

An Assessment of Permanent and Long-term Clinical Contraceptive Methods in Bangladesh

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Acronyms [fill in blanks]

ADB	Asian Development Bank
AITAM	Associates in Training and Management
BAVS	Bangladesh Association for Voluntary Sterilization
BCC	behavior change communication
BCC/M	behavior change communication and marketing
BCCP	Bangladesh Center for Communication Programs
CBPT	capacity building peer team
CHW	community health worker
CM	community mobilizer
CPR	contraceptive prevalence rate
CWFD	Concerned Women for Family Development
ELCO	eligible couple
EMER	Eyi Megh Eyi Roudra
ESP	essential services package
FPCST	family planning clinical supervision team
FWA	family welfare assistant
FWV	family welfare visitors
DGFP	Director General, Family Planning
DH	depot holder
FP	family planning
GOB	Government of Bangladesh
IPC/C	interpersonal communication/counseling
LTFP	long-term family planning method
BIRDEM	Bangladesh Institute for Research in Diabetic and Endocrine Medicine
MAQ	Maximizing Access and Quality
MCWC	maternal and child welfare center
MFST	Mohammedpur Fertility Services and Training Center
MIS	management information system
MO	monitoring officer
MOHFW	Ministry of Health and Family Welfare
MSR	medical and surgical requirements
MOU	memorandum of understanding
NGO	non-governmental organization
NIPHP	National Integrated Population and Health Program
NIPORT	National Institute for Population Research and Training
NSDP	NGO Service Delivery Program
NSV	non-scalpel vasectomy
OR	operations research
PLTM	permanent and long-term methods of contraception
P/V	per vaginal
PSTC	Population Services and Training Center
RSDP	Rural Service Delivery Program
TFR	total fertility rate
TO	technical officer
TOT	training of trainer
UHC	upazila health complex
USC	upgraded satellite clinic
VIPP	

ACKNOWLEDGEMENTS

This needs assessment was funded by the United States Agency for International Development (USAID) and Pathfinder International would like to express its gratitude to the Mission for supporting the activity all along. Special mention needs to be made of Charles Llewellyn, Team Leader, PHN, USAID/Bangladesh, and his colleagues, especially Jeannie Friedman.

Pathfinder International and its partners would also like to extend thanks to the good offices of the Directorate of Family Planning (DFP), Government of Bangladesh, with special thanks to Mr. Fazlur Rahman, Director General of FP Directorate and Dr. Jahiruddin Ahmed. Their continued guidance and support from the outset helped complete the task. The DFP was instrumental in the planning, design of tools, conduct of the study and facilitation of data collection.

NSDP is thankful to the following persons for the continued cooperation and enthusiasm extended in this regard: Abu Jamil Faisal of EngenderHealth, Yasmin Ahmed and Wahiduzzaman Chowdhury of MSI and Yasmin Khan of BCCP. Special note of thanks goes to Jestyn Portugill, then Chief of Party, for his support during the design and evolution of the study.

NSDP would also like to remember respective colleagues from the following for their valuable input and creative suggestions in the review and finalization of the study and report: Associates in Training and Management (AITAM); EngenderHealth; Bangladesh Association for Voluntary Sterilization (BAVS); Mohammadpur Fertility Services and Training Centre (MFSTC); National Institute of Population Research and Training (NIPORT); InHealth; Concerned Women for Family Development (CWFD); Institute of Child and Mother Health (ICMH); OGSB Maternity Hospital and Training Center; Population Services and Training Center (PSTC); Radda MCH-FP Centre; Lamb Hospital; and Ad-din Hospital.

Revisions and valuable inputs were subsequently provided by --- [if relevant]

Editing:

Design and layout:

Pathfinder International and NSDP acknowledge with gratitude the contribution of these and all other individuals whose efforts have helped complete this needs assessment. Their valuable time in the design, process and tools development and conduct of the study is given due recognition.

