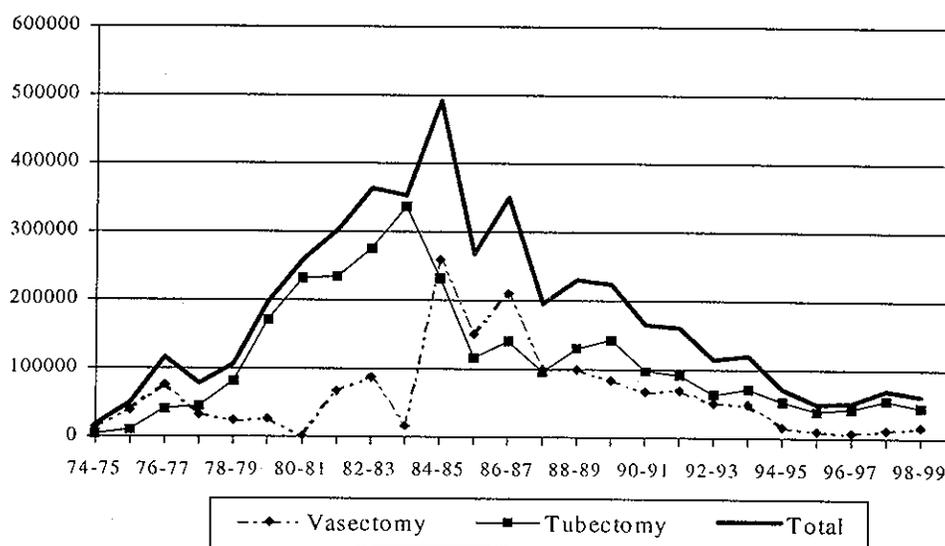
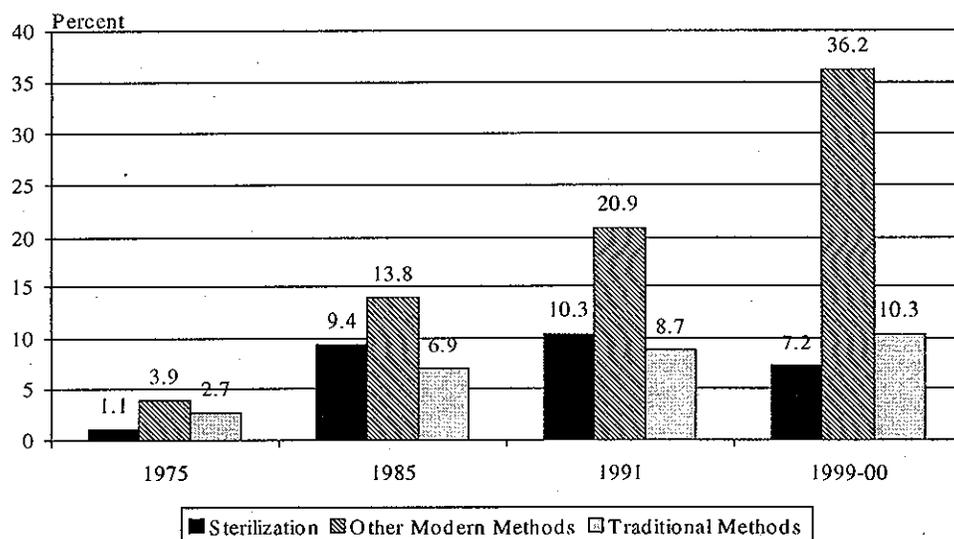


Table 1.1: Trends in Current Use of Family Planning Methods, Bangladesh

Method	1975	1983	1985	1989	1991	1993/94	1996/97	1999/00
<u>Any method</u>	<u>7.7</u>	<u>19.1</u>	<u>25.3</u>	<u>30.8</u>	<u>39.9</u>	<u>44.6</u>	<u>49.1</u>	<u>53.8</u>
<u>Any modern method</u>	<u>5.0</u>	<u>13.8</u>	<u>18.4</u>	<u>23.2</u>	<u>31.2</u>	<u>36.2</u>	<u>41.5</u>	<u>43.4</u>
Pill	2.7	3.3	5.1	9.6	13.9	17.4	20.8	23.0
IUD	0.5	1.0	1.4	1.4	1.8	2.2	1.8	1.2
Injectables		0.2	0.5	0.6	2.6	4.5	6.2	7.2
Vaginal methods	0.0	0.3	0.2	0.1				
Condom	0.7	1.5	1.8	1.8	2.5	3.0	3.9	4.3
Female sterilization	0.6	6.2	7.9	8.5	9.1	8.1	7.6	6.7
Male sterilization	0.5	1.2	1.5	1.2	1.2	1.1	1.1	0.5
<u>Any traditional method</u>	<u>2.7</u>	<u>5.4</u>	<u>6.9</u>	<u>7.6</u>	<u>8.7</u>	<u>8.4</u>	<u>7.7</u>	<u>10.3</u>

Percentage of currently married women age 10-49 who are currently using specific family planning methods. Adapted from Table 6, DHS, 1999-2000.

Figure 1.2: Trends in Contraceptive Use Among Currently Married Women, 10-49



Previous sterilization-related reviews

The current assessment of sterilization performance follows three sterilization-related reviews that have been conducted since 1992. These are:

- Assessment of Clinical Contraception Services in the Bangladesh Family Planning Program, 1992.
- Situation Analysis of Clinical Contraception Service Delivery System in Bangladesh, 1994
- Bangladesh Family Planning Counseling Assessment, 1996.

The reports from these three exercises served as key references for the current exercise. Annex B identifies the principal recommendations and their implementation status as of 2000. While many actions have been taken to address the recommendations of the previous exercises, several critical recommendations have not yet been addressed. Key recommendations from previous exercises that are still relevant and important are identified in the present report.

1.3. Methodology

The assessment was conducted by a nine-person team with members assigned responsibility in one of three key areas: program design and management, client perspective and behavior change communications, and medical quality. Team members and their assigned roles were as follows:

Program design and management	Mr. Quasem Bhuyan	Consultant, Urban Family Health Partnership (UFHP), Dhaka
	Mr. Terrence Jezowski	Senior Director, AVSC International, New York (Overall assessment team leader)
	Dr. Golom Rasul	Program Director, Marie Stopes Clinic Society, Dhaka
Client perspective and behavior change communications	Dr. Ferdousi Begum,	Senior Technical Officer, Rural Service Delivery Partnership (RSDP), Dhaka
	Dr. Sukanta Sarkar	Deputy Chief of Party, Quality Improvement Project (QIP), Dhaka
	Dr. Harriet Stanley	Senior Director, AVSC International, Bangkok (Client perspective team leader)
Medical quality	Dr. Jafar Ahmed Hakim	Deputy Director and Program Manager, Clinical Services, ESP (RH), Directorate of Family Planning, MOHFW, GOB
	Dr. Martha Jacob	Medical Advisor, AVSC International, Bangkok (Medical quality team leader)
	Dr. Murtaza Majid	Consultant, Directorate General of Health Services, MOHFW, GOB

A seven-member Advisory Committee oversaw the work of the assessment team. The Advisory Committee met twice, first at the start of the exercise to guide the team in identify critical issues relating to sterilization performance that should be closely examined during the assessment, and second near the end of the exercise to review and provide feedback to the team on its preliminary findings and recommendations.

Annex C provides the summary schedule for the assessment exercise. Information and insights were gathered in three ways: interviews with program personnel, clients, and community members; observations of services; and review of documents. This included special meetings with a group of women's leaders, a group of researchers, and a group of obstetrician/gynecologists. In-depth interviews and observations were conducted during field visits to service delivery sights in Dhaka and in three geographic areas of the country. The nine-person assessment team was divided into three field teams each including members having expertise in program management, client perspective/BCC, and medical quality. Team A traveled to the southeast to Chittagong, Feni, and Comilla. Team B traveled to the northwest to Rajshahi, Natore, and Bogra. Team C traveled to Mymensingh and Kishoreganj.

During the field trips, the teams visited the following service sites: 5 Thana Health Complexes (THCs), 4 Maternal and Child Welfare Centers (MCWCs), 9 UFHP and RSDP clinics, 3 BAVS clinics, 2 FPAB clinics, and 3 MSCS clinics. Training centers were visited: 3 medical college hospitals and Model Clinics, a Family Welfare Visitor Training Institute (FWVTI), and AITAM (a NGO training site). In addition 5 district health offices, 4 district family planning offices, and 5 thana family planning management teams were visited.

Numerous background documents and published research articles were reviewed and utilized in developing findings and recommendations. Annex D provides a list the key materials.

The following number of interviews were conducted: sterilization clients (N = 38), other clients (77), field and community workers (114), designated family planning counselors (8), service providers including doctors, paramedics and Family Welfare Visitors (104), hospital/clinic manages (29), trainers (5), thana health and family planning teams including the THFPO and TFPO (5 teams), district family planning teams including the DDFP and AD (CC) (4 teams), and district health teams including the Civil Surgeon (5). Annex E provides a list of the principal contacts at each site visited.

Following the field trips, the three field teams team met in a daylong workshop to share and synthesize findings and recommendations. The preliminary findings and recommendations were presented to the Advisory Committee, which provided feedback and suggestions for refinements. Finally, the team made a presentation of the summary findings and recommendations to special de-briefing meeting of program stakeholders (government, NGO and donor officials) on the final day of the assessment. This final report incorporates the feedback of the Advisory Committee and stakeholders debriefing as well as comments of several reviewers of earlier drafts of this report.

1.4. Conceptual frameworks

The assessment team applied two basic conceptual frameworks to guide its fact-finding activities and synthesis of findings and recommendations. First, the team used a simple family planning service demand-supply framework to help focus on issues that might be affecting sterilization demand, access, availability, and performance. Table 1.2 identifies some of the demand and supply factors that were examined and that are specifically addressed in this report. This demand-supply framework serves as the basis for organization of the report that follows.

Second, the team also referred to the client rights – provider needs framework that has been widely used and adapted in reproductive health services to address programming and assessment of quality of care issues. There are various articulations of client rights – provider needs frameworks in the literature. Table 1.3 identifies the principal elements in the client rights – provider needs framework that was used in this exercise to review quality of care issues.

Table 1.2: Factors Affecting Demand and Supply of Sterilization Services

Demand	Supply
<ul style="list-style-type: none"> ▪ Socio-cultural context and trends ▪ Client decision-making ▪ Gender, spousal communications, male involvement ▪ Communications activities ▪ Information activities ▪ Client counseling ▪ Factors facilitating/hindering access to services ▪ Client-provider interactions ▪ Community involvement ▪ Client satisfaction with services ▪ Payments to clients and others 	<ul style="list-style-type: none"> ▪ Sector involvement: public/NGO/private ▪ Infrastructure (e.g., facilities) ▪ Equipment, supplies and logistics ▪ Trained personnel and training capacity ▪ Sterilization technology: male/female, interval/postpartum ▪ Service delivery modalities: static/mobile, vertical/integrated ▪ Medical quality and quality assurance systems ▪ Program leadership and management ▪ Policies, standards and guidelines

Table 1.3: Clients Rights and Provider Needs

CLIENTS have the right to:	PROVIDERS have the need for:
<ul style="list-style-type: none"> ▪ Clear, appropriate information ▪ Easy access to services ▪ Free choice concerning reproductive options ▪ Safe and comfortable services ▪ Privacy and confidentiality ▪ Respect and dignity ▪ Free expression of opinion ▪ Continuity of services 	<ul style="list-style-type: none"> ▪ Clear information (re job knowledge and expectations) ▪ Good training ▪ Good management and supervision ▪ Good supplies ▪ Good working environment

1.5. Follow-up and implementation of report recommendations

The principal recommendations from this assessment are listed in the Summary, pages xvii to xx. The specific and detailed recommendations are noted throughout the report immediately following the presentation and discussion of findings for each topic area.

It is critical that the findings and recommendations from this assessment be considered and addressed as soon as possible by the appropriate officials in the MOHFW, NIPHP, and participating NGOs.

Recommendations:

The MOHFW, NIPHP and other stakeholders should consider the findings and recommendations in this report and develop concrete implementation plans identifying actions to be taken, resources needed, and timeframes that are realistic and feasible for completing the activities. A process should be established for regular monitoring of the implementation of the recommendations in this report and for developing action plans that are developed, implemented, and reviewed regularly. Given its long and specialized experience in providing technical assistance, USAID International can assist the MOHFW, NIPHP and others in developing the action plans, monitoring implementation, and providing technical assistance.

2. DEMAND FACTORS

“A strong program magnifies demand-side effects by helping people understand that the world around them is changing, and to interpret such change in the context of decisions about family size and contraceptive use. When women persistently emphasize the need to limit family size because of population pressure, fragmentation of the land, and the importance of the quality of children, their perceptions reflect both their social reality and the community workers’ decade-long repetition of these themes.” (Simmons 1996:265)

2.1. Evidence of demand for sterilization services in Bangladesh

It is difficult to assess demand for sterilization in Bangladesh because of the way in which services are organized and because there is very little research on client preferences, decision-making and experience. Many of the program managers, providers and field workers interviewed for this assessment suggested that clients were responding to increased access to a broader range of contraceptive methods. Our interviews with clients also indicated a strong preference for temporary methods and concern about the effects of sterilization as the mini-case study examples in the box below illustrate.

Four Clients

In one village visited, four women attending a monthly RSDP satellite clinic discussed their contraceptive decision-making with the assessment team.

#1. A happy mother of four children in her late 30s or early 40s, she has been using the pill for the last five years. She used injections for some time but had stopped using them because of heavy bleeding. She started using contraception after the last child finished breastfeeding. She had heard about the IUD and sterilization but she does not want to switch to another method, despite not wanting any more children. She is happy with her present method.

#2. This mother of two has been using the injectable for quite some time. She thinks she does not want any more children but is not sure what her husband’s opinion is. She used pills for some time but stopped using them because she developed a burning sensation in her body. Her mother had had tubectomy some years ago but for herself she does not think tubectomy would be a good choice. Her mother lost weight after the operation and she would not want this for herself.

#3. Another user of injectables, this mother also has two children. Her daughter is married and her son is 14 years old. She has used injectables for some time. She tried the pill before but each time switched back to the injectable. She knows three tubectomy acceptors and is not interested in sterilization for herself. Two of the users she knows lost weight and one is OK. She also heard about a man who had vasectomy and he also lost weight. She is very happy with injectables.

#4. This woman had a tubectomy 14 years ago. She had no problem after the operation but now has lost weight. Her reproductive life has ended and she is now a grandmother. She would not recommend sterilization to her daughter because there are other methods available and after sterilization the acceptors lose weight.

Historically, programs have paid more attention to the needs of providers than to the needs of the client (Khuda et al., 1997) and, particularly in the case of sterilization services, this is reflected in the lack of client studies. In many areas, services continue to be organized around special field mobilization and recruitment of clients. The reliance of intermediaries in recruitment and referral of sterilization clients makes it difficult to gauge the depth of demand. We did not see much evidence of clients approaching

service sites spontaneously or independently for sterilization and, at least in the case of tubectomy, fieldworkers always accompanied clients. Clients interviewed were poorly informed and appeared to rely almost entirely on the fieldworker to represent them. Doctors and other medical staff would, at times, channel their communication through the fieldworker. During interviews, the fieldworkers would attempt to answer the questions and would intervene if they felt that the client answers did not meet the standards expected.

Data regarding client beliefs regarding sterilization and their own decisions to use the method are lacking. We cannot properly assess the impact of payments on this decision-making.

Despite the unclear picture from the client interviews during the field visits and the lack of client research, we believe there is indirect evidence of continuing demand for sterilization, although it is impossible to get a firm handle on the depth of the demand. First, the results of the recent Bangladesh Demographic and Health Survey (1999-2000) suggests considerable unmet need for contraception and significant numbers of women who do not want anymore children but are not using a contraceptive method. Specifically, 52% of currently married women say they want no more children. In addition, 15% of women, who either want no more children or want to wait two or more years before having another child, are not currently using contraception and are considered to have an unmet need for contraception. We may assume that many of these would choose sterilization given good information, counseling and easy access to services.

We can also extrapolate some indication of demand from observations made by the team at service sites visited. These include:

- Clients arrive having already decided to obtain a permanent method (albeit one that they do not understand very well, but they do know that it's permanent);
- Clients travel long distances and wait for long periods of time in order to obtain sterilization services;
- Staff report having to turn away clients due to not having the budget to make wage compensation payments or to the absence of the provider;
- In sites where community leaders and service providers have put emphasis on vasectomy, a regular sustained client flow has been established;
- Some vasectomy clients are reported to have come for services without a referral.

Social context. Women's lives are changing in Bangladesh and they are making family planning decisions within a context of increasing mobility, knowledge, levels of education, and participation in the labor force. (Simmons, 1996). Service providers and fieldworkers reported that they have seen significant changes in the knowledge and behavior of their clients concerning contraception.

Some have argued that the successes of the Bangladesh family planning program are largely due to the supply side, namely the "strong, persistent government commitment.... (Cleland et al., 1994). Others challenge this view and argue for demand-side explanations: "Fertility decline in Bangladesh occurred in response to the long-term erosion in returns to family size brought about by increasing population densities in a stagnant economy" (Kabeer, 1994:150). These researchers are noting incremental changes, not dramatic transformations in social norms. However, they note, these are influencing factors that need to be recognized and built upon in strategic planning and design of programming approaches. And, while they are seen to be small changes, they can be very dramatic in the lives of individuals. It seems logical to accept the observation that "[a]n appropriate reconstruction of the evidence for Bangladesh suggests the simultaneous effect of both demand and supply." (Simmons 1996:265)

2.2. Decision-making

Clients make decisions regarding family planning over time and in a context of competing needs and demands. In order to provide timely and appropriate information, it is important to understand the decision-making process and the environment.

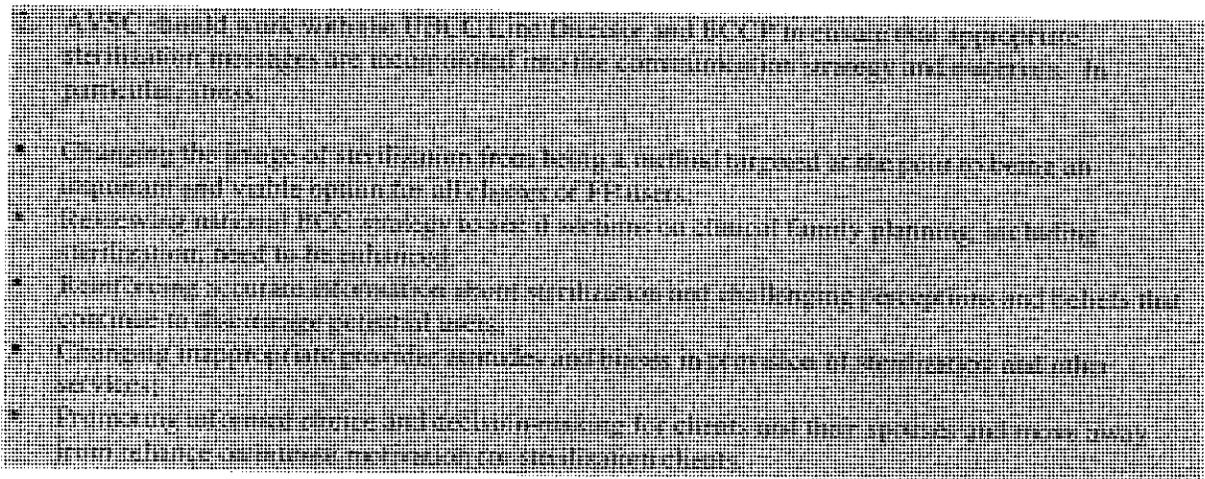
Communication. "The primary aim of the BCC component will be to shift health and family planning service provision from a sectoral and provider-based system to an inter-sectoral, client-oriented, demand-based system and emphasizing community and women's empowerment, with a focus on social and gender issues, elderly and the poor." (MOHFW, 1998: 27)

The recent behavior change communication (BCC) strategies developed by the government task force and the NIPHP do not specifically mention sterilization services in their discussions of clinical methods. The emphasis on promoting "clinical methods" in an integrated, cross-referring, system may further neglect sterilization services as long as they are organized and delivered outside of this same system.