Overview

The NGO Service Delivery Program (NDSP) is a USAID-funded partnership of organizations working to improve health services in Bangladesh. NDSP was launched in 2002 as the continuation of the National Integrated Population and Health Program (NIPHP), which encompassed the Rural Service Delivery Program (RSDP) and the Urban Family Health Program in the earlier phase. NDSP provides an essential package of maternal, child, and reproductive health services through 41 local and national NGOs to a catchment population of approximately 20 million (in 4 million families). NSDP serves 1.5 million customers per month through a three-tiered service delivery structure that includes 6,213 village depot holders, 8,188 satellite clinics, and 278 static clinics. The program aims to expand the range and quality of essential services package (ESP) services provided by NGOs and increase their utilization, especially among the poor. It also works to increase the capacity of NGOs to take on a greater role as providers of ESP services nationally.

With regard to reproductive health, NDSP has a specific strategy to increase the availability of permanent

and long-term clinical contraceptive methods (PLTM) as a way of providing more contraceptive options to clients. The strategy aims to:

1. Improve referrals to Government of Bangladesh (GOB) and non-NSDP facilities that offer these services;
2. Increase the number of NSDP sites that offer these services, particularly in rural areas;
3. Expand the training and role of different provider cadres, including depot holders, community mobilizers, counselors and paramedics;
4. Strengthen the logistics system for equipment and supplies, in collaboration with the DELIVER Project and the GOB; and
5. Increase and target behavior change communication/(BCC/M) efforts.

1.1 Purpose of the assessment

The purpose of this assessment was to conduct a situational analysis of current clinic-level PLTM services to guide the development of an action plan for scaling up clinical service delivery in the NSDP. The study built upon the findings of previous assessments, including those conducted by EngenderHealth. The specific objectives were to:

- 1 Assess the potential of the existing service delivery system to increase the quality, availability, accessibility and use of permanent and long term methods of contraception, including male and female sterilization, Norplant and IUD methods of contraception;
- 2 Assess the training needs of providers and review the existing clinical standards, guidelines (including medical eligibility criteria), and training curricula available for training in PLTM, including the availability of job aids and support for providers following training;
- 3 Assess physical facilities for their readiness to supply PLTM and identify equipment and supplies needed for scaling up service delivery of PLTM; and
- 4 Examine referral linkages among hospitals, NSDP clinics, NGOs and GOB.

1.2 Methodology

The assessment was conducted by a team of professionals with relevant clinical and organizational expertise. Activities included reviewing relevant literature, including previous assessments, training curricula and national service delivery standards and guidelines, and conducting in-depth interviews with policy makers, managers, service providers, community workers and clients. The team conducted facility assessments of 39 NSDP service delivery sites; carried out an exploratory study of customers' perceptions of PLTM; and visited nine training organizations. It also made field visits to Bangladesh government (GOB), and other private or NGO service delivery sites.

NSDP sites were evaluated using a standardized assessment tool that included a) background information, b) customer volume and range of services provided, c) training status of personnel, d) observation of record keeping and treatment protocol, e) observation of rooms, equipment, and commodity storage, f) observation of infection prevention and counseling practices, g) assessment of provider clinical skills/performance, and h) observation of clinic management. The qualitative study of customers' perceptions of PLTM used in-depth interviews with both PLTM and short-term method (STM) users and focus group discussions with providers.

The initial assessment activities took place in July and August, 2002 [change dates?]. Initial results were presented to USAID in August 2002, and the final report was completed in May, 2003. The action plan for scaling up and improving the service delivery PLTM will be completed by the NSDP clinical services and field operations teams by [redacted].

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1.3 Demographic Context and Permanent and Long-term Methods in Bangladesh

The millions of couples in the world who protect themselves from unintended pregnancies follow three distinct patterns of contraceptive method choice, particularly in relation to the use of permanent and long-term methods. The dominant use of permanent methods (female sterilization to a larger extent and male sterilization to a lesser extent) is observed in several developing countries with large populations that have been successful in achieving replacement-level fertility. China, Brazil, and Mexico are examples where millions of couples have adopted permanent methods. A long-term method like the IUD is also widely used, and implants are steadily gaining popularity. No particular method is dominant in Australia, Canada, New Zealand, and the USA. Male and female sterilization, pills, and condoms are the most commonly used methods. This balanced method mix is also common in several European countries that have a very low level of fertility, mostly below replacement level.

The third group of populations, mostly in developing countries, has fertility levels that are still moderate (total fertility rate between 2.1 and 4.0). The contraceptive method mix in these countries is skewed towards temporary short- and long-term methods. Permanent method use is either low or negligible. Examples are Bangladesh, Egypt, Indonesia, Peru, South Africa, and Zimbabwe. The pill is a dominant method in Bangladesh, Zimbabwe, and Peru. Injectables and implants are dominant in Indonesia, and the IUD and pill are dominant in Egypt. India is an exception to this pattern: its fertility is moderate but the use of permanent methods, especially female sterilization, is remarkably high.

Contraceptive use in Bangladesh has risen dramatically from less than 8 percent in 1975 to 54 percent in 2000. This sustained increase in CPR contributed to a reduction in the total fertility rate (TFR) from 6.3 to 3.4 between 1971 and 1994. However, since 1993 the TFR has remained constant. At the same time, the use of long-term methods as a part of Bangladesh's overall method mix declined from a high of 44 percent in 1983 to only 15 percent in 2000, and it is still declining. Permanent method use, which represented more than 10 percent of the method mix in the late 1980s and early 1990s, has fallen to

approximately 7 percent as each year the number of permanent method users exiting reproductive age is greater than the number of new users. The current CPR of 55% is strongly composed of short-term methods, mainly pills. The use of injectables is increasing rapidly, mainly as a result of well-designed NGO service delivery programs. The IUD has never been a popular method, and its use is declining.

The shift from more reliable, long-lasting clinical family planning methods to less reliable, short-term non-clinical methods has meant that many couples who do not want more children are likely to experience unwanted pregnancies and unwanted births. The average desired family size is currently slightly over two children. Age of marriage is exceptionally low, with most women married by age 20. Thus, most women achieve their desired family size by age 25 or before. Given the current contraceptive method mix, a large proportion of women will need to take a pill every day or have a shot once every three months for 20-25 years. Over time, a woman may forget or be unable to take her pill, or may be in a circumstance in which she cannot get an injectable on time, leaving her at risk of an unintentional pregnancy. This situation, coupled with the side effects of these methods, contribute to extremely high discontinuation rates of pills, injectables, and also condoms in Bangladesh.

High contraceptive discontinuation is a cause of low CPR and thus high excess fertility resulting from unintentional conceptions. Excess fertility is in turn a cause of infant, child and maternal mortality. Abortion, due to unintentional pregnancy, is widespread in Bangladesh, and probably increasing over time because of women's increased desire for fertility control. Many abortions are performed in unhygienic conditions and are unsafe, resulting in a large toll of maternal injuries and mortality. PLTM can significantly reduce the risk of unintended pregnancies by providing couples with 20-25 years of inexpensive and convenient family planning.

The demand for contraception in Bangladesh, and for PLTM in particular, has evolved in response to many factors. When the national family planning program intensified its work in the late 1970s, poverty, illiteracy, a traditional economy, high mortality, religious conservatism and superstitions, poor health infrastructure, lack of roads and communications, and many other factors affected couples' decisions to space and limit childbearing. Couples then did not have a definite number of children that they desired. As in other subsistence economies, it can be said that the "quantity of children was more important than the quality of children". The program's challenge was to diffuse the idea of the small family. This was a foreign concept to the population, most of which was illiterate. Nevertheless, the program was backed by strong political commitment, and it gradually succeeded in bringing a change in desired family size. The early stage of Bangladesh's family planning movement focused on female and male sterilization, which had a two-fold challenge. First, providers had to convince couples that small families could be good for them and that there were acceptable ways of achieving this goal. This was a complicated task in the socio-economic and demographic environment of the time. Second, and more difficult, the program had to address fear and social stigma surrounding permanent methods. Medical surgery was rare for most Bangladeshis, and also frightening (as it probably continues to be). Undergoing surgery was a matter of personal courage. Moreover, a lack of knowledge about the physiology of reproduction and sexuality engendered myths and misconceptions about sterilization, especially male sterilization.