Image. Historically, programming strategies for sterilization have focused on making services available to poorer and predominantly rural clients and this has resulted in a series of elements that promote an image of sterilization as being only for the poor. This image dominates provider and manager thinking and is an underlying assumption of much of the discussion around how to improve and expand availability of services. It is an image that also has significant impact on provider attitudes and client expectations and one that is wholly inappropriate for a sustainable, client-centered approach to family planning services.

Regional and global practices tell us that sterilization is an important and viable family planning option for all groups of clients, regardless of income or education levels. At a time when health services are shifting to a client-centered model, it is essential that this learning be integrated into all communication strategies and that the message be replicated throughout the training, orientation and monitoring of providers and managers.

Recommendation:



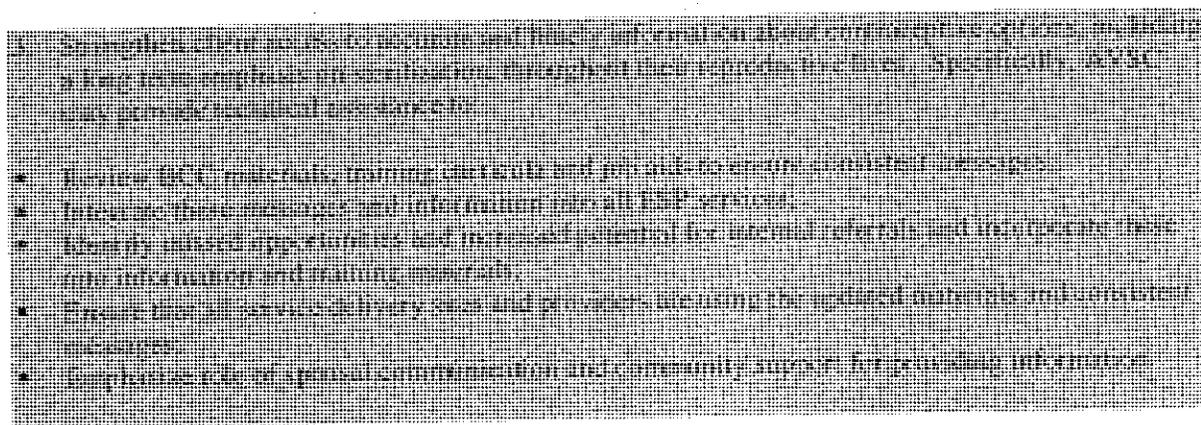
Information. Fieldworkers continue to be the main source of information for sterilization clients. When interviewed about how they inform and motivate their clients, fieldworkers stressed the importance of "convincing" the client and the reliance on the personal relationship. In one case, the fieldworker described how she opened her clothing to let the client see her own scar and to assure her that she had had the procedure and yet was still strong and healthy.

When asked what messages or types of information seemed to work best or were most important to their clients, the fieldworkers were unable to identify messages other than personal assurances that the client would be OK after the procedure. This correlates with our own observations that clients were very poorly informed and that they relied heavily on their personal relationship with the fieldworker. This is consistent with other studies of contraceptive knowledge and home visits, including the observation that the length of client-fieldworker interactions was short, and the percentage of visits in which various family planning and MCH topics were discussed was low (Janowitz et al 1999). Clients do not have adequate or accurate information about contraceptives, nor did they seem to place a high value on interactions with fieldworkers. They assessed the fieldworker program more as a convenience rather than a source of information. Others have argued that the increase in modern contraceptive use was 5 times greater among women in the social network approach than among women who were visited by fieldworkers at home (Kincaid 2000)

Another concern for a program based on fieldworkers as information providers is the observation that high discontinuation rates continue and that there is a need for improved information, management of side effects and referral.

There are specific concerns for sterilization services in this discussion of the role of the fieldworker. During interviews, some fieldworkers explained that they didn't feel comfortable explaining the method and that they didn't want "to confuse the client". They also felt that if the client was screened out or if complications arose, that the fieldworker would be at risk of negative consequences. More needs to be known about this hesitation and what potential fieldworkers actually have to provide information to clients, given their social status and the risks they feel with regards to this method. If there are other reasons for the continued reliance on motivation rather than information, then simply training and providing job aids will not adequately address the situation. For example, one study suggests that participation in a nongovernmental organization program was the most significant determinant of sterilization (and doubled the odds) whereas a visit by a FWA in the past 3 months reduced the odds of sterilization. (Kamal et al 1996)

Recommendation:



Counseling. There continues to be overlap and confusion in the family planning field over the terms 'motivating', 'informing' and 'counseling'. These are often used interchangeably and at times during this assessment, statements were made that clients needed to be "converted" or "motivated" to accept sterilization. Such language used in sterilization services reflects the extent to which older programming approaches continue. In line with the HPSP's commitment to incorporating client rights into all aspects of health care services, it is important that assumptions, attitudes and behavior of program personnel –

and the language that reflects the attitudes and behavior – be challenged and addressed at all levels of service provision.

Once a client-centered, high quality service is established and regularly available, with access to good information and counseling services, community support and effective communication strategies, all references to ‘motivation’ can be removed from programming. It is a term that is well established in the Bangladesh program and so change will take time. At one model site, the organizational charge included ‘motivators’ as a position. Many interviews with providers and social researchers revealed that it is still a relatively common belief that tremendous energy needs to be expended at the individual level in order to motivate or convince a client to accept sterilization. This belief is further revealed by the large number of people who indicated, during our field interviews, that the best way to increase sterilization acceptors in Bangladesh is to re-introduce targets, increase referral fees, and provide referral fees to anyone in the community who brings a client to the center. The current sterilization service delivery paradigm in Bangladesh that relies on payments, mobilization of field workers, and special programs is so embedded in the mindsets of program personnel that it is difficult to engage in a dialogue about other ways to improve services, information and access that would make sterilization services attractive to clients.

In the recent assessment report on counseling services, the authors recommend that “[m]otivation activities should be confined to promoting the concept of family planning, not a specific method” (Rafiqz-Zaman et al., 1996:32). Field observations from this assessment concluded that providers and fieldworkers continue to feel that clients need to be motivated or convinced to accept particular methods.

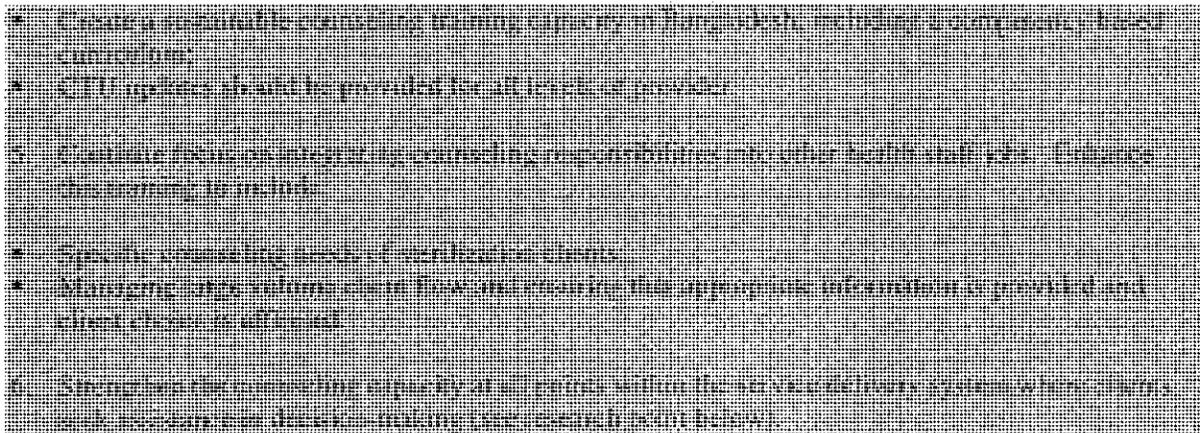
The 1996 counseling assessment made several other recommendations that are still relevant to services now. Rather than repeat much of what can be found in that particular document, this assessment focussed more specifically on the needs of sterilization clients for counseling and ways in which this service can be strengthened during the transition to clinic-based services.

Providers who are trained in counseling should assess client decision-making prior to proceeding with sterilization procedures. Often staff complained that this would be too time consuming and that at peak hours there are too many clients to properly counsel. Some of this attitude may be a result of assuming that every client needs to be exposed to all information about all methods as part of the counseling. In fact, if staff know how to effectively and quickly assess the client’s needs, they can efficiently provide the specific information that client needs. Client waiting periods can be used to provide general information and to help clients prepare for the counseling interaction.

While NGO sites often have a designated counselor on site, government sites do not and this requires that counseling opportunities be “built into” the services in ways that provide opportunities for clients to ask questions and obtain assistance. Counseling training will need to be designed to appropriately strengthen skills for these responsibilities.

Recommendations:

- Programs and providers should follow up and implement the recommendations from the 1996 counseling assessment report, which remain relevant to the situation faced by the current assessment. In particular, NGOs should be ensuring the following recommendations from the 1996 assessment are followed:
- Adequate time for counseling should be allocated.
 - Responsibilities for counseling should be identified in job descriptions.
 - Counseling protocols should be developed and documented.
 - Appropriate staff members should be developed for all levels of service delivery.



2.3. Access

Many access barriers are address through improved quality and availability of services. These issues and recommendations will be covered in detail in the next sections of the report. Clients have experiences of access and barriers that are often not incorporated into the design and delivery of services. One of the most effective ways to address this is to initiate ongoing client feedback for providers and managers. This regular evaluation can be informed and enhanced by appropriate client research that explores particular issues in depth. At the same time, public sector and NGO programming can also be informed by commercial or private sector research as these studies often highlight emerging trends among urban or higher income groups that will influence, and perhaps lead, social change within their own client group.

Providers and clients often put different emphasis on components of quality and this is reflected in programming and monitoring approaches. A client may experience significant difficulty as a result of issues such as rudeness, lack of privacy or social class and these can be missed by assessments that give more attention to technical skills, availability of commodities or hours of operation. All are important components but traditionally programs have neglected, and not addressed, those issues most important to clients.

In this section we document observations in two areas where the client perspective needs to be much better understood. As mentioned before, sterilization services are organized around several assumptions and practices that set them apart from other reproductive and family planning health services. We suggest that a client perspective on these practices is essential as Bangladesh moves to an integrated services package and clinic-based delivery.

Fieldworkers. FWAs or fieldworkers have played a critical role in facilitating access to family planning for rural women in Bangladesh. Some studies have suggested that the introduction of ‘outside visitors’ coming to communities to speak with women effectively altered the gender balance. Women were now receiving information directly and this may have empowered them locally. (Piet-Pelon et al. 122). Furthermore, they suggest, this shift was effective in overcoming some community resistance.

Others have questioned the extent to which reliance on home-based service delivery has actually “reinforced women’s isolation and powerlessness by accommodating existing gender norms.” (Schuler et al 1995) Shifts in reproductive norms, they argue, do not necessarily represent a corresponding shift in gender norms and, in fact, the home-based delivery system exacerbates many problems – “overreliance on the village-based workers, a lopsided method mix, misinformation about methods and about availability of safe abortion services, fear of methods and side effects, and inadequate assistance with side effects.” (134) While acknowledging the remarkable accomplishments of the Bangladesh family planning

program, the authors assert that women may become 'trapped' in a dependency model that relies almost entirely on intermediaries between the client and the services.

Another study questions whether fieldworker visits "are necessary to motivate couples to want smaller families." (Arends-Kuenning et al 1999:190) They acknowledge that fieldworker visits may act as a catalyst for change but that smaller families have become a community norm since the late 1980s and therefore, these visits actually have "little direct effect on fertility preferences in rural Bangladesh, specifically on the transition in women's preferences from wanting more children to wanting no more." These observations echo those of Simmons (1996) who argues that women in rural Bangladesh see their lives in socioeconomic transition and that a central feature of this transition is a commitment to smaller families. Basing her assertions on many in-depth interviews with rural women, she challenges the conclusions of Cleland et al (1994) that Bangladesh "appears to possess no features that are conducive to fertility decline except for a strong, persistent government commitment to reducing population growth." (xi)

Under the HPSP, women are beginning to access clinical services in larger numbers. However, the issues described above continue to exist in the way in which sterilization services are organized. Clients are strongly 'motivated' and misinformed by fieldworkers and they rely heavily on them in decision-making and accessing of services.

Anecdotal evidence and several client interviews gathered during this assessment indicate that female sterilization clients know little or nothing about the procedure, although all understood that it is permanent. When asked probing questions, some suggested that they were going to have an injection and then "something is going to happen" and they will no longer be able to have children. Others thought it was a surgery but could not describe it in any way. During interviews with fieldworkers and paramedics, they explained that it would "confuse" the clients to try and give them that kind of information. At the same time, because sterilization services are organized 'outside' of the regular service provision, these same clients often did not go through the 'normal' route of registration and information or counseling that others accessed. When fieldworkers were asked who, then, would provide the client with more thorough information, they replied vaguely that "someone in the clinic" would do this but they could not identify a position or person specifically responsible for the role.

Transition to clinic-based services. "At the community level, the services will be provided from a fixed centre, namely 'community clinic'. This is a significant shift from the existing domiciliary-based service delivery system. While the move is initiated, the existing mobile services will continue for some time in order to ensure coverage of clients who may not have access to the community clinics, either due to cultural/religious barriers or initial behavioural stand of the service delivery changes." (HPSP 20)

Many providers and managers continue to believe that, while other services are shifting to a clinic-based system, sterilization services will require ongoing motivation and referral from fieldworkers. This is reflected in their recommendations for "better accountability" or "targets" for fieldworkers and for increasing payments for them and for others who bring clients to the site, in order to increase sterilization performance. They explained that clients would not be able to make the decision or get to the services without the assistance of these fieldworkers. As argued above, this is certainly the situation presently in place and during the transition period, fieldworkers will continue to play an essential role in facilitating access for women to services.

However, the entire sterilization service delivery system is premised on this role of fieldworkers and it remains separate from other services in significant, systemic ways. The long term programmatic and management implications of this "vertical" approach to sterilization is discussed later in the report. In

this discussion, our primary concern is what affect this may have on the emerging ability of clients to access clinical services and an integrated package of essential services.

Historically, studies of the impact of motivational efforts, and particularly payments provided to fieldworkers and others, have been concerned with issues of coercion. As awareness grew and donors and governments developed healthier programming approaches, the focus became more on issues of informed choice. An environment that supports healthy decision-making and informed choice requires that several factors be in place: that clients have access to accurate and understandable information; that clients have access to a range of methods; that there be no social sanctions or rewards that interfere with the client's right to make a choice that best suits them and so on. This emphasis on informed choice leads us to question the role of intermediaries, even when those intermediaries have historically played an important role as catalysts for change.

As clients begin to access health services at clinical sites, they will be exposed to new ways of thinking, of obtaining information and of making decisions. If we fail to provide sterilization services in a way that encourages the health-seeking behaviors envisioned by the HSPS and other program planners, we will have failed the client and the system.

The HPSP states that "service accessibility by women and children will be monitored, deterrence and disincentive to service and facility utilisation by them would be identified and addressed." (HPSP 65) Long term planning for sterilization services needs to take into account the broader HPSP goals.

Community Involvement. "The long term goal of community participation as enshrined in the Health and Population Sector Strategy is to develop sustainable processes that lead to organised communities working in partnership with Government for the achievement of common goals for the sector." (HPSP 64)

If sterilization is going to be accessed by women in a clinic-based service system, they will require increasing support at the family and community levels. Once community norms incorporate a respect for couples' right to limit their family size and a corresponding respect for, and trust in, sterilization as a viable family planning option, it will become easier for women to arrange their own transport and support when going for services. Moves to more fully integrate sterilization into the static services will enable communities to evaluate its effectiveness and to learn from a cohort of satisfied users. Present concentrated motivational efforts present an image to the community that these are exceptional events and targeted at particular individuals.

Recommendations:

- Increase service accessibility by fully integrating voluntary and involuntary sterilization services with other reproductive health services and placing an emphasis on informed choice.
- Provide planning services, including sterilization, as a fully integrated and community-accepted part of health services.
- Increase education and training for managers in how to use client research as a means of identifying and addressing needs.
- Increase access to voluntary services by:
 - Encouraging that services are provided in a way that makes it easy for them to access them.
 - Consider access within the home, through community health workers, reproductive health counseling.
 - Strengthening manager's ability to work directly with clients to identify and address reproductive health needs and barriers to service.

- Working with community-based organizations and health workers to provide the method.
- Providing information about vasectomy to husbands for women and vasectomy-related support.
- Encouraging vasectomy use when a couple expresses a strong desire.

2.4. Male Involvement

Emphasis on women’s health and family planning sometimes results in men’s reproductive and sexual health needs being overlooked. (Collumbien et al 2000) Male programming has focussed largely on vasectomy and this will continue to be an important initiative in Bangladesh’s sterilization program. However, there are many other aspects of male involvement that deserve equal attention in order to bring them more fully into the decision-making and the utilization of reproductive health services. AVSC is a global leader on male involvement issues and can assist in addressing this need

Recommendations:

- The AVSC staff will provide interdisciplinary support to health workers to improve their skills and involvement in family planning and reproductive health. AVSC should lead the task force to:
- Identify barriers (attitudinal and behavioral) among other partners for their working in male involvement and address them.
- Develop a strategy to involve men in FPP at various levels.
- Promote the power to address all aspects of male involvement and limited to vasectomy (e.g. special model institutions and decision-making).
- Link with related work on other services or programs (e.g. genital surgery).
- Conduct a literature review and assess related future research to be done.
- Develop communication strategies and systems.
- Develop and conduct research, curricula and health materials to reduce male involvement.
- Provide orientation and training to staff, partners and service providers.

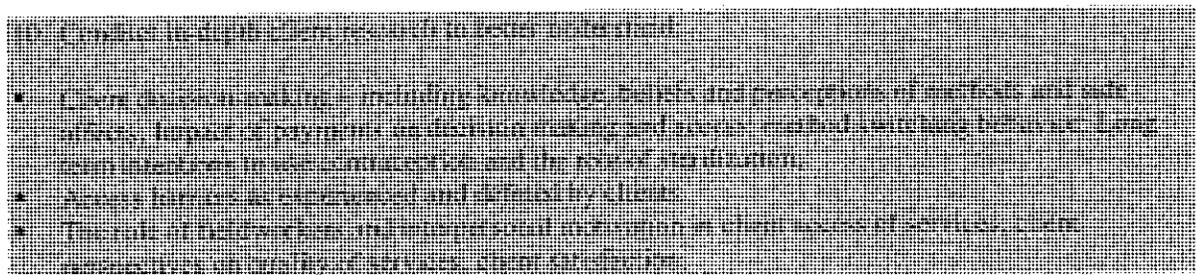
2.5. Client Satisfaction

In order to assess client satisfaction with reproductive health services, we often rely on indicators that include continuation rates and increased utilization of services. When assessing client satisfaction with sterilization services, however, we are more concerned with their reports of information and support during decision-making, the quality of the procedure, and with issues of regret. Therefore, specific research will need to be done to better understand client experience.

Quality of care. Quality of care has an important effect on contraceptive behaviour in Bangladesh. (Koenig et al 1997) With temporary methods, clients are more likely to continue contraceptive usage if they perceive a high quality of care, are well informed about side effects and receive adequate support in coping with them. Switching between modern methods may reflect a wide range of options and the increased opportunities for women to choose methods that better meet their personal needs. (Steele et al 1999) This decision may be informed by information and counseling or the introduction of a new method. There are many socioeconomic and demographic variables that may affect this decision. In Bangladesh, research suggests the most important “individual-level characteristics found to affect women’s switching behavior are family size, education, and experience with the method of contraception used immediately prior to the method presently used.” (ibid 324) For example, “modern-method users are more likely to switch to a traditional method if they have problems with the method they are using.” (325) Of particular concern in the Bangladesh study was the finding that a relatively high proportion of women were not simply switching methods but were abandoning contraceptive practice altogether.

Little is known about client perceptions of quality of care in Bangladesh and, as they begin to access more of their health care in clinical settings, it will be important to better understand their experiences and perceptions as part of improving services. Particular attention will need to be paid to sterilization clients.

Recommendation:



2.6. Payments to clients, providers, and field workers

In Bangladesh, payments to sterilization clients, providers and referral agents have a relatively long history, are entrenched in mindsets of managers, providers and clients, and are widely considered essential to encouraging and supporting sterilization demand. The assessment team was asked to review the impact and necessity of the payments system.

The GOB has had a continuous policy and system for sterilization payments since 1975. The rationale for the payments to clients is to facilitate access to services by compensating for travel, wage loss, and food. The rationale for referral agent payments is to cover their travel expenses. And the rationale for provider payments is to compensate them for the additional work they perform. In addition a new *saree* is provided to tubectomy clients and a new *lungi* is provided to vasectomy clients. The rationale for providing these garments is to ensure the cleanliness of the surgical site. There are also per case payments to service institutions, which are intended to cover the sites' miscellaneous expenses associated with sterilization service delivery.

Table 2.1 provides the current payment schedules and rationales for payments associated with clinic-based contraception methods. In response to declining sterilization performance, the government increased compensation payments to clients in January 1996 from Tk. 175 to Tk. 275 to account for inflationary effects. It also reintroduced the field agent payments at the rate of Tk. 50 per trip, rather than per case, to cover travel expenses of government field workers. Payments to providers and service institutions have remained at the same levels as previously despite inflation.

The assessment team examined the current impact of payments on program management and demand for services. From a historical perspective, the payments system has been controversial and associated with administrative irregularities and reports of voluntarism abuse (Cleland and Mauldin, 1991). Many have argued that the payments, regardless of the rationales, function as incentives and invite problems with the quality and management of services. Indeed, the government stopped payments in 1988 to field workers and other individuals who received per case payments for referred sterilization clients because of substantial evidence of coercive practices by the field agents and fraudulent reporting.

Administratively, the payments have evolved into an elaborate system that is costly and difficult to manage. Extensive administrative systems have been put in place to disburse funds to service organizations to distribute the payments, to account for the funds, and to control and prevent fraudulent reporting. The government regularly conducts field audits to verify that the procedures reported

performed and paid for were actually performed. These audits involve going into villages to identify and verify the reported sterilization clients.

Table 2.1: Government of Bangladesh Payments for Clinical Contraception, October 2000

Recipients	Payments				Rationale
	Tubectomy	Vasectomy	IUD	Norplant	
Clients	Tk. 275	Tk. 275	Tk. 15	Tk. 295	<u>Tubectomy and vasectomy</u> : Tk. 175 on day of surgery for wage loss, food and transportation + Tk. 100 on follow-up day for wage loss and transportation. <u>IUD</u> : for transportation <u>Norplant</u> : for transportation. Tk. 50 on day of implantation and Tk. 35 during 7 subsequent follow-up visits (1 month, 6 mos., 1 st , 2 nd , 3 rd , 4 th , and 5 th years.
Providers	Tk. 20	Tk. 20			Wage supplement
Provider assistants	Tk. 15	Tk. 12	Tk. 5		Wage supplement
Referral agents	Tk. 50	Tk. 50			For transportation costs. Paid only to GOB field workers.
Service site	Tk. 30	Tk. 30			Institutional reimbursement for service site expendable supplies and contingency expenses

In addition, an 'imprest fund' system has been established whereby advances are made to service organizations performing sterilizations. Many sites reported problems in receiving adequate and timely advances of the imprest funds. In some cases, delays in receiving the imprest funds have resulted in canceling sterilization services and refusing clients who show for sterilization.

Client payments. As regards to the effect of client payments on client demand for and overall performance of sterilizations, one encounters a paradoxical situation. On the one hand, the majority of program managers, providers, field workers, and clients we spoke with argued – sometimes passionately – about the necessity of payments. Without payments, they argue, demand for sterilization would fall drastically. However, these perceptions and opinions do not square with the facts: sterilization performance has steadily continued to decline over the years to historic low levels despite the presence of the payments, the January 1996 increase in client payments to offset inflation, and the re-introduction of travel payments to government field workers.

There is no current research available on the impact of the payments on client decision-making and thus we are left with opinions and anecdotal reports. We spoke with clients, field workers, and providers about their importance. No clear picture emerged. There is little question that clients generally welcome the payments. Clients and providers both reported that wage compensation is essential for poor clients to access sterilization. Because income is lost as a result of the time taken off after the procedure, the payment makes it possible to consider this method – thus facilitating access. During assessment

interviews, the several stated that they would not have been able to access sterilization if it had not been for the payment. However, they indicated that their decision was not overly influenced by the money as it does not represent a high payment. At least one client reported that the wage compensation made it possible for her to get her husband's approval for the method. However, no clients reported that they chose sterilization in order to get the payments. Some sterilization clients interviewed said they would have the procedure even if the payments were not there. Non-sterilization clients were generally aware of the payments, but said the payments would not influence their decisions to choose sterilization.

Clients are increasingly demonstrating a willingness to pay for contraceptives and services in Bangladesh (Quayyum et al., 1997; Islam et al., 1997) and, in the context of this changing environment it is not unreasonable to expect that clients will also begin to accept the idea of absorbing certain costs associated with a method. Furthermore, there are many ways in which these expenses encountered by the client could be addressed through improved quality and availability of service and without reliance on monetary payments. For example, as services become more available there will be less need for long distant travel. The changes to the requirement that clients stay overnight will also result in less cost.

Nevertheless, most field workers, providers and government managers tended to argue in favor of the payments. When asked what could be done to improve use of sterilization services, field workers and providers tended often first to suggest increasing the payments to clients. There is an entrenched assumption and expectation among program workers that since the payments have been available for so long that they are therefore required. They often said performance and services would fall drastically if the payments were removed, even though as noted above the evidence is that performance has already fallen with the payments in place. Nevertheless, a few field workers, providers and managers stated that payments were not crucial and that more clients would come for sterilization services if they were regularly and more easily available and of better quality.

We observed that payments are equal for both vasectomy and tubectomy clients, despite the fact that the former requires much less time off (and subsequent wage loss) and that other additional expenses are not relevant to the male client, e.g. feeding a young child who accompanies the client, or staying overnight after the procedure.

Field worker payments. Per case payments to field workers have been banned by the GOB because of reports of coercive practices and fraudulent reporting. Current GOB policy permits only Tk. 50 per trip for government workers who accompany clients regardless of number of clients. Many NGOs reimburse their salaried field workers and community volunteers for actual expenses in accompanying clients. However, other NGOs are paying relatively large per case payments (Tk. 200 to 300) to non-salaried individuals and to anyone else who brings clients to their clinics. The special programs conducted by some NGOs to assist the district government in boosting sterilization performance are currently centered on making per case payments (Tk. 100 to 150) to whomever refers clients, even though per case payments fall outside of current GOB policy. These per case payment schemes create problems including diverting clients from other NGOs whose policies allow only reimburse field workers' actual travel expenses. Government FWAs, who are receive Tk. 50 per trip for accompanying clients to government services, will often take clients instead to the NGO for the larger per case payments. One local NGO manager complained that the higher per case payments by some NGO clinics "are polluting the system and making it difficult for us to serve clients at our clinics." There was strong cry from the other NGOs and many government representatives that the payment systems need to be uniform and that the same guidelines need to be followed by all service organizations to minimize the problems.

There is little question that fieldworkers who incur expenses in bringing clients to sterilization service sites should be compensated for their out-of-pocket expenses. However, as noted there are concerns

about equity and uniformity among payment systems and ensuring that administration the payments does not lead to situations where the payments act as financial incentives for field workers.

Case Study

One NGO community worker was found helping a discharged tubectomy client leave the clinic. She agreed to share her experiences. She had come a long distance with the client and had used a boat and then the bus and from the bus depot, a rickshaw. In the past three years she had escorted two other clients to this clinic. This client had also brought along her 2-year-old son and the community worker had looked after the child for two days at the clinic. She explained the breakdown of her costs: Tk. 5 for boat fare, Tk. 10 for bus travel and Tk. 5 for the rickshaw fare. So, she will eventually spend Tk. 80 altogether for travel plus money for food. In response to our question about why she brings clients from such a long distance for this sterilization service, she replied with determination, "As a social worker I consider this to be my social responsibility."

Provider payments. The provider payments, as noted in Table 2.1, are quite small in comparison to the payments to clients and referral agents. We spoke to providers about the importance of the payments. No provider stated that they would refuse to perform or assist in sterilization procedures if the payments were not there. In fact, some providers stated that, in any case, the provider payments are so small as to constitute an insult. Many providers agreed, when asked, that these payments could be eliminated with no discernible impact on the program

Policy considerations. The team discussed the payments with the assessment's Advisory Committee, representatives from government, local and national family planning NGOs, professionals, and women leaders in the family planning and health community. Although by no means unanimous, there is a rising chorus of opinion that the sterilization payment system should be phased out. Several reasons are given. The payments have not had any impact on performance in recent years. They divert attention from many other important issues including proper management and supervision of routine service delivery. They are expensive and an administrative burden to the program. They are associated with coercive practices in the past and today dysfunctional payment practices continue. Clients are not paid to use other health services that are there for their benefit. They set sterilization aside as separate from other health services and reinforce the image of sterilization as a method for the poor. By setting sterilization aside for special treatment, some argue that the payments undermine the principles of integrated service delivery that underlie the HSDP and the mandate from ICPD.

Some maintain that the policy environment has changed in Bangladesh and the time is now right to take a clear decision to phase out the payment system. The assessment team itself is unanimous in its recommendation that the system should be phased out. The team members did not agree however about how soon this should happen. One concern is that since clients and workers are habituated to the payments and their removal in the absence of significant improvements in family planning service delivery systems and their management would result in the further decline in performance. This is an untested assertion and there is a need for careful field trials of providing sterilization services without payments. However, these field trials will require preparation. Technical assistance will be needed to ensure services are client-focused and support informed decision-making, well-managed, easily available, and good information about the services is widely available through multiple communications channels.

The GOB is already taking steps to change its policies regarding the financial and in-kind payments. The provision of *sarees* and *lungis* to clients will be phased out in the next year as surgical clothing is provided to services sites. There is also discussion to phase out the IUD and Norplant payments.

3. SUPPLY FACTORS

This chapter reviews several factors that affect the supply of sterilization services including sectoral involvement, type of sterilization services offered (i.e., male/female, interval/ postpartum), service delivery approaches (i.e., static/mobile, vertical/integrated), and services organization and management. Two critical dimensions of supply – training and quality of services – are addressed in the subsequent two chapters

3.1. Sectoral involvement

As a result of investments over more than two decades, there is substantial clinical service delivery site potential in the public and NGO sectors for providing male and female sterilization services in Bangladesh. However, particularly in the public sector this potential is not realized in routine availability and performance at these sites. To a large extent public sector performance and capacity has deteriorated since the early 1990s. The NGO network and reach is significantly smaller than in the public sector, with performance dominated by a relatively small number of NGO sites. However, NGO service sites make significant contribution to national performance in relation to their numbers. Information on private sector sites performing sterilizations is not available, but anecdotal reports suggest that their contribution is relatively small.

Public sector. Public sector sites performed slightly more than 70% of the total sterilizations performed in Bangladesh in 1998/99. GOB guidelines permit sterilizations to be performed at the level of THC's and above. Table 3.1 identifies the major types and number of public sector facilities that have potential for providing sterilization services. Information about the number and type of public sector facilities are actually performing sterilizations on a regular basis is not readily available.

Table 3.1: Public Sector Facilities with Potential for Sterilization Services

Type of Public Sector Facility	Number
Thana Health Complexes	397
District Hospitals	57
Maternal and Child Welfare Centers	90
Medical College Hospitals	
- with Model Clinics	8
- without Model Clinics	5
Other tertiary facilities	2
Other public sector sites (e.g., selected UHFWCs)	250
Total:	809

Since the mid-1970's, the GOB has made substantial investments in most of these public sector sites to develop service delivery capacity for clinical family planning services including sterilization. These inputs have included training of surgical teams, construction or renovation of operating theatres and pre- and post-operative space, procurement and installation of essential medical equipment, the establishment of surgical expendable supplies system (i.e., the medical surgical requisites, or MSR), and the creation and deployment of Family Planning Clinical Supervision Teams (FPCSTs) for supervision and ongoing support of the sites and surgical teams.

Despite these inputs and ongoing service support systems, the current performance at the majority of public sector sites is reported to be very low or nil. The factors for this under-utilization of the very large potential public sector capacity are explored elsewhere in this report. They include:

- a decline in actual demand as other long-term contraceptives have become more available;
- inadequate organization and management of services and personnel at the district and thana levels (see Section 3.7, below); and
- inadequate training capacity (Chapter 4).

Non-governmental sector. NGOs play an important role in sterilization services in Bangladesh. In 1998/99 NGOs contributed nearly 30% of national sterilization performance, and in earlier years have contributed even larger proportions. NGOs participate in sterilization services in four principal ways: providing sterilization services at NGO static clinics and through mobile teams; providing information about sterilization through interpersonal, community and mass media activities; referring sterilization clients to government or other NGO service sites; and introducing and testing new program and technical innovations. While numerous NGOs throughout the country are involved in some way, three national NGOs and two large NGO networks are currently making significant contributions to sterilization service delivery capacity. Table 3.2 summarizes the current and planned service site capacity of these key NGOs and NGO networks.

Table 3.2: NGO Static Clinic Sites Offering Sterilization Services, Current and Planned, as of October 2000

NGO or NGO Network	Total Static Clinics	Current Sterilization Sites		Additional Sites in 2001/2002		Planned Capacity by 2001/2002	
		Female	Male	Female	Male		
▪ Bangladesh Association for Voluntary Sterilization (BAVS)	14	14	14	-	-	14	14
▪ Family Planning Association of Bangladesh (FPAB)	44	16	16	-	-	16	16
▪ Marie Stopes Clinic Society (MSCS)	21	2	8	-	6	2	14
▪ Rural Service Delivery Partnership (RSDP)	175		10	4 roving teams	10	4 roving teams	20
▪ Urban Family Health Partnership (UFHP)	146	9	28	29	10	38	38
Total:	396	37	72	29	26	66	98

Established in 1974, the **Bangladesh Association for Voluntary Sterilization (BAVS)** was a pioneer and leader in introducing and standardizing sterilization services in Bangladesh. In the mid- to late 1970s BAVS helped to demonstrate that sterilization services would be acceptable to Bangladeshi men and women and assisted the government in introducing services in the public sector. During the 1980s BAVS established a network of 22 sterilization clinics throughout the country, served as the principal training center for sterilization surgical teams from the public sector, helped to develop national service delivery standards, and introduced client counseling, safer anesthesia regimens, and the NSV technique into the national program. However, as a result of unresolved management and quality problems, donor funding for BAVS was withdrawn in 1990 and BAVS substantially scaled back its work for the next several years. With GOB oversight and funding, BAVS revived its clinical network. Today BAVS manages 14 clinics that provide minilaparotomy and NSV services and directly contributes 22% of total national sterilization performance. BAVS clinics also provide other clinical contraceptives (injectables, Norplant and IUDs), although at a much lower level than sterilization services. BAVS Dhaka began to offer maternity care services in April 2000.

The **Family Planning Association of Bangladesh (FPAB)** is an affiliate of the International Planned Parenthood Federation (IPPF) and was the pioneer for introducing family planning services in Bangladesh in the 1950s. Today FBAB offers minilaparotomy and NSV services as part of its comprehensive FP and MCH activities in 18 of its 44 clinics. However, FPAB clinic performance is quite variable. Five of FPAB's 18 clinics offering sterilization perform approximately 75% of total FPAB cases with the remainder performing a few procedures per month and in some case less than ten cases for the entire year. In total, over the past two years FPAB has performed sterilizations at an average rate of 3000 procedures contributing about 5% of national sterilization performance per year. Some of the FPAB clinics operate under the UFHP umbrella (see below)

Marie Stopes Clinic Society (MSCS) is an NGO operating a network of 21 clinics throughout the country, which provide a range of FP and RH services. It receives funding from Marie Stopes International and DFID to provide sterilization services through 10 of its 21 clinics and to conduct special programs for sterilization in collaboration with government (see Section 3.3, Integrated and vertical programs). Of the 10 clinics offering sterilization, 8 offer NSV and 2 offer tubectomy. (Two clinics offer laparoscopy services for a fee of Tk. 2000 Taka to middle class clients.) MSCS has plans to establish sterilization services in 6 additional clinics over the next year. In 1999 (Jan-Dec), MSCS clinics directly performed or assisted government through the special programs to perform 3388 tubectomies and 9839 NSVs (total = 13,227), and 5060 tubectomies and 6449 NSVs (total = 11,509) in the first 9 months of 2000. At these rates we estimate that MSCS clinics currently contribute, directly or indirectly, approximately 20% of recent national sterilization performance.

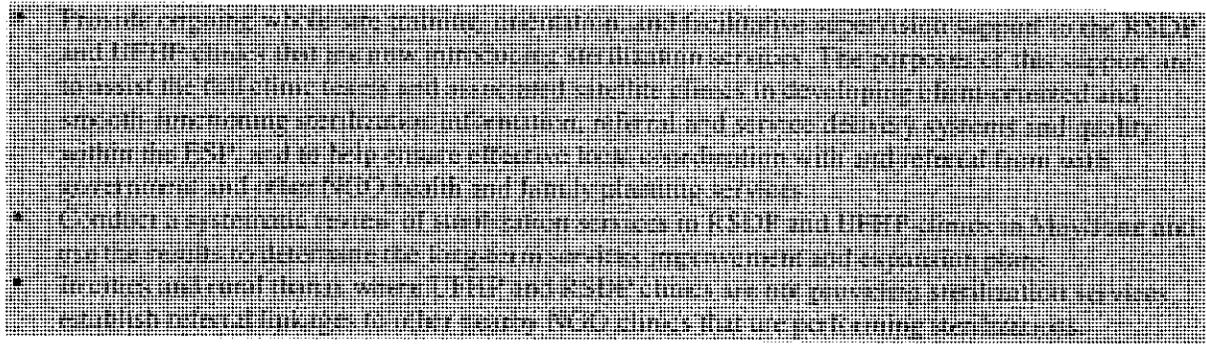
The **Rural Service Delivery Partnership (RSDP)** is an USAID-funded NIPHP project effective 1997 to 2002. It serves as an umbrella organization for 19 rural-based NGOs that currently operate 175 static clinics and 7,467 satellite clinics offering the ESP. The current 2000/2001 RSDP workplan sets the objective of establishing and integrating NSV services in 20 static clinics and by offering minilap services in 17 static clinics through 4 'roving' (i.e., mobile) surgical teams. To date, 10 NSV service sites have been established. RSDP managers told the assessment team that it expects to further establish sterilization services in additional RSDP sites in future years based on the result of this initial introduction phase.

The **Urban Family Health Partnership (UFHP)** is also an USAID-funded NIPHP project effective 1997 to 2002. It serves as an umbrella organization for NGOs providing the ESP in 85 municipalities including the 4 City Corporations through 146 static clinics, 108 'upgraded' satellite clinics and 441 regular satellite clinics. The current 2000/2001 UFHP workplan sets the objective of establishing long-term family planning methods including minilap and NSV services in 38 UFHP clinics by September 2001. Through September 2000, service teams at 28 sites have been trained in NSV and 9 have been trained in minilap. UFHP managers also reported that based on the experience of the first year, it hopes to expand sterilization services to additional UFHP clinics in subsequent years.

With initial training of the first generation of surgical teams now underway, it is too early to assess the capacity and performance of the nascent RSDP and UFHP clinics offering sterilization services, or to project realistic expansion to a new clinics in future years.