In spite of these challenges, the government program was effective in recruiting a large number of women and men for sterilization services. The CPR increased sharply and the contribution of permanent methods continued to rise until the mid-1980s. However, in the late 1980's service delivery approaches began to shift in a variety of ways. Family welfare agents (FWAs) and community health workers (CHWs) supplied pills and condoms to women at their doorstep and these became the most common methods provided by both national and NGO programs. In addition, sterilization activities underwent policy changes [that made the procedure safer but also more cumbersome to receive-is this accurate?]. As a result, the number of new users of permanent methods began to steadily decline.

The perceived quality of sterilization services may also have played a role in its decline. The sterilization-related fatality rate was relatively high, as was the overall mortality level, due in part to poor health infrastructure. Furthermore, the procedure can cause complications that need to be treated. A stronger follow-up mechanism was needed to manage these and build confidence in the safety of the procedure.

Overall mortality has since declined as a result of socioeconomic development and access to health care, while better and simpler procedures have led to lower sterilization-related fatalities. Improvements in the health infrastructure have increased public confidence in the health care system. However, the demand for permanent methods remains extremely low in Bangladesh. Recent BDHS reports do not show data on clients' demand for these methods. The 1993-94 BDHS indicates that fewer than 5% of women who are not currently using a method but wish to use in the future said that they would like to adopt female sterilization. No women said that their husbands would like to adopt vasectomy. This presents a challenge for permanent and long-term method promotion.

Given marital and childbearing patterns in Bangladesh, there is strong potential for the use of permanent and long-term methods to increase. Permanent methods in particular can offer significant relative advantages for couples who choose them. BCC activities at different levels and contexts can disseminate these facts to enhance the perception of permanent methods. For example, a simple calculation of the number of pills a woman has to take in her life can be an effective message for recruiting permanent-method users. Programmatically, PLTM are highly cost effective, especially in a population with low age of marriage and small desired family size. They are also simple tools for reproductive management. Setting up a high-quality family planning program in which PLTM are widely available is very possible given the current strength of the government and NGOs.

2. DEMAND FOR SERVICES

To examine the question of demand, the assessment team commissioned an exploratory study of clients' perceptions about PLTM. Eighty-four clients, both short- and long-term method users, were selected randomly from the clinic registers of twelve NSDP NGOS and interviewed using pre-tested questionnaires. Service providers' perspectives were also gathered through 12 focus group discussions.

The study builds upon the findings of an assessment of sterilization services conducted in 2000 by EngenderHealth, which found the following, in summarized form: The increased availability of other contraceptive choices had an impact on sterilization use. It is not clear that low sterilization use is a reflection of low demand for the method. There is evidence of unmet demand for sterilization and long-term methods. It is probable that many couples would opt for sterilization if services were better known and more accessible and available. Couples do not receive adequate information to make them aware of services or to support their contraceptive decision-making. Also, sterilization has an image of being the contraceptive method of the poor. There is a need to reposition it as a choice for everyone, emphasizing the personal and health advantages for everyone.

The present study explored perceptions that inhibit clients from using PLTM. It found that non-PLTM users were generally aware of the methods, but they lacked specific information to help counter rumors. Providers felt that rumors and misconceptions about side effects scare away potential IUD and Norplant users, while the fear of surgery (the procedure itself as well as the time required for recovery) scares away potential sterilization users. Problems during the early use of the IUD in Bangladesh, as well as stories about women having trouble when they wanted their Norplant implants removed fuel these rumors, according to providers.

Another factor inhibiting the use of sterilization in particular is a perception that it is somehow not socially or religiously acceptable. Sterilization users spoke of remaining silent about their choice within their communities out of concern for being stigmatized. Retaining control of their contraceptive use was also important for some clients who chose short-term methods so that they could decide when to stop without having to depend on a provider.

The major constraints/barriers to using PLTM were identified as:

- Dependency on short- and medium-term methods
- Fear and social/religious concerns
- Misconceptions about complications and side effects

However, the study also found that there was very high satisfaction among PLTM users (22 out of 24 were satisfied with the methods). Users appreciated the ease of use and the cost effectiveness of PLTM. Although providers said that it is difficult to motivate STM users to switch to PLTM without offering monetary or in-kind incentives, clients felt that the decision to use PLTM was too important to be influenced by a small amount of money. Many did feel, however, that they should receive free services or medicines after accepting a PLTM.

Overall, these findings suggest that with better information and a more accepting societal view of PLTM, demand for the methods may increase.

2.1 Behavior Change Communication for Permanent and Long Term Clinical Methods

NIPHP BCC Activities

Behavior change communication has in the past and can again play a major role in stimulating interest in PLTM. During NIPHP, a number of BCC activities relating to PLTM were undertaken for UFHP and RSDP. These were carried out as part of a broader comprehensive BCC/IEC strategy launched in 2001 to support the role of NGOs in providing the essential service package (ESP). The strategy was an integrated, multi-channel campaign that incorporated mass media, print media, outdoor media, and community based and interpersonal communication. It included a **brand campaign** that has focused on building/increasing customer/client traffic in rural and urban clinics, and a **category campaign**, which has focused on improving health practices.

The branding campaign centered around a new "Smiling Sun" logo symbolizing the warm, caring, and friendly integrated family health services provided at RSDP and UFHP clinics. It was launched nationally via press ads, three TV and radio commercials, posters, and stickers. A community and local level campaign was also conducted to promote the logo, with billboards, signboards, and badges for service providers. The category campaign targeted four health issues: child health, maternal health, family planning, and communicable diseases using outdoor media as well as community level interpersonal communication, group meetings, and loudspeaker announcements. Guidelines for providers were developed to enable them to implement the campaign at all levels. Despite being fairly new, field visits and focus group discussions undertaken for this assessment have shown the campaign (the branding part in particular) to have achieved wide publicity. People recognize the "Smiling Sun" as a symbol of quality health services, and this may be a helpful starting point for further BCC efforts specifically targeted to PLTM use.

Long-term family planning methods were promoted to reach NIPHP's first BCC objective of *Increased use of family planning methods, including spacing for newlyweds and longer-term methods for higher parity couples*. Mass media, print, outdoor, and interpersonal communication means were used. Under the health category campaign, one TV and one radio commercial were produced and aired through various channels, with the message "Visit a smiling sun clinic for LTFP." These commercials were the same for UFHP and RSDP.

UFHP in particular undertook an additional, intensive BCC/M campaign to promote LTFP. This included creating a group meeting tool bag to enable service promoters to conduct group meetings efficiently. These have been in use for three years. UFHP also produced a comprehensive flip chart for counselors and paramedics, as well as take-away brochures. It conducted a special initiative to promote NSV in 26 areas using billboards, posters, and brochures, and produced an IUD training video for service providers. RSDP also produced print materials on LTFP, including two flip charts and a take away brochure, for use by community mobilizers and depot holders.

The assessment team examined the status of PLTM BCC efforts through visits to several urban and rural clinics. It found the clinics' performance in BCC activities to be far from satisfactory. In one clinic, there were no materials on PLTM displayed. In another, there were too many posters on a variety of issues all over the walls, diluting their messages. No take away brochures could be seen in this clinic, reportedly because they were out of stock. A client interviewed there reported that he did not receive brochures. The team also observed that numerous other BCC materials were stacked on a shelf haphazardly. When asked about brochures on specific topics, a staff member was not able to retrieve them readily. The team also found many "Smiling Sun" brochures lying on a table outside the clinic under the open, drizzling sky. A TV/VCR was available for playing the spots and enter-educate drama serials, but was not being used in a planned manner. Upon our request, the operator played the EMER drama sequence, which had no relevance to methods. She also could not show the other video spots that were supposed to be in stock.

She mentioned that the clients are given options as to what they want to see and the VCR is played accordingly.