Recommendations:

Specifically, a key recommendation is to develop RSDP and UFHP support to:



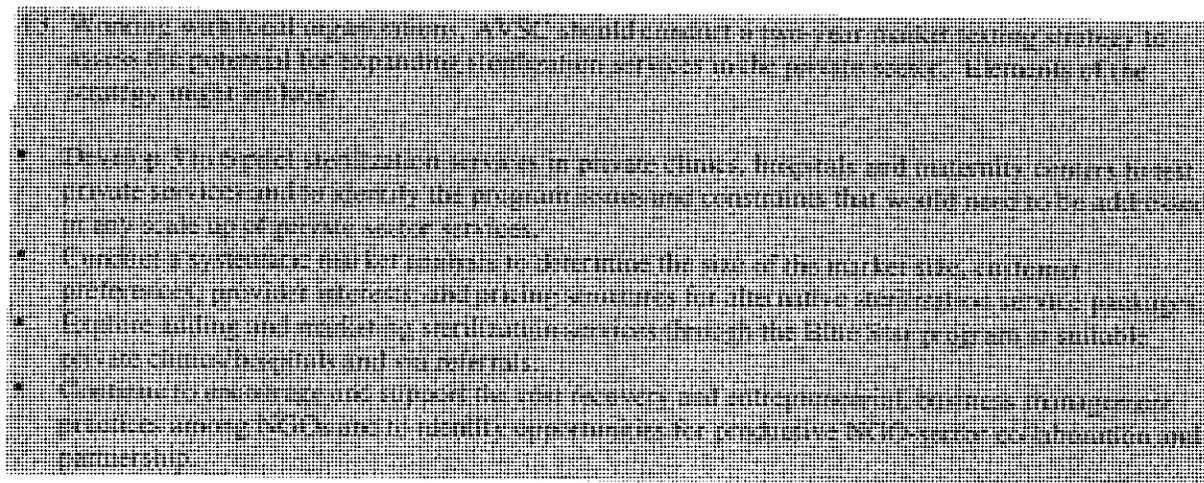
Private Sector. According to the 1999/2000 DHS, 3.7 % of current sterilization users (3.7% female, 0% male) reported private sector facilities as their source of supply. This reflects the general absence of sterilization in the private sector facilities. Indeed, little investment has been made to date in making sterilization available through the private sector. Nevertheless, the assessment team believes that there is significant potential for expanding access and use of sterilization services by tapping the private sector.

- 80% of Bangladeshis reportedly seek some of their medical care from private sector sources. Services in the private sector are perceived to be of better quality than services in the public sector.
- According to the 1999/2000 DHS, 22% of all contraceptive users are obtaining their contraceptive supplies or services from private sector medical outlets or facilities.
- The Social Marketing Company's "Blue Star Injectable Program", started in 1999 is showing encouraging results. Still in its early phases, the program is demonstrating that with good training, quality assurance and active promotion, private providers will be interested in offering clinic-based contraceptive services and that many clients will pay for these services. Managers of the Blue Star program also report the providers are willing to provide injectable services with relatively low, affordable fees.
- Anecdotal evidence suggests that several private Ob/Gyn doctors may be performing sterilizations for their clients, perhaps as a postpartum procedure in conjunction with C-section deliveries, or as an interval laparoscopy.
- Many government and NGO doctors who are trained in sterilization also manage their own private practices or work in private clinics. Anecdotal reports indicate that some of these doctors are using their sterilization training in their private practices. For example, at one MCWC center visited, one of the surgeons who has performed thousands of sterilizations in the public sector since being trained at BAVS in the 1980s reported that he offers minilap sterilization under epidural anesthesia in his private clinic and charges clients 1000 Tk. for the service.
- The private medical care sector is vibrant, entrepreneurial and expanding rapidly in Dhaka, Chittagong and other major municipalities throughout Bangladesh. Private clinics, hospitals and maternity centers – large and small – are being increasingly at a rapid rate. NSV can be offered in simple treatment rooms of private doctors. Interval minilap and laparoscopy can be offered in suitably equipped clinics and hospitals. Postpartum services can be offered in maternity centers.

Thus, it seems that this may be a good time to explore the potential of involving the private sector more actively in offering affordable sterilization services to lower-middle and middle class couples. We anticipate several challenges in creating a significant private sector market for sterilization services in Bangladesh. First, the negative image of sterilization as a method for the poor will need to be addressed (see Section 2.2.1., above). Second, given the current negative image, the current and potential market for sterilization services among lower-middle and middle class couples will need to be assessed. Third, the market analysis will also need to identify market segments, alternative sterilization service packages, pricing structures for the alternative services, and the interests of private doctors in providing services.

Fourth, suitable systems will need to be established for certifying and accrediting private providers to provide quality services and for maintenance of quality over time. Fifth, innovative training approaches may be needed for private practitioners who would likely be reluctant to spend significant time away at off-site training courses.

Recommendations:



3.2. Male and female sterilization services

Bangladesh has chosen minilaparotomy and NSV as the program methods for female and male sterilization services which are most suitable to the country's needs and service delivery environment. The introduction of these comparatively lower-resource methods has helped to make sterilization services widely available in all types of public and NGO sector facilities throughout Bangladesh.

Table 3.2 shows that as overall sterilization performance has increased or declined in Bangladesh, the relative proportion of vasectomy and tubectomy cases has fluctuated and shifted considerably. In different national program phases, vasectomies have exceeded tubectomies, although the trend since the late 1980s has been steadily declining numbers and proportions of vasectomies. However, vasectomy performance has fluctuated more dramatically than tubectomy performance suggesting that vasectomy is more sensitive to program attention or pressure. Indeed, the largest numbers and highest proportions of vasectomy performance in the program are associated with the intensive sterilization campaigns of the mid-to late-1980s in Bangladesh, which utilized targets, mobilization of and incentives for public sector field workers to recruit clients, and male field agents and recruitment efforts in the NGO sector, especially BAVS, who worked and motivated clients on a per case incentive basis. When this special attention relaxed, vasectomy performance has tended to decline.

Despite the historical cycles of high and low vasectomy performance, the number of vasectomies is not insignificant, especially in relation to the number of tubectomies performed. Today, with overall sterilization performance at all-time low levels, about 1 in 4 sterilizations is a vasectomy. Although this ratio is a significant reduction from early program phases, it still compares quite favorably to most other countries in the world where the proportion is much lower. Nevertheless, our observations suggest that many more men would choose vasectomy and the relative share of vasectomies could increase. Our analysis of service site statistics collected during the assessment suggest that 70 to 80% of all current vasectomies are being performed by three NGOs (BAVS, FPAB and MSCS). Furthermore, within these three NGOs our observation is that a relatively small share of the clinics within their networks of clinics are performing most of the vasectomy procedures. This again suggests the influence of provider or

program attention and the role of special or innovative program interventions to make vasectomy services and information more easily available and accessible.

Table 3.3: Ratio of Male to Female Sterilizations, Five-Year Intervals

Period	Percent Vasectomies	Percent Tubectomies	Total Number
1974/75 – 1978/79	50	50	368,196
1979/80 – 1983/84	15	85	1,475,808
1984/85 – 1988/89	53	47	1,536,690
1989/90 – 1993/94	41	59	785,615
1994/95 – 1998/99	21	79	301,663

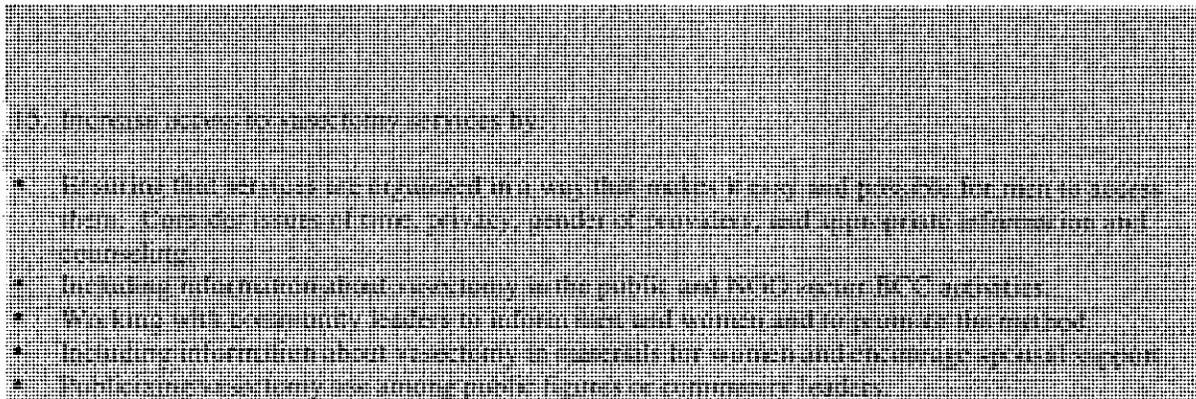
Despite the evidence that significant numbers have been performed in Bangladesh indicating some level of acceptability and demand for the method, many field workers, providers and managers who we interviewed maintained that vasectomy was unpopular. Many respondents also maintained that Bangladeshi women are, in fact, major factors in decision-making in that many women do not want men to have vasectomies because they are afraid that men will become sick or weak after vasectomy, thus affecting their ability to work and support the family. However, there are no studies to substantiate this claim. There is a need for studies to better understand vasectomy decision-making and the factors that influence Bangladeshi men's decisions about vasectomy.

Thus, we believe that with program leadership that provides ongoing attention to men and vasectomy services, quality services that appeal to men, and ongoing management and supervision, a higher level of vasectomy services can probably be sustained in the Bangladesh program, and almost certainly at levels higher than current performance.

Recommendations:

The following recommendations are provided for enhancing quality vasectomy services, increasing numbers of services, increasing sustainability, and cost. The recommendations focus on best practices, dissemination and replication, and require special attention to be well integrated within the existing services and the needs of individuals and their spouses, and to all within a broader health management framework. Health service providers are expanding existing services and will be able to assist in developing the new health. Steps may include the following:

- Conduct a field review of those private and public sector clinics that are currently performing vasectomy services to identify and evaluate the factors and activities that are contributing to their operational performance. These visits may have revealed guidelines that should be analyzed, documented, and disseminated accordingly.
- Review and disseminate findings from site visits and field research into a guide to new approaches.
- Test new models for male sterilization and vasectomy services in a small number of pilot clinics, using the public sector or low-cost private clinics.



3.3. Interval and postpartum female services

Nearly all female sterilizations in Bangladesh are offered and performed during the interval period. Very few postpartum tubectomies are performed. Nevertheless, the assessment team has concluded that there is a significant opportunity to improve availability and access to sterilization services by introducing and expanding postpartum services as a national program method. There are several considerations that lead to this conclusion:

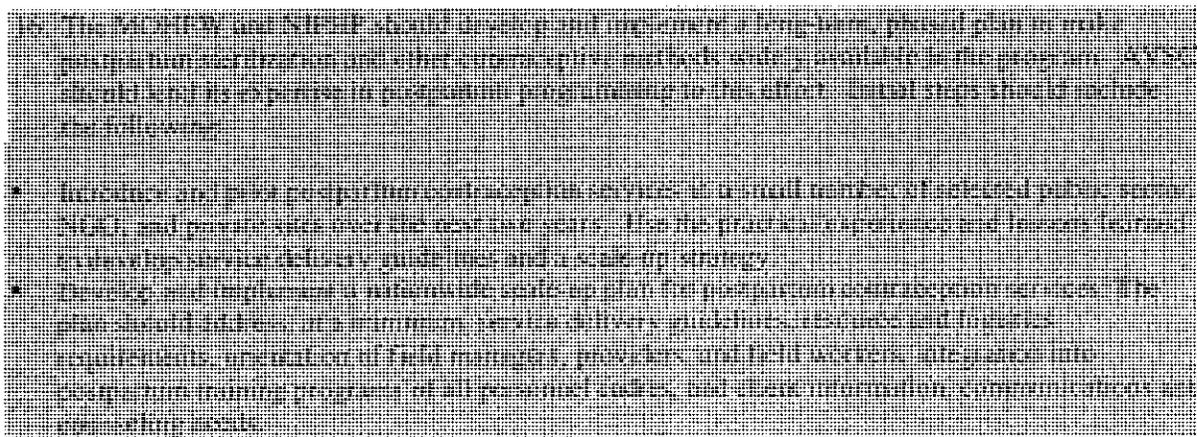
- Potential clients for postpartum services are pregnant women who are attending antenatal care services. Antenatal care services provide an excellent and cost-effective opportunity to determine family size or limitation intentions of pregnant women and to counsel them about their postpartum family planning choices. Repeated antenatal visits provide women opportunities to support women with appropriate information in their decision-making process about their contraceptive choices following delivery. It also provides the appropriate time to obtain the client's informed consent and for the client to discuss the decision with her spouse. Another important advantage of immediate postpartum sterilization is that the client compensation fees for travel and field agent fees would not be required.
- There are large and increasing numbers of clients attending antenatal clinics in a range of public, NGO and private health facilities including at THCs, district hospitals, MCWCs, medical college hospitals, NGO clinics offering the ESP, as well as private hospitals and maternity centers.
- Antenatal services will become increasingly available as the ESP is introduced throughout the country in the public and NGO sectors under the HPSP and NIPHP.
- Institution-based deliveries in Bangladesh are increasing. The 1996-1997 Bangladesh DHS reported that 23% of all deliveries among urban respondents occurred in health facilities.
- There is anecdotal evidence that postpartum services will succeed in Bangladesh. As one example, the FWVTI in Rajshahi reported that the majority of sterilizations performed at its attached MCH clinic in the early 1990s were postpartum sterilizations. Monthly caseload was relatively high compared with other clinics in the area and the services were easily managed with no problems. (However, when the site was tapped to become a sterilization training center for the national program, it was required to train in interval minilap. The postpartum service was abandoned and meanwhile interval sterilizations are also no longer regularly offered or provided as there no longer is a training program.)

Despite the opportunities and advantages that available and accessible postpartum services offer, services organization requirements and challenges are different from interval services and precautions must be taken to ensure proper client counseling. Specifically, clients should be well counseled and provide their informed consent during the interval period. They should not be counseled during the labor or

immediately after delivery. The woman's decision should be reconfirmed again before the procedure, especially there is any observed health problem with the infant.

Any initiative to introduce postpartum sterilization services should be done within a broader program of strengthening comprehensive postpartum family planning services. It should be noted that other contraceptive methods, including the IUD, are suitable and safe for delivery during the immediate postpartum period, and should also be available as options to postpartum clients. Postpartum contraception training curriculum and service delivery guidelines would need to be developed. The curriculum and service delivery guidelines should give particular attention to the special counseling needs of postpartum family planning clients.

Recommendations:



3.4. Static and mobile services

A long-standing objective in Bangladesh has been to make male and female sterilization services available upon demand on a regular basis at the service delivery facilities in the public sector that are listed in Table 3.1, above. This objective was achieved to a large extent in the 1980's as a result of massive training and infrastructure improvement inputs. However, this extensive static service delivery capacity has deteriorated to a large extent throughout Bangladesh as a result of factors discussed in this report including the lack of institutionalized and sustainable training capacity, the ongoing conflict and lack of coordination between health and family planning personnel, poor local supervision and a lack of commitment, proactive management and leadership by district- and thana-level managers and providers who are demoralized for various reasons.

The deterioration of regular static sterilization services must be considered within the context of poor quality of other family planning services at public sector sites since sterilization services are being managed, supervised and provided within the same environment by many of the same personnel who are involved with sterilization services. The team observed that at virtually all public sector facilities it visited, the family planning and MCH clinics were observed to be poorly managed and supervised. Typical problems observed by the team that could be addressed by proper local management and supervision included the lack of systematic client flow and crowding at the family planning clinics, poor internal referral from other services within the hospital or clinic, inadequate client counseling and support for proper counseling (private space, job aids, client educational materials), and dirty service areas including IUD insertion and examination rooms. Thus, in such dysfunctional environments where local managers and providers are not attending to fixable problems, it would be exceptional to find well-organized static sterilization services.

Given that the caseload for sterilization services has fallen, static service sites with trained personnel and adequate facilities have fallen out of the habit of organizing work for routine sterilization services. Thus, when the occasional client does arrive at the hospital/clinic for sterilization the facility and the surgical team may not be prepared to receive and serve the client. The trained surgeon may be absent, or preoccupied with other services. If busy with other work, s/he may not be interested in scrubbing and preparing for one case. The operating theatre and equipment may not be ready to provide surgery. The team heard several anecdotal reports of clients being turned away for these reasons and told to return another day. Some sites have solved the problem by designating a specific day or days during the week when the hospital and staff will be ready and available to provide services. If family planning workers and field agents, other hospital staff and the community are all well-informed about the regular schedule of weekly designated day(s) for sterilization services, this would minimize the chances that clients will be turned away at the door and it would permit the service team to work most efficiently.

Because static services have deteriorated substantially in many areas, many district family planning managers are relying on mobile surgical teams that travel to and provide sterilization services at static health facilities where routine sterilization services are not being offered.¹ In some areas the mobile teams are visiting sites on a regular schedule but in other areas the scheduling is more ad hoc and irregular. In general, field workers are informed about the mobile team service date in advance of the visit and instructed to bring sterilization clients on that day. Recently, mobile services have been organized as "special programs" to stimulate field agent client recruitment and referral activities by providing per case payments (see Section 3.5, below).

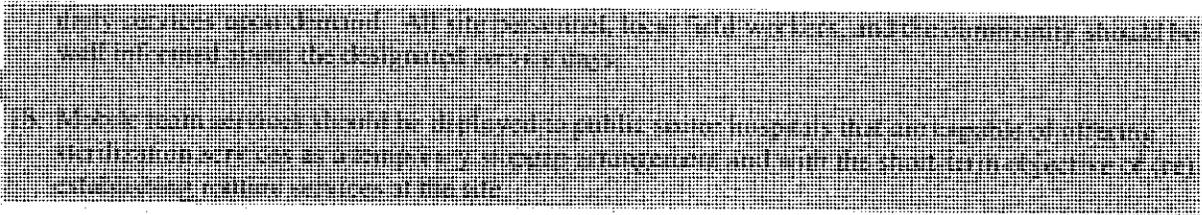
The program's MIS does not maintain statistics distinguishing sterilizations provided through static or mobile services so it is difficult to gauge the extent to which mobile team services have supplanted regular static services. However, it is possible that mobile teams now perform most tubectomies in public sector sites. District family planning officials reported in the districts visited that they frequently use mobile teams, and mentioned that substantial caseloads (10 to 20 cases or more) are frequently performed on days the mobile team visits. And with the recent introduction of "special programs", providers and field workers are more interested in providing.

Mobile team services can be an acceptable approach to increasing the availability and access to services when they are performed in full compliance with service delivery guidelines. However, they generally are more expensive and often they serve to circumvent local service site teams from taking responsibility and solving the problems that stand in the way of serving clients on a regular basis by the local service team itself. It is best if mobile team services are provided to localities as a temporary stopgap arrangement and in the context of developing and implementing an action plan for eventually establishing routine services at the site. The major input requirement for this is the commitment and leadership of district and thana program managers working in partnership with the local service team to develop and follow through on a plan to overcome the constraints.

Recommendations

[REDACTED]

¹ These mobile team services are sometimes referred to as 'camps'. However, the term is misleading. Camps in the early program historical context in Bangladesh were frequently massive promotional events with hundreds, even thousands of sterilizations performed over a short period often in non-health facilities such as schools or even tents. These practices are no longer sanctioned or permitted within the Bangladesh program.



3.5. Integrated and vertical approaches

As noted earlier, it is GOB policy to provide family planning services, including sterilization, in an integrated fashion within broader MCH services and the ESP mandated by the HPSP. The provision of integrated services, the elimination of method-specific services with client inducements, targets and incentives (per case payments) was included in the 1994 ICPD Programme of Action, which has been fully endorsed by the Bangladesh government. The implementation of HPSP is well underway and many actions have been taken in recent years to comply with the spirit of ICDP. Nevertheless, the provision of sterilization services in Bangladesh is characterized by vertical service delivery approaches.