In general, clinics need step-by-step instructions on how to use and store BCC materials as well as on how to operate their TV/VCR equipment. To cut down on excess materials, a clinic's BCC material inventory should be based on the population of its catchment area and eligible couples (ELCOs).

Recommendations:

To overcome the identified social barriers and fears about PLTM, the team recommends a comprehensive BCC plan that equally targets customers and providers. The plan should develop community awareness about the methods, their advantages, disadvantages, possible side effects, and the availability of services. To help to destigmatize PLTM, satisfied users should be encouraged to share their experiences and become advocates for the methods through group meetings and other fora.

To create consistent demand for PLTM, promote them at various levels:

- 1 ***At the national level***, mass media will be used to stimulate discussion about PLTM among intended audiences. An existing TV and radio commercial will be modified and aired in the initial stage of the plan. A set of new TV and radio commercials will be produced based on findings of a KAP survey.
- 2 ***At the community level***, frontline service cadres i.e., depot holders, community mobilizers, and service promoters will be equipped with a promotional kit with general information about PLTM and suggestions on urging those interested to visit Smiling Sun clinics for more detailed information. An existing UFHP tool bag can be revised and modified for this purpose.
- 3 ***At the clinic level***, waiting times will be used to educate about and promote PLTM. This will include a poster on FP methods highlighting the advantages of each and urging clients to ask their provider for more information.

To improve the quality of PLTM services:

Enhance IPC/C skills of providers: Given the vital role of IPC/C in customer satisfaction, the team proposes extensive training for paramedics and counselors.

Give service providers tools to ensure informed choice: A comprehensive flip chart will be provided to paramedics and counselors for use during counseling sessions. After counseling, a take-away printed brochure on PLTM will be given to customers to share with a partner.

Arrange TOT on BCC for regional and clinic managers: A TOT will be provided to all regional and clinic managers so that they can implement, monitor, and evaluate BCC activities. Also, develop a tracking system for BCC personnel and their activities in the field.

Establish an informative waiting room: All the clinics have waiting rooms. These will be utilized as an information corner with the key messages on the materials conveyed in learning steps, or phases. Guidelines on how to use each BCC material/job aid will be provided to clinics.

2.2 Client Satisfaction

Client satisfaction was assessed rapidly through a small number of exit interviews of PLTM acceptors in NSDP clinics. A set of close-ended questions (Appendix E) was used to gather clients' perception of satisfaction in terms of counseling, privacy, cleanliness, procedure, respect shown, price, and time spent at the clinic. Twenty clients were interviewed in nine clinics. Results should be interpreted bearing in mind the small sample size and the known limitations of exit interviews.*

* Limitations of client exit interviews include possible overstated levels of satisfaction due to clients being polite or
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Almost all the respondents gave positive responses to the questions, suggesting that PLTM-using clients are generally satisfied with the services provided in the clinics visited. All the clients interviewed appreciated the providers' behavior towards them and described providers as caring. However, although 90 percent of respondents were informed about, and could list some advantages of their chosen method, only approximately half were informed about disadvantages. A third were not informed about side effects and more than half were not informed about potential complications. Nevertheless, 80 percent said they received enough information about the method from the provider prior to accepting it, and 90 percent were comfortable with their choice. Regarding BCC materials, NSV clients mentioned that the relevant take-away materials were not provided to them, even though the materials were available at the clinics.

The finding that PLTM users are generally satisfied with services reinforces the point that satisfied users need to be harnessed as "diplomats" for PLTM.

Recommendations:

1. As mentioned above, improve providers' IPC/C skills and their capacity to provide complete information about methods.
2. Distribute relevant take-away materials to all customers, even those who are illiterate, since neighbors and relatives can help in explaining the information.

2.3 Payment Given to Clients, Providers, and Field Workers

Bangladesh has had a system for paying providers, referral agents, facilities, and clients for PLTMs since 1975. Payments are given to providers for the work they perform in relation to each PLTM case. The facilities are reimbursed for supplies used and a small reimbursement is given to staff members in the clinic who prepare the operating theater. The referral agent who accompanies the client receives money for transportation. Male and female clients receive a *lungi* or *saree* respectively. These new pieces of clothing are meant to protect the site of the operation from infection.