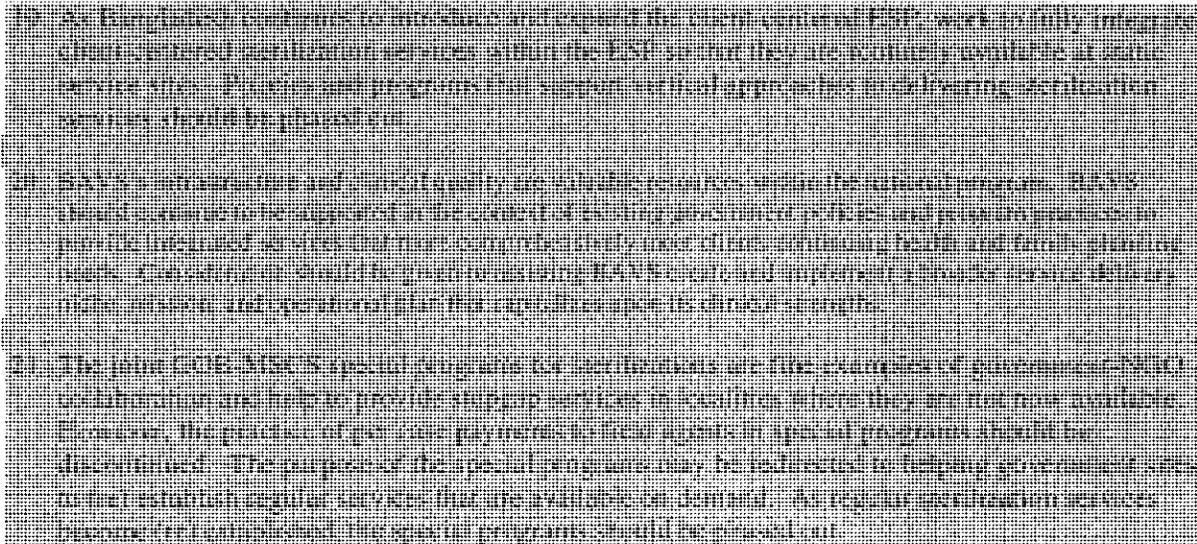
Sterilization services have a long history of being provided and promoted in a vertical manner in Bangladesh. This is reflected in the special sterilization-focused campaigns and targets of the 1970s and 1980s, which have now been abandoned. It is currently reflected in the extensive reliance on mobile teams to provide sterilization services in sites where the service is not routinely available. It is also reflected in a system of payments in sterilization services, which is not found with other essential health services (see Section 2.6). These practices reinforce a general mindset in the program that extraordinary measures must be taken for sterilization services to be successful. A standard model for successfully offering sterilization as an integrated service routinely available on demand, without use of mobile teams or payments, does not prevail in the Bangladesh program.

There are currently two programs in Bangladesh that are vertical in nature. First, BAVS is a predominantly sterilization-focused organization, although other family planning services are marginally available at the clinics and maternity services have recently been introduced on the Dhaka clinic. The two BAVS clinics visited by the team in the field continue to operate in much the same manner as BAVS clinics did during the sterilization campaign era of the 1980s. The managers and field agents at these clinics reported that many of the field workers associated with these BAVS clinics are non-salaried and are paid on a per case basis for clients referred. The team received various reports from these BAVS workers and other NGOs that the per case referral rate was between Tk.100 and 300, which is at variance with GOB policy for transportation payments for referral agents. In general, at these two clinics there appeared to be no ongoing health care relationship with the clients either before or following sterilization services. At these two clinics, the designated counselors reported receiving no special counseling training; one of them is a former field agent himself. Field workers from these two clinics are reportedly often enlisted from the ranks of those who worked with BAVS in the 1980s.

Second, since 1999 MSCS clinics have been conducting "special programs" for sterilization as a collaborative activity in support of district family planning officials in order to boost performance. Funded by Marie Stopes International, special programs are in essence government mobile team services organized by district family planning officials with special support from local MCSC clinics. In many respects, the special programs provide an example of good government-NGO collaboration. This special support includes arrangement and payment for the transportation of the surgical team to the service site, meals for the surgical team, and per case payments to any field workers, government FWAs or otherwise, who bring clients. Payments were reported to be between Tk.100 and 200 per case.

Many respondents reported to the team that per case referral payments in these two programs produce negative consequences for the national program. In particular, other NGOs were quite vocal in their complaints. The payments, they claim, help divert clients from existing NGO and government referral channels that are not providing the same payments. They create an environment whereby other NGOs feel they must compete in order to attract clients. One UFHP clinic manager reported that, contrary to UFHP policy, her clinic now pays field agents at the MSCS rate, otherwise field workers would not bring sterilization clients to her clinic. (See also Section 2.6. concerning field worker payments.)

Recommendations:



3.6. Structural issues

The historical bifurcation of the MOHFW into health and family planning wings from the central level to the field level has negatively affected the delivery of sterilization and other family planning services over the past two decades. The HPSP Programme Implementation Plan states the fundamental problems well:

“At present the Ministry of Health and Family Welfare is organised into two separate cadres at all levels for providing health and family planning services. While the health services infrastructure and personnel are largely supported from the revenue budget, most of the family planning infrastructure and personnel continue to be supported on a development project basis. The current structure does not adequately respond to the needs of maternal health and clinical contraception despite potentiality and limits the potential for increasing the range, quality and effectiveness of services. On the cost side, the current structure is a major cause of waste and inefficiency. Functionally, the bifurcation impedes referrals, generates internal conflicts, and contributes to the low utilisation of public facilities. Delivering ESP effectively and efficiently will necessitate a unified line management system. In addition, the current management system provides few incentives to improve quality of care, and respond to clients’ needs. The management culture in the sector needs to be changed so that the providers are motivated to serve the needs of clients.” (MOHFW, 1998: 29-31)

In terms of the delivery of sterilization services, the bifurcation has meant lack of involvement of health personnel in providing sterilization services. Doctors on the health side often refused to perform sterilization, even if they were trained, because “it was not their job”. The separation between health and

family planning meant many lost opportunities for referring clients from health services to family planning (and vice versa). The separation resulted in disputes over supervision and control between the two sides, which seriously affected productivity. And, the lack of job security and career advancement for family planning personnel, contributed to low morale and also affected productivity.

Under the HPSP plan, some steps have been taken since 1998 to resolve some of the underlying difficulties. Ten percent (10%) of the family planning personnel have been transferred to the revenue budget, and the plan is to transfer the remaining by 2003. Decentralization of authorities to the thana level for health and family planning activities is underway. Health and family planning personnel working at the thana level have recently been restructured in a unified management structure, with the Thana Family Planning Officer (TFPO) now reporting to the Thana Health and Family Planning Officer (THFPO). However, unification at the district level and above has not occurred and as a result the health and family personnel at these higher levels, upon whom the thana personnel depend for support, reportedly continue to work at odds with one another. Meanwhile career advancement for family planning personnel continues to be an unresolved issue.

The assessment team met with health and family planning managers at the district and thana levels and discussed the changes that are underway. It is clear in talking to these personnel that the animosities that have characterized their relationships in the past continue, and that most health and family planning workers are filled with anxiety about the changes underway. It was difficult in most places to talk to the government managers about improving the sterilization services without engendering heated discussion about the conflicts and the changes that are underway. Until personnel move through the change process and accept their new roles and responsibilities, it may be very difficult to make significant progress at the district and thana level in improving sterilization services.

3.7. Field-Level organization of services and management

As noted earlier, public sector capacity to perform sterilization services has deteriorated significantly in the past decade despite an extensive infrastructure and the past investment in developing service delivery capacity. The decline in the number of personnel trained to perform sterilizations is an important factor, as discussed in the following chapter. However, the assessment team believes that an equal if not more important factor is the lack of routine systems for organizing, integrating and managing sterilization services at the local. Furthermore, there is a lack of proactive initiative by the district and thana health and family planning offices in developing and managing the systems. The structural problems previously discussed, and the resulting conflict and low morale, have contributed to the local leadership problem.

In any case, some of the problems at the field level that will need to be addressed in order to create functional and routine service delivery systems for clinical contraception services include the following:

- The district and thana health and family planning offices need to develop a deeper understanding about what client-focused, integrated, high-quality and efficient clinical contraception services look like. At the present time, the understanding of these managers is clouded by the payments systems and special initiatives to recruit and 'motivate' that prevailed in the past and continue to today. It is difficult for them to conceive of, and thus plan for, a routine system that does not depend upon payments, special organization of field workers, etc.
- Under unification, the roles and responsibilities of health and family planning managers and providers at the district and thana levels with respect to the delivery of clinical contraception services must be made explicit and clear. In particular, the health side supervisors (e.g., Civil Surgeon and staff at the district level and THFPO and staff at the thana level) need to clearly understand their responsibilities for clinic-based family planning services.

4. TRAINING

The 1992 clinical contraception assessment concluded that one of the key reasons for the decline in clinical contraception performance at that time was insufficient numbers of trained surgical teams and the lack of institutionalized training capacity. The principal recommendation from the 1992 exercise was that the GOB should develop a long-term strategy and program to institutionalize clinical contraception capacity. Since 1992, there has been some progress in developing this capacity but it is still too early to tell whether the programs initiated will be sufficient to meet long-term demands and whether the training programs themselves will be successful and sustainable. Prior to 1992, NGOs, in particular BAVS, conducted most sterilization training for both the public and NGO sectors. It is noteworthy that at most public sector sites visited by the assessment team which were still performing sterilizations, the surgeons were trained by BAVS during the 1980s. The contraction of BAVS in 1990 left a serious training gap that has not yet been entirely replaced, particularly for the public sector.

4.1. In-service training: public sector

Accurate data is lacking on the number of public sector service sites that do not have personnel trained to provide and assist in sterilization surgery. However, district and thana officials and providers in the public sector frequently identified the lack of trained personnel as the main reason for no or low sterilization performance at the site. It is difficult to evaluate such statements because health wing doctors involved principally with curative services and who are trained in sterilization have often refused to perform sterilizations. With unification and the clarification of responsibilities for performing clinical contraception services at public sector sites, there is a need to reassess the clinical contraception personnel resources and training needs at each public sector site.

In any case, in planning for the training program (described below) that is being set up at the medical college hospitals, the Directorate General of Health Services and AVSC in 1998 estimated that 1997 GOB physicians and 2035 nurse-paramedics needed to be trained in minilaparotomy and NSV over four years to ensure adequate number of trained personnel in half of the 464 thanas. These numbers were determined by surveying GOB district and thana health facilities and requesting them to identify personnel who needed to be trained.

From 1992 to 1996, NIPORT worked in managing the public sector training program in selected MCWCs, MFSTC, and a medical college Model Clinic. However, the project was not successful and was ultimately terminated. The major reasons for ending the program included lack of strong clinical leadership and supervision, weak trainers, and inadequate caseload at the practical training sites. In addition, NIPORT's status changed as a result of health sector reforms and it was no longer well positioned to implement the program.

Since 1998 under the HPSP, responsibility of public sector clinical contraception training including for sterilization has been transferred from NIPORT to the Line Director, In-Service Training, Directorate General of Health Services. With funding from UNFPA and technical assistance from AVSC, a project has been underway since the start of 1999 to develop and support public sector training in clinical contraception including sterilization and RTI/STI case management through the 13 medical college hospitals and MFSTC. UNFPA is funding the technical assistance, curriculum and materials development, trainee travel and per diem and other program costs while the GOB covers trainer salaries and other recurring costs. Of the 13 medical college hospitals, 8 of them have family planning Model Clinics that are linked to the Ob/Gyn departments of the medical colleges. The medical college hospitals were chosen as in-service training sites because they have experience as teaching institutes and have experienced clinicians and trainers. Achievements to date under this program include development of the

training curriculum and teaching materials, identification of the trainers, and conduct of a training of trainers (TOT) course.

The medical college hospital sterilization training program is still in the first phases of implementation and it is too early to assess whether the program will be successful. To date, four medical college hospitals have started training: Dhaka, Mitford, Chittagong and Mymensingh. Members of the assessment team visited three medical college hospitals to observe facilities and interview trainers, and were briefed by the local AVSC team that is providing technical assistance to the program. The interviews and observations indicate significant challenges that will need to be addressed by this program in order to succeed. These include:

- Selection and experience of medical college teachers to serve as clinical trainers. The selected trainers from the medical college hospitals already are busy teaching and performing clinical duties. In addition, their teaching styles are well established and it may be a challenge to orient and convert them to the training curriculum and approaches developed for the program. The clinical skills of the trainers are reportedly uneven and needs to be assessed especially in the areas of infection prevention, surgical and anesthesia techniques, counseling and client-provider interactions, and practical demonstration of resuscitative procedures. There is a lack of information of the number of trainers at each of the training sites who are competent to perform minilaparotomy and NSV.
- Caseload. Assuring adequate caseload during the training courses is a major challenge. Most of the medical college hospitals, including the 8 with attached Model Clinics, reportedly do not have sufficient sterilization caseload to provide adequate practical experience during the training courses. Information is lacking about average minilaparotomy and NSV caseload at each training site. Furthermore, the medical college hospitals are not under the control of the Directorate of Family Planning and therefore there are no formal linkages for referring clients from the Directorate of Family Planning field outreach system. During the recent TOT, there was insufficient caseload for the trainers. The caseload issue is by no means insurmountable but it will require proactive and continuous attention and coordination by each of the medical college training teams. Ways to increase caseload for training include establishing effective client information and referral systems within the medical hospitals themselves, establishing ongoing coordination for client referral with local NGOs and local district and thana family planning officials, or sending trainees to nearby government and NGO clinical site where there is a regular caseload and a skilled sterilization trainer or coach.
- Quality of services at the training sites. The team observed that the quality of clinical services at training sites visited was inadequate, particularly in the areas of counseling, infection prevention, emergency preparedness, and pre-, intra-, and post-operative client monitoring. Client flow and referral systems at the training sites do not exemplify good practice. It is essential that the training sites model high quality services for the trainees and demonstrate the importance of following all service delivery guidelines.
- Follow-up of trainees. There currently are no provisions in the program for follow-up of trainees at their home institutions after training. At a minimum there should be close coordination between the training centers and the FPCST/QATs assigned to their region so that trainees' home sites are given priority for supervision visits within a few weeks or months following. Home sites of new trained surgeons should receive comprehensive assistance from supervision teams and district health and family planning officials. Application of Whole Site Training principles would be an especially appropriate methodology for follow up of recently graduated trainees.
- Management of training. Improvements need to be made in the management and supervision of training. At the local training sites, the management needs include site preparation, developing training schedules, scheduling trainers, and supervision and coordination of activities. Local supervision is ad hoc and hampered because the trainers reportedly focus attention on their

clinical and curative work. As regards, overall training program management, as the training centers are located in medical colleges they are under the Directorate General of Health Services, which has not been oriented to supervise and provide on-site assistance to the training program.

Recommendations

23. With the initiation of the training program, each training center can be holding a monthly clinic to be provided to each medical college hospital training center to strengthen the following:
 - Review the trainees' basic approach and MSV service delivery skills including especially in the areas of counseling and infection prevention, counseling and client response, reproductive and practical demonstration of reproductive procedures.
 - Arrange refresher training for trainees whose clinical skills are deteriorated over a course.
 - Assist the training site in recognizing and improving family planning activities so that it complies with the service delivery guidelines and serves as a model of quality services for trainees. Areas of particular concern include client flow, counseling, infection prevention, emergency procedures, and pre-, intra- and post-operative client monitoring.
 - Assist the training site in developing a specific action plan for ensuring adequate clinic facilities for practical training purposes.
24. The NIPHP, with technical assistance from AVSC, should systematically evaluate the private sector training programs with the medical college hospitals in 2001 after most of the training sites become operational to determine the quality of services and services are training at the training sites and any adjustments in the program that may be needed.
25. Develop and implement a plan for creating the private sector support the follow-up of their trainees thereafter within a few weeks after training and technical on-site assistance for improving their clinical skills and the quality and quantity of services at the local site. A closer formal link or partnership between the training centers and the FPCST/NGOs may be considered for this purpose.

4.2. In-service training: NGO sector

Accurate data on the long-term training needs in NGO sector sites do not exist. However, the UFHP, the RSDP, and MSCS are all anticipating expanding the number of clinics in their networks that offer sterilization services. There is a need to clearly identify current and project long-term training needs for the NGO sector. Likewise, if a strategy is adopted to introduce sterilization services in the private sector, an assessment of long-term training needs to implement the strategy will be needed.

Associates in Training and Management (AITAM) Welfare Organization is the principal training organization for sterilization for the NGO sector. It was established in 1991 with USAID funding, technical assistance from AVSC, and with the collaboration of 4 agencies including Pathfinder International, the Asia Foundation, FPCST and FPAB. The purpose of the organization is human resource development through competency-based clinical training for government, NGO and other organizations. Since its inception, it has organized 462 training courses in Dhaka and throughout Bangladesh, and has trained more than 6000 participants from nearly 70 organizations in various topics of reproductive health. It recently was notified by a Japanese donor about being awarded a grant for construction of a training facility.

AITAM is one of 10 organization recognized to provide training in various aspects of the ESP for NGOs participating in the NIPHP. It provides training on a fee basis to doctors and paramedics in temporary

and permanent family planning methods, counseling, RTI/STI prevention and management, antenatal and post-natal care, and child survival interventions. Until recently it provided training to both GOB and NGO service providers. Table 4.1 summarizes the training courses AITAM conducted in 1999/2000. For training in sterilization, AITAM follows the standardized GOB-approved curriculum. It has a suitable classroom and AV equipment for conducting didactic training. AITAM has one full-time trainer and 2 part-time trainers. These trainers provide training at the training center and follow-up trainees at their home institutions following training. Practical training is done at several service delivery sites including MFSTC where caseload has been problematic.

Table 4.1: AITAM Training Performance, 1999/2000

Training Course	Training Duration	Number of courses	Trainee Category	Number of Trainees
Minilaparotomy and no-scalpel vasectomy	18 days	7	Doctors	35
			Paramedics	35
Minilaparotomy only	12 days	5	Doctors	25
			Paramedics	25
No-scalpel vasectomy only	8 days	21	Doctors	168
			Paramedics	168
Basic course in family planning	17 days	5	Nurses & FWVs	75
			Nurses & FWVs	150
Clinical contraception	12 days	10	Nurses & FWVs	60
Family planning counseling	6 days	4	Counselors	60
Maternal care and RTI/STI	11 days	7	Nurse & FWVs	106
Child health interventions and other reproductive health	12 days	12	Doctors	85
Child survival interventions	10 days	10	Nurse & FWVs	164

AITAM has two training sites, one in Shaymoli in Dhaka and the other in Tongi. Table 4.2 gives the number of clients served by AITAM sites over the past year. AITAM had sufficient in-house caseload to meet NSV training requirements in 1999/2000. However, in-house service levels to meet 1999/2000 minilaparotomy training requirements was not sufficient. In order to help meet the training requirements, AITAM arranges practical training sessions at BAVS and GOB service sites. Already, AITAM is hard-pressed to assure quality practical training for the current introduction of sterilization services in the UFHP and RSDP programs. Ad hoc arrangements for arranging caseload will not be a suitable solution in the future if the training needs for the NGO and private sectors increase. There is a need, therefore, to determine the long-term training requirements of the NGO and private sectors and to find approaches for assuring adequate caseload for any increases in the numbers of trainees.

Assuring trainee follow up has also become an issue for AITAM. With only one full-time Master Clinical Trainer who has a heavy and growing training load, it is not feasible to follow up every trainee at his or her home institution after training. In addition, the costs of follow up are not included in the training fee. AITAM needs to address the follow-up situation in creative ways by working collaboratively with the clinical supervisors in the national NGOs. Some possibilities might be to tap the FPCST/QATs for follow-up visits, or to develop a small network of NGO clinical supervisors and skilled NGO and GOB surgeons throughout the country who could be trained to conduct the follow-up visits in their localities. The costs of trainee follow-up should also be built into the training fee as this will help ensure that it happens.

Table 4.2: AITAM Service Performance, 1999/2000

Type of Service	Number of clients served
Minilaparotomy	290
No-scalpel vasectomy	840
IUD	1350
Norplant	15
Injectable	222
Oral contraceptives	360
Antenatal care	1152
Postnatal care	564
RTI/STI services	1255
Child health services	1884

In addition, PRIME II is working under the NIPHP program to develop and improve training programs for nurse-midwives and paramedics. Given the critical role of nurse-midwives and paramedics in communicating with clients about all aspects of their reproductive health including sterilization, it is important that the training curricula, activities and materials developed for these providers be consistent with the national program's BCC messages about sterilization and with the sterilization training curricula for surgical teams.

Recommendations

- 26. APMC should provide technical assistance to AITAM to conduct a comprehensive assessment of the long-term demand for clinical reproductive services in the NE region, prioritize and develop a long-term strategy and action plan to address the needs. Specifically, the government strategy and action business plan should address, inter alia, the following:
 - Projected training and types of trainers for various types of clinical reproductive and other services
 - Resource requirements (financial, trainers, facilities, etc.) needed to respond to meet the training requirements
 - Assessing the clinical and training skills of the AITAM trainers
 - Assessing sufficient investment for the various types of practical training
 - Identifying innovative approaches for assessing trainer follow-up
 - Reviewing the cost recovery and training fee structure with an eye toward increasing the sustainability of AITAM
- 27. Ensure that the training curricula, activities and materials developed by nurse-midwives and paramedics with PRIME II assistance are consistent with the national government's BCC messages about sterilization and the training curricula for surgical teams.

The following additional recommendations apply to both the medical college hospital and AITAM in-service training programs:

- 28. The criteria for certification of trainers need to be updated to include the BCC messages and the competency of trainers. Trainers need to be periodically re-certified by directly assessing their clinical and training skills.

20. The clinical rotations in the FP/ST/FP/ST should be limited to interns and medical students. They are faced as needed by general obstetrician training and follow-up of trainees in their specializations. The FP/ST/FP/ST should also receive orientation in adult learning, teaching, training, and facilitative supervisory skills, which are essential when monitoring or supervising and technical assistance.

21. The content of pre-service and in-service training can be improved. In particular, more practical training is needed in basic skills such as tying knots, securing hemostats, retractor, and management of lacerations and vaginal injuries. Practical training and in-service training in adult learning and facilitative supervisory skills is necessary to accomplish training courses. Practical training needs to be more hands-on and based on adult learning principles. A list of adult learning techniques is available to MOHSW and AFAM to improve practical and in-service training.

22. In-service training follows an agenda that is less than that of service. The provider's clinical skills, knowledge, attitudes, infection prevention practices, counseling, and referral, management of services, teamwork, adequacy of facilities and equipment at the service site, and other details of the service delivery system that are important factors in the delivery of safe, direct, and cost-effective services. Thus, the principles of Whole Site Training and facilitative supervision are particularly suited for in-service follow-up activities and should be adopted.

4.3. Pre-service training

Pre-service preparation of medical students and interns for family planning and sterilization services is weak in Bangladesh. The present system in Bangladesh allows for a two-week training in family planning during the fourth and fifth year of medical college. Reportedly, students often fail to attend these sessions with little consequence, and thus receive no exposure to family planning. Also, Ob/Gyn interns rotate two weeks through family planning services, but surgical interns do not receive such exposure.

Recommendations

23. Both family planning theory and clinical exposure should be included in the medical school curriculum and medical rotations. Written exams and clinical assessments for specific rotations should be used as a means of ensuring that students will take the family planning clinical rotation.
24. Clinical training in family planning for both Ob/Gyn and surgical internships should be made mandatory.

5. MEDICAL QUALITY

Program managers and donors have given substantial attention to medical quality in sterilization services in Bangladesh since the late 1970s when lapses in quality resulted in relatively high morbidity and mortality and threatened the reputation of the program. A number of important steps have been taken over the past two decades to improve and assure medical quality. These include standardizing surgical and anesthesia techniques and other clinical protocols for sterilization, developing/disseminating service delivery guidelines, upgrading surgical facilities and equipment, improving the medical supplies logistics system, conducting periodic assessments of medical quality, and establishing a system of regional medical teams to supervise services. Despite the investment and many improvements, the 1992 assessment of clinical contraception services identified continuing serious problems with medical quality. The current assessment has concluded that many of these problems persist and have not yet been systematically addressed. In particular, as discussed below the poor quality of infection prevention practices remains the most urgent medical safety concern.

The medical quality of sterilization has a direct impact on clients' perceptions and utilization of services. During the assessment, clients, field workers and providers reported that clients are concerned about surgery, the safety of the procedure, post-operative complications, and negative health effects following the procedure. Reports of serious complications or even deaths attributed to sterilization pass rapidly in the local community and damage the reputation of sterilization as a safe procedure. Many respondents noted that there are more requests for sterilization in facilities with the reputation for having skilled and experienced providers and high-quality services.

The assessment team adapted the clients rights and providers needs framework (see Table 1.3, Chapter 1) in developing an assessment checklist, organizing observations, and synthesizing conclusions regarding medical quality issues. (Huezo and Diaz, 1993; IPPF, 1997) The assessment involved interviewing clients and providers, observing clinical facilities and equipment, reviewing service site records, and observing sterilization procedures. A total of six NSVs and three minilaparotomies were observed.

5.1. Safety

A paramount right of clients is to obtain safe and comfortable services. Safety must be addressed during every phase of service delivery: pre-operative history-taking and examination, medication administration, surgical technique, anesthesia, intra- and post-operative care and monitoring, infection prevention, emergency preparedness, and client follow-up.

Pre-operative screening and examination. Pre-operative client screening – history taking and physical examination – is essential for determining each client's fitness for sterilization and for confirming that the decision for sterilization is informed and voluntary. In accordance with international guidelines, Bangladesh does not impose any absolute medical restrictions for either male or female sterilization (MOHFW, 2000; WHO, 1996). Special precautions may need to be taken before, during and/or after surgery if there is an observation or history of previous abdominal surgery, obesity, PID, hypertension, heart disease, and relevant skin/scrotal lesions. Client assessment will thus help in deciding the timing, surgical approach, surgical skill requirements and institution where the procedure can be safely performed.

Paramedics performed history-taking and preliminary client examination of clients at all the visited sites. The surgeon also examined the client and verified informed consent at the majority of sites. Ruling out pregnancy by reviewing menstrual history was done at all sites. However, history-taking and risk assessment for RTI/STIs was not done or was inadequate at most sites. Bimanual examination to determine abnormalities was done at all sites. However, speculum examination to identify abnormal

discharge, the possibility of cervicitis, and other cervical pathology is not routinely performed at all sites. Thus, pre-existing conditions such as cervical lesions, infections, and menstrual irregularities may be missed and this may lead to clients' blaming sterilization for problems after sterilization.

At one site a vasectomy client was rejected on medical grounds (scrotal swelling), but the situation was not well managed. The client was turned away without medical treatment or referral to an appropriate site, and the client was simply advised that he and his wife should consider female sterilization instead.

Minilaparotomy. In Bangladesh, minilaparotomy under local anesthesia with light sedation is the program method for female sterilization. The team observed and assessed critical aspects of the standard minilaparotomy technique: entry of the abdomen, identification and retrieval of the Fallopian tubes, safe and atraumatic occlusion, assurance of hemostasis, client comfort and alleviation of pain, and closure of the abdominal wall. At one site, the surgeon who was observed had difficulty opening the abdominal wall and required assistance for the QAT officer who happened to be present at the site. None of the observed sites are using the uterine elevator, tubal hooks and Babcock's forceps to retrieve the fallopian tubes, which allows for less manipulation of and trauma to tissue and reduced risk of infection. However, no difficulties were observed in retrieving the fallopian tubes.

In 2000 a delegation of MOHFW, National Technical Committee, donor and NGO officials visited Nepal to observe clinical contraception services in that country. The observation tour was organized by AVSC and hosted by the AVSC/Nepal country office. Following the visit the MOHFW revised the regime for sedation using IV drugs (MOHFW, 2000b) The previous regime was Inj. Pethadine 50 mgms., Inj. Phenergan 25 mg., and Atropine 0.6 mg. intravenously just prior to surgery. Under this regime clients were kept overnight, necessitating special staffing coverage and special arrangements by clients and their families. The overnight stay was thus perceived to be an additional expense and a barrier to services.

The new regime was designed to permit clients to be discharged on the same day if she is fit for discharge and had a person to accompany her. However, the client retains the option to remain overnight if she so wished even if medically fit to be discharged. The new regime is Inj. Pethedine 25 mgms. (reduced from 50 mgs.), Inj. Phenergan 12.5 mg. (reduced from 25 mg.). The dose of Inj. Atropine 0.6mgms is to stay the same as previously. For clients weighing less than 35 kg, the dose is to be halved. These drugs are to be administered intravenously immediately before starting the minilap procedure. The MOHFW plan is to gradually replace Inj. Pethadine with Inj. Pentozocine 30 mgms at all centers. The new guidelines encourage the practice of 'verbocaine', i.e., engaging clients in conversation to distract, help monitor and allay client's fears during surgery.

As the program move to same-day discharge of minilap clients given the lower anesthetic dosages, the providers will need to be increasingly careful and vigilant and their treatment and care of clients. Surgical technique will need to be meticulous, handling of internal viscera will need to be more gentle, monitoring of clients intra- and post-operatively will need to be done consistently, and clients will need to be examined carefully before discharge.

In all the procedures that were observed, clients were not overly sedated using the current regime. One of the 3 observed minilaparotomy clients operated under the new regime experienced discomfort during the procedure. "Verbocaine" was not used during any of the procedures observed. Intra-operative monitoring of vital signs was inadequate. Monitoring of clients who receive intravenous sedation must be improved in order facilitate detection of complications and immediate emergency interventions if necessary.

Laparoscopic sterilization. Laparoscopic sterilization is not a program method in Bangladesh and the GOB discourages its use in the public sector. It is an appealing method in that it can be performed

relatively quickly, causes minimal discomfort, and leaves a very small scar. It nevertheless requires much greater skill, has a greater risk of serious complications than for minilaparotomy, and requires expensive equipment that is more difficult to properly maintain. It also is not suitable for postpartum sterilization. Thus it should only be performed at referral sites with highly skilled surgeons who perform large numbers of laparoscopies, and where there are strong support systems to maintain the equipment. (IPPF, 1997; AVSC, forthcoming)

One of the NGO sites visited provides laparoscopic sterilizations for a fee of Tk. 1000-2000. There are two doctors providing laparoscopic sterilization at this site. Both have received specialized training and have together performed over 3500 laparoscopic sterilizations since their training in the early nineties. The team did not assess the quality of laparoscopic services at this site.

Vasectomy. No-scalpel vasectomy (NSV) is the program method for vasectomy in Bangladesh. All six vasectomies observed by the team were NSVs. At one site, the surgeon was observed to have difficulty in isolating and retrieving the vas and in assuring pain control through proper administration of local anesthesia. All other NSVs observed were performed skillfully and clients were comfortable during surgery. However, the practice of 'verbocaine' during the procedure could allay client fears and improve comfort.

At most of the observed sites, the surgical area was shaved. However, the revised Bangladesh standards (MOHFW, 2000a), recommends that shaving of the surgical area be avoided as this can result in small nicks and abrasions that provide opportunities for bacteria to proliferate increasing the risk of post-operative wound infections. If necessary, hair around the surgical site can be trimmed.

Intra-operative monitoring is important and could be improved during vasectomy procedures. This needs to be emphasized during training and supervision of services.

Post-operative care. At most of the sites visited, space was available for immediate post-operative care for female sterilization clients. However, in high-volume situations such as when Special Programs are conducted or when a mobile team visits, post-operative care space is not often adequate. Also, in some public sector sites the post-operative sterilization clients are sent to the general wards for recovery and these are frequently dirty and not well maintained. Service sites need to ensure that recovery wards are clean and have an adequate number of beds for sterilization clients.

At the observed sites, staff were designated to provide post-operative care, and stethoscopes and BP instruments were available in the recovery areas. However, the actual monitoring of clients was inadequate and needs to be improved.

Infection prevention (IP). Aseptic and antiseptic precautions are essential to prevent both immediate and long-term infectious morbidity and mortality. Inadequate IP practices can lead to surgical site infections, (Mangram et al., 1999), tetanus (Grimes et al., 1982), and transmission of infections like HIV/AIDS, Hepatitis B and Hepatitis C (IPPF 1996). Infection prevention must be strictly adhered to in preparation of equipment and the OT, in the OT during the surgery, and following the surgery during the processing of instruments, gloves and linen. Safe waste disposal methods (for sharps and final disposal of waste) needs to be adopted at all sites providing medical services. Infection prevention practices needs to be adhered to all times of service delivery and in all areas of the facility.

Internationally, infection has been reported as one of the leading causes of mortality and morbidity following sterilization. (Khairullah, 1992; Ruminjo and Lynam, 1997; Ruminjo and Ngugi, 1993; Bhatt, 1991; and Githiari, 1989) In Bangladesh, tetanus was reported to be the cause in 25% of deaths following sterilization and infection other than tetanus in 5% of deaths (Grimes et al., 1982a, 1982b). Table 5.1

shows the number and rate of sterilization-attributable deaths due to tetanus of for the period 1982-1992. The 1992 clinical contraception assessment suggested that widespread lapses in IP practices were a major reason for the dramatic increase in tetanus deaths from 1988 to 1991.

Information on IP practices was collected both by observation and by interviewing the staff who were actually involved in the procedures like high-level disinfection (HLD) and autoclaving. Many of the deficiencies noted in the 1992 assessment persist.

Table 5.1: Deaths Attributable to Sterilization Resulting from Tetanus

Year	Total number of sterilization deaths	Deaths per 100,000 sterilizations	Tetanus as cause of death	
			No.	Percent
1982	23	5.8	7	30.4%
1983	15	3.7	4	26.7%
1984	13	2.0	6	46.2%
1985	9	2.9	2	22.2%
1986	7	2.1	2	28.6%
1987	6	2.4	1	16.7%
1988	10	4.5	8	80.0%
1989	20	9.3	18	90.0%
1991	12	6.3	12	100.0%
1992	3	2.1	2	66.6%

Source: FPCST Project, Directorate of Family Planning, MOHFW

IP practices varied greatly between the sites and also within a site. In general, the NGO and MCWC sites followed IP practices more carefully than the other GOB facilities. Particularly alarming, the medical college hospitals and attached Model Clinics, which will be the training sites, were deficient in following standards IP practices. Decontamination of used items during screening and post surgery is not routinely performed, even though staff at most sites are knowledgeable about proper procedure. Appropriately prepared chlorine solution is available in the operating theatres, but not in the screening and examination rooms. And, even when chlorine solution was available it was not used for decontamination following the procedure.

The method of preparation of surgical site was also inappropriate at some of the sites. At several NGO and GOB sites, the staff performing autoclaving/HLD were not knowledgeable about autoclaving and HLD. Disposal of sharps and final disposal of waste also was inadequate at many sites. Litter, sharps (needles, blades), and used ampoules were observed on the ground in areas often used by both the staff and clients. Procedures and appropriate containers for sharps disposal are lacking.

Emergency preparedness. All sites providing family planning services should be able to cope with the rare emergencies that do occur. Functioning resuscitation equipment and adequate emergency drugs and supplies should be available and easily accessible at all times to staff providing sterilization services. Staff need to be trained in emergency procedures and receive periodic refresher training.

All surgeons interviewed received training in the management of emergencies during their medical school training. However, surgical sterilization training courses include only didactic training in resuscitation; there is a need for practical training.

Emergency drugs, expendables and equipment were available at nearly all sites. However, at some sites these were not easily and quickly accessible to staff. At most sites, staff were not familiar with resuscitative and emergency management procedures and protocols. Emergency drills are not conducted.

Recommendations

14. The MCH/FPW should focus a risk reduction strategy on preventing pregnancy throughout the reproductive system through birth control and family planning and sterilization services and facilities and address a comprehensive risk reduction strategy to systematically address the deficiencies and gaps and needs identified. The risk reduction strategy should incorporate recommendations from the health and family planning wing, NGOs, the FPX/ST/CA/TA, medical schools, and training institutions, as these are the groups best positioned to address the complex FPX/ST/CA/TA training objectives and the risk factors. At a minimum, the action plan needs to address the following:
 - evaluation, identification, and dissemination of the national FP service standards;
 - upgrading the FP components in all pre- and in-service training activities;
 - reforming training recruitment for starters and the FPX/ST/CA/TA;
 - identifying and clarifying the national base of FP responsibilities at each level of health service (HE);
 - equipping individual service sites through Whole Site Training and IIT approaches to correct IP, IP/ST/CA/TA, and
 - improvement of on-site facilities and problem-solving supervision of IP by the FPX/ST/CA/TA.
15. Job aids for FP services should be developed and displayed in sterilization service sites to assist operators involved with sterilization to adhere to safety guidelines. Areas where job aids would be useful include infection prevention procedures, client counseling, and other service procedures. APOC can assist the MCH/FPW and NIPHP in developing the job aids.

5.2. Continuity of care

Appropriate action in the event of abnormal findings, maintenance of client record, provision of post op instructions and medications, and follow-up care are all aspects of continuity of client care.

Appropriate action for abnormal findings. Services sites need to be able to manage abnormalities diagnosed during client screening or surgery, or make referrals and arrangements for treatment at suitable facilities where the problem can be treated. It was observed that sterilization clients are not frequently rejected on medical grounds. As noted earlier, however, one vasectomy client rejected for scrotal swelling was not treated or referred to another site for treatment.

Client's Record. Client's records must be maintained to ensure continuity of care both at the site and after discharge. All relevant data should be recorded legibly, accurately and completely as this will be relied on and referred to in future follow up as and when required. The team observed that nearly all sites visited used and adequately completed the standardized client record and informed consent forms, and that they were reasonably well maintained.

Post operative instructions. Post operative instructions and medications are given to the clients both during the counseling and immediately prior to the client's departure from the service site. Most sites provided the clients with written instructions in Bangla. However, warning signs are not given to clients orally at most sites, and are not included in the written instructions given to the client. It has been noted that even if the clients themselves might be unable to read and write nearly always there is a person known to them who will be read the instructions to them. The alternative would be to develop and distribute pictorial instructions.

Male clients are given 20 condoms following the surgery at most of the sites visited. However, more emphasis needs to be given at service sites on providing clients with information about the rationale and duration for using family planning after vasectomy as well as instructions for how to properly use condoms.

Post-operative medications. Most of the sites provided the clients with some form of medication to be taken post operatively. The common medications given were a -day course of antibiotics (Amoxycillin) and analgesics (Paracetamol). Recently, the MOHFW issued revised guidelines to discontinue routine administration of post-operative antibiotics following surgical sterilization. This is most certainly a move in the right direction as routine use of antibiotics following surgical sterilization for prophylaxis is "not necessary when recommended infection practices are conscientiously followed" (IPPF, 1997). Inappropriate use of antibiotics adds to program costs and can increase the prevalence of antibiotic resistant microorganisms that can cause infection leading to increased expense, morbidity and also potential for increase mortality. However in special circumstances (e.g., risk of bacterial endocarditis) use of prophylactic antibiotics is still indicated. (IPPF 1997).

Adherence to strict aseptic and antiseptic precautions during client examination and surgery is a better way to prevent these surgical site infections. It is essential that clients and appropriate family members are educated on wound care, warning signs of infection and whom to contact if problems arise.

Careful screening to rule out pelvic infections, strict asepsis and antiseptic precautions during surgery, attention to hemostasis during surgery, gentle handling of tissues, minimizing devitalized tissue, educating the client and family on post operative care, warning signs and referral have all been shown to reduce post operative infection rates. (Grimes et al., 1982; WHO, 1996)

Referral Mechanism. Many of the sites visited did not have a referral system to appropriate centers for further management of a client with an abnormal finding during screening or surgery or in the event of a complication. Government facilities were provided with an ambulance for transport of clients to referral centers and had identified referral centers. The availability of ambulance for use when required could not be ascertained. Coordination with referral sites and formal feedback mechanism was often inadequate. Difficulties have been reported by NGO sites without facilities for providing surgical sterilization when they referred clients to government facilities for surgical sterilization.

Follow up care. There is a need for more information on follow-up rates, complications identified during follow-up, the quality of services delivered at the time of follow up, clients perspectives on the quality of follow-up services, and the alternative services used by sterilization clients in Bangladesh for post-sterilization care. All sites reported that they advised clients to return for follow up one week following surgery and post-operative instructions were given. However, most sites do not maintain information on follow-up rates. Thus, the true extent of follow up cannot be determined. Clients reportedly often came back if they had to have their sutures removed though many surgical procedures did not require suture removal (NSV and when catgut was used as skin sutures). Some clients complained that follow-up was not adequate, specifically that they were not well treated by clinic staff or that their concerns and complaints were not addressed. Some respondents speculated that lack of proper post-operative care and failure to address clients' post-operative health complaints was one of the reasons why sterilization requests have fallen.

Recommendation



...responsibility for ensuring a referral system is in place at each site must be clearly established. ...

5.3. Supplies, equipment and infrastructure

Most of GOB facilities visited had adequate infrastructure for sterilization services. Most of the sites had running water and electricity/generator. However, several GOB facilities were poorly maintained and poorly organized. At some of the sites the arrangement of the operating area, scrub area and instrument processing area was inappropriate to maintain asepsis. Often there was no system for clients to be seen in an orderly fashion and crowded around the provider's table making it difficult for the provider to counsel, screen and examine clients and also maintain confidentiality and privacy. In general, NGO sites were more spacious, cleaner, and better organized than GOB sites.

The MSR system was working well at all sites visited. A few of the sites reported temporary shortages of expendables like gauze, spirit, Savlon, and injectable contraceptives. However, these were managed locally at the site and did not adversely affect services.

Availability of essential equipment varied. In general facilities had adequate equipment although it was not always well maintained. Among the GOB sites, the MCWCs were observed to be better equipped often having spare items as well. NGO facilities were adequately equipped. Some facilities had broken equipment like autoclaves that had been in disrepair for over a year and that had not been fixed or replaced. Arrangements for equipment repair and maintenance did not exist at many sites and where it was available often had a tedious process that resulted in long delays. Some MCWCs contracted locally with Hema Enterprises Health Care Services for repair of anesthetic equipment. While this arrangement is reported to be efficient and working, it is limited to anesthetic equipment only.

No-scalpel vasectomy requires two important instruments – a specially designed ring forceps to encircle and firmly secure the vas without penetrating the skin and a sharp tipped dissecting forceps which punctures and stretches a small opening in the skin and sheath of the vas. These two instruments are crucial for doing the procedure well. Many sites reported that the NSV instruments they received are defective and led to difficulties in performing the procedure.

Recommendations

...The NGO/FW should ensure the procurement and distribution of high quality NSV instruments. Arrangements to procure and distribute good quality NSV instruments to all facilities providing NSV services has to be a top priority.

5.4. Information and updates for providers

In addition to their initial training, providers require regular updates and orientations concerning technical and programmatic information and guidelines relevant to their jobs. The revised Bangladesh family

planning manual (MOHFW, 2000) was published in Bangla and will soon be available in English. The revised standards were available at all sites visited. However, at some sites the guidelines and recent administrative circulars had not been disseminated to the concerned staff. In addition, there is no routine system for periodic updates on advances in contraceptive technology and programmatic best practices. Related to the need for continuing education, is the need for career advancement. As noted earlier, morale among family planning personnel has been low in part because of limited opportunities for professional development and career advancement.

Recommendation



5.5. Supervision and monitoring

A good supervision and monitoring system is needed to maintain quality services and also to provide guidance, support and on-site training. At present, the MOHFW's FPCST/QAT system and the Quality Assurance visits done by NIPHP for its affiliated NGOs are the principal vehicles for routine medical supervision and monitoring.

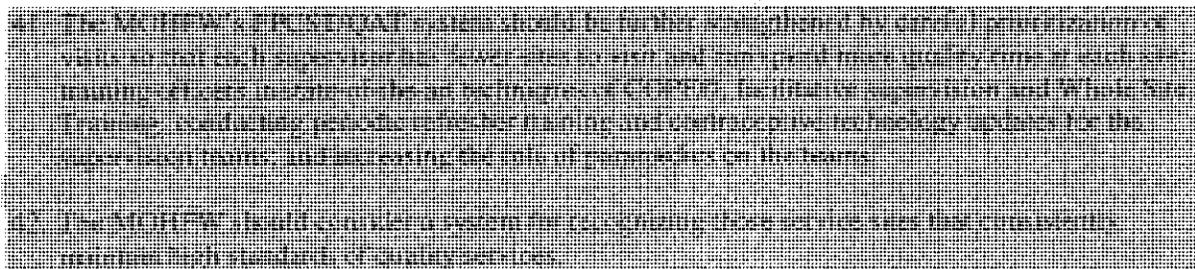
The principal issue for the GOB system is the large geographic area and number of sites that must be covered by each team and the difficulty of providing quality supervisory and technical assistance support given the large number of sites. In July 2000, the MOHFW reorganized the supervision system. There currently are 8 FPCST/QAT officers who are trained and experienced doctors in clinical contraception procedures. Each regional FPCST/QAT officer is responsible for visiting facilities on an average 8 districts. In general, this encompasses all MCWCs, district family planning offices, THCs, district reserve stores, and union level facilities in that region. During visits the FPCST/QAT officer is to observe services, discuss problems with local site managers and providers and, at the conclusion of the visit, write and send a report to the Directorate of Family Planning in Dhaka. However, given the number of sites to be visited, sites are not regularly visited. The time spent at the sites is quite brief and, therefore, there is often not enough time to observe counseling, clinical procedures, and infection prevention practices.

The FPCST/QAT officers also provide immediate on-site technical assistance if problems are observed. (During one field site visit where a FPCST/QAT officer was in attendance, one of the providers had difficulty opening the peritoneum. The FPCST/QAT officer who was present stepped in, performed the procedure in a skilled manner, and mentored the doctor who was having the difficulty.) However, in general, FPCST/QAT officers do not have formal training in such state-of-the-art practices as simple problem identification and solving methodologies (e.g., COPE©), facilitative supervision, and Whole Site Training. Also, paramedics are not part of the FPCST/QATs. Adding a paramedic to each team would allow more aspects of service delivery to be better monitored. For example, the medical FPCST/QAT officer could concentrate on clinical aspects and technical assistance while the paramedic assessed infection prevention practices and adequacy of equipment and supplies.

In the NIPHP, over 300 urban sites and rural facilities are visited at least once a year. The NIPHP system is intended to be comprehensive and focuses on both clinical and management aspects of service delivery. The team spends 2 days at each site and visits both the static and satellite sites observing services and onsite training, conducting feedback session for all the staff at the site, and providing the site with written feedback in the form of an action plan.

At present, there are no provisions for recognizing and rewarding GOB sites that maintain consistently high standards and that correct problems identified during supervision team visits.

Recommendations



5.6. Complication reporting system

Sterilization attributable mortality and major morbidity are rare around the world. However, every major complication or death can undermine the reputation of the program and most of the deaths and major/ life threatening complications that do occur following sterilization can be prevented.

In order to identify problems and take corrective and preventive programmatic action, a strong complications data collection and reporting system is required. The GOB has set up a system of reporting deaths and complications both major and minor complications following surgical sterilization. Staff at each site have been given the responsibility to maintain a complication register. There is a system of compensation for clients having complications following surgical sterilization, which encourages the reporting of complications. In the event of a death following sterilization, the MOHFW organizes a team to investigate the cause of death. Table 5.2 shows the number and rate of deaths attributable to sterilization in Bangladesh for the period 1990-1999. There were a total of 3 deaths following female sterilization in 1998 and 1999. Two of the deaths were as a result of peritonitis following minilaparotomy. One was confirmed by post mortem to have had a bowel injury that was not recognized or managed.

Table 5.2: Sterilization-related mortality in Bangladesh, 1990-1999

Year	# of vasectomy procedures	# of Tubectomies performed	Tubectomy related deaths	Vasectomy related deaths	Total sterilization deaths	Sterilization deaths per 100,000 Procedures
1990	67,372	122,789	12	0	12	6.3
1991	74,525	95,606	10	0	10	5.8
1992	64,175	75,505	3	0	3	2.2
1993	41,259	69,727	3	0	3	2.7
1994	34,566	56,318	3	0	3	3.2
1995	10809	48,222	3	0	3	5.6
1996	7981	37,024	1	0	1	2.2
1997	9858	47,282	0	0	0	0
1998	16981	51,458	2	0	2	2.9
1999	17,700	41,671	1	0	1	1.7

Source: MOHFW, Directorate of Family Planning

A few sites visited had complication registers that were available for review by the team. However the complication registers were not kept up to date. Also there was no standard definition or criteria for complication reporting and was often difficult to discern the true nature of the problem that was recorded. At one site the register for the period of 1997 –1998 reported 4 cases (2 NSV and 2 Minilaparotomy) had

to be abandoned due to technical difficulties to isolate, retrieve the vas/ fallopian tube. A few minor complications like wound hematomas and discharges following surgical sterilization were also reported.

Recommendation

The Committee on the Status of Women in the Health Services Sector has reviewed the existing literature and prepared information on contraceptive methods for the health care providers. The committee has also prepared a list of contraceptive methods and their side effects, efficacy, and duration of use. The committee has also prepared a list of contraceptive methods and their side effects, efficacy, and duration of use. The committee has also prepared a list of contraceptive methods and their side effects, efficacy, and duration of use. The committee has also prepared a list of contraceptive methods and their side effects, efficacy, and duration of use.

ANNEX A Scope of Work

Background:

Voluntary sterilization (minilaparotomy and vasectomy) prevalence rates have been declining since the early 1990's and are now at extremely low levels. The proportion of eligible couples using voluntary sterilization as a method of contraception dropped from 10.3% in 1991 to 7.2% in 1999. Female sterilization declined from 9.1% in 1991 to 6.7% in 1999; and male sterilization declined from 1.2% to 0.5% during the same period (source DHS 1999 – 2000).

The contraceptive method mix has been shifting towards greater use of short-term methods. In 1991, 33% of the modern family planning method users were using permanent contraception. In 1999 the proportion has dropped to 17%. (source DHS 1999-2000) It is extremely important to better balance the method mix and insure that the full range of contraceptive services are available to provide clients with maximum freedom to choose the method best for them. More than half of the currently married women want no more children but are not using voluntary sterilization. The current program emphasis on supply methods and the lower quality and availability of services for long-term clinical methods, are major reasons for women to rely on short-term methods that are not appropriate to their desire or need. The increased use of more effective and longer term contraceptive methods such as voluntary sterilization, Norplant and IUDs will help Bangladesh to reach its national development goal of replacement level fertility in the near future.

There have been some recent assessments conducted that investigated the causes of the decline in the use of voluntary sterilization and provided suggestions to improve the situation, but none since 1996. One such assessment was conducted in 1992 and was followed by a situation analysis in 1994. In 1996 another assessment was conducted that looked primarily at voluntary sterilization counseling issues. These studies provided valuable information and many of the recommendations may still be valid. However, USAID/Bangladesh wishes to update and expand current knowledge of the situation and to have a team of experts develop new programmatic recommendations based on direct observation in a number of settings in Bangladesh.

Government of Bangladesh (GOB) Position and Support:

After the release of the latest DHS report, the GOB began discussion at different levels about the status of voluntary sterilization service delivery in Bangladesh. In one such discussion meeting, the MOHFW Director General of Family Planning stated that an in-depth review of the situation should be undertaken in order to provide recommendations on how to increase the use of voluntary sterilization in the country. Several other GOB officials and NGO representatives have expressed similar feelings. In response, USAID/Bangladesh agreed to support such an assessment. The details of the assessment exercise are described below.

Assessment Objectives:

The assessment exercise will be conducted with the following objectives:

1. To assess the potential of the existing service delivery system (including but not limited to management, training, and supervision) to increase the availability, quality and use of voluntary sterilization (minilaparotomy and vasectomy) in Bangladesh.

2. To examine the attitudes and behavior of service providers, NGO leaders and local and national government officials and determine how their planning and decisions have affected the current service provision capacity and client use of voluntary sterilization services.
3. To examine the desirability of continuing the current provision of payments by the GOB and NGOs to providers, clients and referral agents.
4. To make specific recommendations to USAID, the GOB, and other interested donors on effective means to expand the availability of voluntary sterilization services, while maintaining a high level of medical quality and ensuring complete voluntarism in the program.
5. To provide specific recommendations on means to improve behavioral change communication (BCC) activities for voluntary sterilization programs and incorporate these recommendations into the new NIPHP BCC strategy.
6. To provide specific recommendations on improving and better ensuring coordination between GOB, donors and NGOs on voluntary sterilization service delivery programs.
7. To identify specific areas where coordination between the MOHFW Directorates of Health Services and Family Planning is required in the provision of voluntary sterilization services and suggest means of establishing such coordination at various levels.

Assessment Activities:

1. A local Advisory Committee will be convened in Bangladesh, which will supervise the team's work and provide overall guidance. The recommended representatives of that Committee are mentioned in the next section. The Assessment Team will meet with the Advisory Committee to receive specific guidance in conducting the assessment and on the expected outcomes.
2. The Assessment Team will conduct the following activities and report back to the advisory committee:
 - a. The Assessment Team will review the existing literature, including the prior assessment and situation analysis reports. The recommendations of the previous two assessments will be compiled into a matrix and the status of implementation will be reviewed.
 - b. In-depth interviews will be conducted with policy makers, senior and mid level managers, service providers, communication experts, referral agents and clients.
 - c. Field visits will be made to service delivery centers and training sites in at least three geographic areas of Bangladesh. The selected delivery centers will include GOB hospitals and thana complexes, NIPHP (urban and rural), FPAB, BAVS, Marie Stoppes International, other NGOs with service delivery programs, and private facilities. The team will observe voluntary sterilization procedures and client counseling.
 - d. All findings will be compiled into a report. Recommendations will be provided specifically for USAID

to incorporate into its NIPHP program. Additional recommendations will be provided for the GOB and other donors such as UNFPA, IPPF and Marie Stoppes International concerning national policy and coordination of the service delivery programs.

Timeframe:

1. Formation of the Advisory Committee. – Third week of September 2000.
2. Assessment Team reviews existing literature, designs assessment exercise, develops questionnaires and sets up tentative schedule of field trips, in liaison with local AVSC office – Last week in September
3. Advisory Committee reviews the design of the assessment exercise and the data collection tools. - First week of October 2000.
4. Assessment Team conducts assessment starting October 14, 2000 for approximately three weeks duration.
5. Report writing, presentation to Advisory Committee for discussion, incorporation of changes. – first week of November 2000.
6. Report printing. – Second week of November 2000.
7. Report dissemination. – Second week of November 2000.
8. Meeting of Advisory Committee to discuss planning schedule for implement of recommendations. – Third week of November 2000.

Team Composition:

The following persons are proposed for the Assessment Team:

1. Mr. Terrance Jezowski, AVSC International, New York, Team Leader (program management, planning, and global perspective)
2. Representative from the Ministry of Health and Family Welfare. (Official GOB policy and public service delivery program)
3. Ms. Harriet Stanley, AVSC International, Bangkok (program manager and BCC specialist)
4. Dr. Martha Jacob, AVSC International, Bangkok (clinical specialist)
5. One representative from each of the Directorates of Health and Family Planning.
6. A representative from Marie Stopes Clinic Society, Bangladesh. (NGO perspective)
7. A representative from UFHP.

8. A representative from RSDP.

The following Advisory Committee will supervise the team's work and provide overall guidance:

1. Representative from the Directorate of Family Planning.
2. Representative from the Directorate General of Health Services.
3. Mr. Neil Woodruff, USAID, Dhaka.
4. Dr. A. J. Faisel, AVSC International, Bangladesh.
5. One representative from UNFPA, Dhaka.
6. Dr. Ahmed-Al Kabir, UFHP.
7. Dr. M. Alauddin, RSDP.

Expected outcome:

The findings of this assessment will provide recommendations to senior policymakers in the GOB, USAID, UNFPA and other donors for developing specific plans to improve the availability, quality and use of voluntary sterilization services in Bangladesh. USAID will consider support for implementation of an expanded voluntary sterilization service delivery program, within NIPHP. The GOB and its donors such as UNFPA and World Bank will implement improvements in national policy and the public sector service delivery program, and other NGOs will closely coordinate their efforts in the provision of services and referral of clients.

Coordination of the Assessment:

The Assessment Team will work with the PHN Office of USAID Dhaka and with the Advisory Committee. AVSC/Bangladesh will provide all logistical support to the Assessment Team.

ANNEX B
STATUS OF IMPLEMENTATION OF THE RECOMMENDATIONS OF THE PAST
THREE STERILIZATION RELATED ASSESSMENTS/STUDIES

RECOMMENDATIONS	IMPLEMENTATION STATUS AS OF 2000
Assessment of clinical contraception services in the Bangladesh Family Planning program, 1992:	
1. An in-depth, comprehensive review of family planning counseling in Bangladesh should be conducted and a long-term strategy and program should be developed and implemented to extend the availability and improve the quality of counseling.	A comprehensive counseling assessment was conducted in December 1996 jointly in collaboration with NIPORT. The assessment provided a set of recommendations, which is discussed further in this matrix. No long-term strategy or program was developed for the public sector. The NGOs acted upon many of the counseling assessment recommendations.
2. As part of the assessment the training curricula of FWVs, FWAs, nurses, doctors, and other cadres of health workers should be reviewed with respect to the existence and adequacy of the family planning counseling modules.	Strong family planning counseling modules was included in the doctors and nurses/paramedics training curricula on clinical contraception. Some changes were made in the FWV's and FWA's curricula.
3. The counseling components in service delivery manuals for the different clinical contraceptive methods should be reviewed and revised as necessary.	The revised national family planning manual contains a separate elaborate chapter on counseling.
4. Client screening in service delivery manuals should be reviewed and if necessary revised.	Client screening checklists were developed and then revised recently.
5. The availability of the basic essential instruments and supplies needed by all service sides for proper screening of clients should be determined during the Situation Analysis of the national service delivery system and deficient sites should be supplied and adequate stores of replacement instruments and supplies be maintained. District level medical supervisors and the FPCSTs should have the capacity to supply or replace basic examination equipment during on-site routine supervisory visits.	A Situation Analysis of the Clinical Contraceptive Service Delivery System was carried out in 1994. In that an in-depth review of the availability of the basic essential instruments and supplies was carried out.

RECOMMENDATIONS	IMPLEMENTATION STATUS AS OF 2000
6. There should be an immediate comprehensive assessment of infection control standards and systems affecting the delivery of clinical contraception services in Bangladesh, and the development of a long-term project to improve standards, training, supervision, equipment, and practices. This is a top-priority recommendation.	Within the purview of the Situation Analysis exercise the infection control standards and systems were reviewed. But no comprehensive assessment was carried out. Neither any long-term project to improve IP was developed.
7. The situation with respect to autoclaves (their presence, functioning, and adequacy) should be assessed during the Situation Analysis working autoclaves should be installed wherever needed.	The situation with respect to autoclaves was assessed during the Situation Analysis.
8. FPCSTs and district-level medical supervisors should provide on-site technical assistance and on-the-job training to personnel at sites where deficiencies in infection control and asepsis are noted, and FPCSTs should have the capacity to repair broken autoclaves during field visits. Consideration should be given including equipment technicians in the FPCSTs.	The FPCST Teams started to provide on-site technical assistance to personnel at sites where deficiencies in IP were noted. An equipment technician was made available to work with FPCSTs. Since June 2000 The FPCSTs have been disbanded. The FPCST responsibilities have been given to a batch of selected ADCCs.
9. Service delivery manuals and guidelines for clinical contraceptive methods should be updated, printed in both Bangla and English and distributed to all service providers as soon as possible. Over the longer term a program should be developed and implemented to review, update and redistributed manuals to all service providers on regular basis.	During 1999 – middle of 2000 the national Family Planning Manual got revised and reprinted. The revised manual is now in the process of being distributed. A long term program to update, review, revise, reprint and redistribute the FP manual has not been developed.
10. The clinical skills of doctors and FWVs should be observed and assessed during the visits of FPCSTs and district-level clinical supervisors. On-the-job or refresher course training should be arranged for service providers who need to improve their skills. FPCST team members should have the skills needed to conduct on-the-job training.	The clinical skills of doctors and FWVs are observed and assessed by the FPCSTs. On the job refresher tailor made training courses has not been developed.
11. The team endorse the stated goals under the revised FPCST project to provide refresher training to the district level assistant directors (clinical contraception) and the medical officers (clinical contraception) and to instruct them in supervision and monitoring techniques. A strategy and workplan for accomplishing this should be spelled out and implemented	Many of the ADCCs and MOCCs have received refresher training on clinical contraception. But they have hardly ever received training on facilitative supervision. No strategy or workplan for working on this issue has been ever developed separately.

RECOMMENDATIONS	IMPLEMENTATION STATUS AS OF 2000
12. Consideration should be given to a special technical assistance project to improve the clinical contraception supervisory, training and problem solving skills of the FPCST members them.	No such special training provided to the FPCSTs.
13. Every effort should be made to select well-qualified and skilled senior consultants for the FPCSTs.	GOB has been always selecting the best available person to work as FPCST according to specific set of criteria.
14. A survey should be conducted of service sites where voluntary sterilization and IUD services are supposed to be available in order to determine the exact situation with respect to the availability of service providers who are adequately trained to provide these services. This survey should be used to plan for arranging either comprehensive or refresher training on a priority basis for this backlog. The survey could be conducted as part of the Situation Analysis.	Since 1999 GOB has started a comprehensive training program for the doctors and nurses/paramedics on clinical contraception and RTI/STI at the 13 Medical College Hospitals. Before initiating the said program a training needs assessment was conducted.
15. The immediate and critical training backlog should be addressed on a priority basis through a variety of interventions including implementation of the AVSC-funded project with NIPORT to prepare a number of government service sites to offer sterilization training, and through ad hoc interventions including the organization of special short-term practical courses in service sites (government and NGOs) with relatively high caseload, and the dispatch of training teams to local sites to conduct training of local service delivery teams.	After the 1992 Assessment till middle of 1996 efforts were undertaken by NIPORT with the financial and technical assistance of AVSC International to provide training to the doctors on sterilization. After that till the middle of 2000 there had been no training of the physicians conducted.
16. The GOB should conduct a comprehensive need assessment and develop a long-term strategy and program to institutionalize clinical contraception training capacity. Donors should support this goal and technical assistance agencies should assist in the assessment and all phases of the development of the training institutions and programs. The long-term strategy and program must address developing both pre and in-service training capacity.	Efforts have been taken to institutionalize clinical contraception training at the 13 Medical Colleges. But there is no such long-term strategy to institutionalize clinical contraception training capacity.

RECOMMENDATIONS	IMPLEMENTATION STATUS AS OF 2000
17. The comprehensive need assessment of training should address the question of how to set and maintain the high quality of training courses. The needs assessment should also address how to keep strong linkages between clinical contraception training and other components of a comprehensive quality assurance program such as monitoring and supervision and the development and use of service delivery standards.	Very little attention is being given to the issue of maintaining high quality of clinical training and a strong linkage between different training programs, quality assurance program, monitoring and supervision, and the use of the service delivery standards.
18. Given the past failures, leadership must come from the highest levels of government in placing a very high national priority on pre-service family planning education and training in medical colleges. The involvement of future generations of doctors in family planning depends on their receiving adequate exposure during their medical college education.	There is almost no attention given to the pre-service family planning education and training in medical colleges.
19. NIPORT should continue its long-term project with AVSC funding to develop institutionalized in-service training capacity in several governmental service sites around the country. The comprehensive training assessment and long-term training strategy development exercise that has been recommended should review the overall design of the project.	NIPORT has no longer the role of providing clinical training to the doctors since July 1998. Now the doctors receive training on sterilization at the Medical Colleges.
20. The needs for comprehensive and refresher training of FWVs should be surveyed, possibly as part of the recommended Situation Analysis. The comprehensive assessment of training needs and the development of a long term training strategy and program should look carefully at FWV training and the linkages between FWV training and supervision. The Recommended assessment of infection control practices must consider the important role of FWVs.	The scope of work for the Situation Analysis did not include reviewing the comprehensive and refresher training needs of FWVs. But a separate skill analysis and training needs of the FWVs was conducted in 1995 jointly by NIPORT, GTZ and AVSC International.
21. The potential for introducing family planning into the pre-service training, curriculum of nurses should be assessed during the comprehensive assessment of training needs	No such assessment looking into the potentials of introducing FP into the pre-service training curriculum of nurses has ever been carried out.

RECOMMENDATIONS	IMPLEMENTATION STATUS AS OF 2000
22. The potential for introducing family planning into the pre-service curriculum of MAs should be examined during the comprehensive assessment of training needs.	No such assessment looking into the potentials of introducing FP into the pre-service training curriculum of MAs has ever been carried out.
23. The MAs role in assuring infection control should be reviewed, job descriptions rewritten to emphasize this aspect of their job, and refresher training given as needed. This may be examined during the recommended assessment of infection control practices.	The role of MAs in assuring IP has never been reviewed and no refresher training ever designed for them.
24. Strengthen coordination between the MOHFW and other relevant ministries through a central coordination committee headed by the ministry of MOHFW with the secretary, MOHFW as vice-chairman and the DG, Family Planning as member secretary.	Coordination between MOHFW and particularly with MOLGRD has been strengthened a lot.
25. Involve the top officials in the MOHFW in forging commitments and finding solutions for developing effective pre-service training in family planning for medical students attending the medical colleges.	No effective pre-service training in FP for medical students attending the medical colleges has been developed.
26. The establishment of other committees, with appropriate representations, may be considered: a committee headed by the Additional Secretary, MOHFW, to resolve policy issues between the directorates of health and family planning; a committee headed by the DC, Family Planning, to resolve national program implementation issues and committees at the district and upazila levels, headed by local public representatives, to resolve local program implementation issues.	Such suggested Committees at different levels exist.
27. Management training that is provided to top officers in health, family planning, NIPORT, and nursing should give more emphasis to the importance of coordination and integrated teamwork.	Coordination and integration are now the most important cornerstones within the current Health and Population Sector Program (HPSP).
28. To improve the morale of family planning personnel, the GOB should consider including their positions under the revenue budget in order to improve their status, job security, and career advancement opportunities.	GOB has undertaken several steps in connection with the mentioned issues within HPSP.

RECOMMENDATIONS	IMPLEMENTATION STATUS AS OF 2000
29. Unfilled positions in the medical officer ranks should be filled as soon as possible.	GOB always has a continuous effort of filling all vacant positions.
30. The MOHFW should commission a thorough management audit of its structure, personnel management and supervisory systems with the aim of clarifying roles, job descriptions, lines of supervision, and personnel performance review systems with the aim of improving responsibility and accountability within the system.	The MOHFW after a careful review of all of the mentioned aspects has undertaken the implementation of HPSP.
31. The Directorate of Family Planning should conduct a Situation Analysis of the national family planning service program in order to get an accurate picture of the current status and needs in manpower, training, facilities, equipment and supplies, IEM materials, and other essential components of service delivery. This type of information is critical for effective planning and decision-making. The Situation Analysis may be done with the assistance of local and international research organizations. One outcome would be to develop a simple system that allows directorate staff to independently conduct similar exercises from time to time in the future.	A Situation Analysis of the Clinical Contraceptive Service Delivery System in Bangladesh was undertaken in 1994. AVSC International provided financial and technical assistance in conduction of the Situation Analysis.
32. The GOB should carefully study and consider adjusting the level of compensation payments to clients in order to offset at least partially, the inflationary erosion in the value of the payments.	GOB has adjusted/increased the compensation payments to clients.
33. The GOB should consider providing a modest conveyance allowance to government field workers, and possibly to registered <i>dais</i> and NCO field workers, in order to cover the reported out-of-pocket costs of these program workers. The average out-of-pocket costs of these field workers need to be determined. These conveyance payments should be carefully tested in a few study areas before deciding on general implementation.	GOB has started paying Taka fifty per case on a flat rate as a modest conveyance allowance to field workers accompanying sterilization clients to the centers.

RECOMMENDATIONS	IMPLEMENTATION STATUS AS OF 2000
Situation Analysis of Clinical Contraceptive Service Delivery System in Bangladesh, 1994	
<p>1. All service delivery facilities (FWC, THC, MCWC, M. Clinic) should open in time. Based on the pattern of the existing client flow and timing of the arrival of the service providers, the rescheduling of office time of the FWCs needs to be considered. The suggested timing is 9:30-17:00, instead of the present timing 8:30-16:00. The problem of absenteeism of the service providers, more prominent at the higher tier SDPs, should be overcome. Thus, office orders, regarding the opening and closing time of the SDPs should be immediately issued and strict compliance with office attendance be directed to all officials providing clinical contraception services.</p>	<p>Such office orders were issued but that did not yield any change.</p>
<p>2. Re-use of disposable syringes should be stopped immediately, and used disposable syringes should be destroyed as per the officially set rules. To this end, all relevant personnel should be informed through office memo/order about the possible problems of re-using disposable syringes and the need to destroy used disposable syringes. Monitoring of this can be included as one of the additional responsibility of the FPCST and other relevant supervising officials of the Directorate of Family Planning.</p>	<p>Certain steps have been taken in this regard but due to a weak monitoring system actions are not properly implemented.</p>
<p>3. More emphasis should be given by the providers, especially at the lower SDPs, to comply with the minimum aseptic measures, such as disinfecting the injectable site, washing hand before examination, use of sterilized gloves. A two pronged strategy would be useful (a) informing the service providers regarding the necessity of compliance with the aseptic measures; and (b) making sure that the supervisors, while making their supervisory visits, emphasize on the issue.</p>	<p>Maintenance of IP steps remains to be one of the weak areas of the health and family planning service delivery system both in the public and NGO sectors.</p>

RECOMMENDATIONS	IMPLEMENTATION STATUS AS OF 2000
4. Service providers should be informed that the following technical activities should be performed in the case of all new clients for clinical methods: taking weight, measuring BP, enquiry about PV bleeding, performing PV examination etc. The higher level supervisors should monitor these.	Service providers are well informed about the certain technical steps to be performed in case of all new clients coming for clinical methods. But due to poor attitudinal problems the providers do not follow the required steps.
5. Rejected client registers, complications, and incomplete operation registers in respect of sterilization should be made available and properly maintained at all relevant SDPs. Also, the other registers supplied for both sterilization and IUD should be properly maintained at all SDPs. It is more likely that SDPs not having those registers and/or not maintaining those registers properly are less concerned about complication/management of side effects. Thus, a reporting mechanism should be established for complicated cases of clinical contraception.	Record keeping for rejections, complications and incomplete operations remains to be very poor.
6. It should be ensured that at any given point in time all the SDPs should possess autoclaves and BP machines in working condition. Thus, there should be a system of ascertaining the status of availability of working autoclave and BP machines in the SDPs as well as ensuring supplies.	There is no system of ascertaining the availability of working autoclaves and BP instruments at all SDPs.
7. Availability of the following emergency drugs and items in IUD kit at the FWC level should be ensured: Injection Narcan, Solucortef, Adrenaline, Calcium Gluconate, Phenergan, Saline, Flashlight, Forceps (hysterectomy straight), Solution cup, and sterilizer (boiling type). Also, at the THC level the availability of the following MSR items for sterilization should be ascertained: Uristicks, Folly's Catheter, Atrumatic catgut with needle, and promethazine injection.	For IUD service delivery emergency drugs are not required. For sterilization emergency drugs and instruments are available at all SDPs. Inj. Calcium Gluconate is no longer considered an emergency drug.
8. In order to ensure quality service as well as to attract clients and potential clients to the SDPs, physical facilities such as piped running water, electricity, latrines for clients, medical examination room, IUD insertion room should be improved and maintenance of privacy and cleanliness of the examination room/area should be ensured.	Maintenance/availability of the mentioned items has a wide variation at different SDPs. But overall there has been improvement of the situation through out the country on the mentioned items.

RECOMMENDATIONS	IMPLEMENTATION STATUS AS OF 2000
9. Since most of the IUD users who came with problems were the users of CT-380A, a change in the brand with lesser side effects and complications should be considered.	Already CuT-380A has been replaced by CuT-200B.
10. Further promotion of the usage of injectable contraception can be ensured by nationwide implementation of the doorstep program. In order to successfully, implement the program, training to the FWAs on doorstep injectables needs to be provided.	Usage of Injectable nationwide has been increasing very well. But the doorstep Injectable service delivery has not been expanded countrywide.
11. The IEC component of the program should be strengthened. A three-pronged strategy can be envisaged: (a) ensure higher use of the IEC materials which are already in the field, especially greater use of IEC materials with new clients; (b) organize motivational meetings with the community leaders; and (c) ensure availability of relevant posters, contraceptives on board (for display) and anatomical models at all SDPs.	IEC for clinical methods particularly sterilization and IUD is almost absent. No systematic and consistent information regarding IUD and sterilization is disseminated anywhere in the country.
12. In order to enhance the degree of informed choice of methods, the service providers, in their interactions with the new clients and potential clients, should be encouraged to discuss more about the possible side-effects and possibilities of method switching.	During the provider-client interaction discussion on the possible side effects, their consequences and method switching hardly takes place with due seriousness.
13. Service providers' training on clinical contraceptive services should be strengthened. Refresher training should be an ongoing process. Priority should be given to those not having any refresher training. Toward this end, a comprehensive training need assessment should be undertaken.	Very recently comprehensive training on sterilization has been initiated. There is no refresher training on IUD.
Bangladesh Family Planning Counseling Assessment, 1996:	
1. A definition of 'counseling' should be agreed upon. The definition should include what it hopes to achieve, and the relationship between counseling and other forms of communication like motivation and information giving.	No such definition has been developed regarding counseling.

RECOMMENDATIONS	IMPLEMENTATION STATUS AS OF 2000
2. All of the GOB job descriptions should be revised to say who is responsible for providing counseling at each level of service delivery.	Recently job descriptions have been revised but it does not reflect the counseling perspective.
3. After the policy statements have been drafted and approved, holding of series of dissemination workshops seems logical and useful.	No separate counseling policy was ever drafted and dissemination seminar planned. No such information available regarding the holding of the dissemination workshops.
4. IEC materials need to be made available for clients who have accepted a method, or are considering doing so. Currently clients whether using a method or not do not receive any written material that they can refer to once they get back home.	In some NGO clinics (very limited) IEC materials are handed out to the clients.
5. Gearing public information campaigns toward improving contraceptive image would be helpful for the overall benefit of family planning program.	No such national FP campaign has been carried out in the recent past.
6. A series of activities should be undertaken to strengthen the linkage between counseling and supervision.	No such systematic activity has ever been undertaken to formally link up counseling and supervision.
7. Information given to clients and potential clients through out the service delivery system especially but not exclusively in the GOB sector should be standardized.	Information given out to the clients is pretty consistent and standardized.
8. Additional thought should be given to the role of physicians in providing counseling services.	The role of the physicians in providing counseling services has never been clearly mentioned.
9. Perhaps the most important single activity that can be undertaken to improve counseling in Bangladesh is to improve or build an institutional skill/competency based training capacity. In this connection specific materials will have to be developed.	In the public sector no competency based training project has been set. In the NGO sector some improvement has occurred in this field.
10. A cadre of trainers for counseling training, in both public and private sectors needs to be developed.	No separate cadre of counseling Trainers has been developed either in public or private sectors.
11. The competency based new training materials/module should be integrated in all relevant existing training curricula.	No competency based training materials has been developed on counseling.
12. A methodology of contraceptive technology updates for all level of providers should be put into place.	The methodology of regular Contraceptive Technology Update at all levels has not yet been started.

ANNEX C
Tentative Schedule of Activities of the Sterilization Assessment Team

14 October to 02 November '2000

Date	Time	Activities	Responsibilities
14/10 Saturday		Arrival of the 'outside Bangladesh' Team Members.	
15/10 Sunday	09:30 a.m.	Briefing meeting with USAID.	
	11:00 p.m.	Meeting of the Assessment Team.	
16/10 Monday	10:00 a.m.	Visit to an UFHP clinic.	
	03:30 p.m.	Meeting with women leaders at AVSC International.	
17/10 Tuesday	10:00 a.m.	Visit to Marie Stopes Clinic, Elephant Road, Dhaka.	
	03:00 p.m.	Meeting with the Advisory Committee.	
18/10 Wednesday	10:00 a.m.	Visit FPAB Dhaka clinic and meet senior staff.	
	03:30 p.m.	Meet Prof. Abul Barkat (demographer, researcher and economist) and his colleagues at AVSC International.	
19/10 Thursday	09:00 a.m.	Meeting with Dr. M. Alauddin and RSDP staff.	
	11:30 a.m.	Meeting with Dr. Ahmed-Al Kabir and UFHP staff.	
	01:00 p.m.	Internal Team meeting at BCO. Team prepares for field visit.	
20/10 Friday		Departure of Groups A & B for field visits by air. Group A – Chittagong. Group B – Rajshahi. Group C – Mymensingh (Group will travel by road and leave on 21 October).	

Date		Activities	Responsibilities
<p>21/10 Saturday</p> <p>To</p> <p>25/10 Wednesday</p>		<p>Group-A: 21/10 – Visit Chittagong Medical College Model FP Clinic, visit Marie Stopes clinic, night-halt at Ctg. 22/10 – Visit UFHP Mamata clinic, Patiya Thana Health Complex, night-halt at Ctg. 23/10 – Visit Feni MCWC , meet CS, DDFP, ADCC, night halt at Comilla BARD 24/10 – Visit Comilla FPAB clinic, meet the clinic and staff of Vision 2000, night halt at Comilla BARD. 25/10 – Visit Chandina Health Complex and return by road.</p> <p>Group-B: 21/10 – Visit Rajshahi FWVTI, meet CS, DDFP, ADCC, night halt at Rajshahi. 22/10 – Visit an UFHP and a RSDP clinic at Rajshahi, night halt at Rajshahi. 23/10 – Visit Natore MCWC and the BAVS clinic, night halt at Bogra. 24/10 – Visit Thengamara Hospital, Bogra, Gabtali Thana Health Complex, and return to Dhaka by road.</p> <p>Group-C: 21/10 – Visit Mymensingh Medical College Model Clinic, meet trainees and Trainers, meet CS, DDFP, ADCC, meet BMA representatives, and night halt at Mymensingh. 22/10 – Visit FPAB Mymensingh, meeting with FPAB field workers, visit TARC Mymensingh, night halt at Mymensingh. 23/10 – Visit Kishoreganj MCWC, meeting with CS, DDFP, ADCC, night halt at Mymensingh. 24/10 – On way to Dhaka visit Trishal Thana Health Complex.</p>	

Date		Activities	Responsibilities
25/10 Wednesday	09:30 a.m. 10:00 a.m. 02:00 p.m.	Terry meets SMC senior staff. Visit BAVS Mirpur clinic (Group – C). Visit AITAM (Group – C).	
26/10 Thursday	Whole day 01:00 p.m.	Team meeting. Lunch with QIP and BCO staff.	
27/10 Friday		Team Members work on their individual assignments.	
28/10 Saturday	09:00 a.m. 09:00 a.m. 01:00 p.m.	Terry, Martha and other Team members meet Prof. A. B. Bhuiyan and OGSB representatives at Hotel Sonargaon. Harriet and selected Team members meet Director, BCCP at BCCP office. Lunch at Faisel's residence.	
29/10 Sunday	10:30 a.m. 12:30 p.m.	Meeting with Mr. Shamim Ahsan, NIPHP Policy Advisor. Meeting with the Advisory Committee.	
30/10 Monday	07:30 p.m.	Dinner at Santoor Restaurant.	
31/10 Tuesday	04:00 p.m.	Debriefing session with USAID, NIPHP partners and GOB at YWCA Auditorium.	
1/11 Wednesday		Final touches on the draft Report.	
2/11 Thursday	10:00 a.m.	Meet Director General, Directorate of Family Planning	

ANNEX D
BACKGROUND DOCUMENTS AND REFERENCES

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