In December 1997, the government developed policy guidelines for payment to family planning clients, facilities, staff, and community based volunteers such as family welfare agents (FWAs) and traditional birth attendants (TBAs) who accompany clients to the clinic. The table below shows the payments authorized in 1997 and current payments:

not wanting to jeopardize their care as well as to clients not being aware of their rights to quality care. However, factual questions, such as whether certain information was provided, may be less prone to these limitations.

Sterilization

Expenditure	Cost, Tk			
	Male VSC 1997	Female VSC 1997	Male VSC 2002	Female VSC 2002
Client, for wage loss, food allowance and transportation	Tk. 275	Tk. 275	Tk. 300	Tk.300
Transportation allowance for FWA or TTBA accompanying the client	Tk. 50	Tk. 50	Tk. 75	Tk. 75
Contingent expenses (purchase of kerosene, soap, stove wick, towel etc.) paid to the clinic for each client	Tk. 30	Tk. 30	Tk. 35	Tk. 35
Fee for operating surgeon	Tk. 20	Tk. 20	Tk. 50	Tk.50
Fee for the surgical assistant	Tk. 3	Tk. 3	Tk. 10	Tk.10
Fee for the OT in-charge	Tk. 3	Tk. 3	-	Tk. 10
Fee for the lab technician	Tk. 3	Tk. 3	-	-
Carrying stretcher, autoclaving under supervision of FWV, and overnight stay for MLSS	Tk. 1.5	Tk. 3	Tk. 5	Tk. 10
Payment to Aya for shaving, carrying suture, cleaning OT and Post-Operative room	Tk. 1.5	Tk. 3	Tk. 5	Tk.5
Payment to the sweeper	Tk. 1	Tk. 1	Tk. 5	Tk.5
Payment for the FP office assistant	Tk. 1	Tk. 1	Tk. 5	Tk.5
Total	Tk. 389	Tk. 392	Tk. 490	Tk. 505
Transportation and other expenses for recanalization	Tk. 500	Tk. 500	Tk. 1000	Tk. 1000
Recanalization fee for surgeon			Tk. 2000	Tk. 2000
Recanalization fee for surgical assistant			Tk. 500	Tk. 500
Transportation and fee for a client who wishes sterilization, but is found unsuitable to receive it	Tk. 50	Tk. 50	-	-

IUD

Expenditure	Cost, Tk 1997	Cost, Tk 2002
Transportation for the client	Tk. 15	Tk. 30
Insertion fee for service provider	Tk. 5	Tk. 25
Contingent fee for the clinic for kerosene, soap, etc.	Tk. 15	Tk. 20
Total	Tk. 35	Tk. 75
Transportation and fee for a client who wishes an IUD, but is found unsuitable to receive it	Tk. 15	-

Norplant

Expenditure	Cost, Tk 1997	Cost, Tk 2002
Transportation for the client	Tk. 50	Tk. 50
Contingent expenses for the clinic	Tk.5	Tk. 30
Transportation for the client following insertion *	Tk. 245	Tk. 100
Total	Tk. 300	Tk. 180

* In 1997 the transportation payments for Norplant were divided into 7, to be made at each follow up visit (35 Tk per visit). In 2002, payments were divided into 2, Tk. 50 for each visit.

Both the RSDP and UFHP projects used these payments to a limited degree until April, 2003, when NSDP ended all payments for PLTM procedures. Since ending the payments, there has been some evidence that clients are opting to seek PLTM services at government clinics, where payments are still available.

The use of this payment system has received strong international as well as local criticism. During

interviews and discussions carried out for this assessment the team did not find anyone supportive of the policy. Paying out the incentives is an incredible administrative burden, possibly doubling the actual cost. The payments are so low in most cases that they do not serve as an incentive, although they are welcomed by most who receive them. Clients don't want to be identified by their *lungi* or *saree* as having been sterilized, but at the same time, are open to receiving some kind of financial help, possibly with other medical costs. Surprisingly, aside from the study of perceptions of PLTM, the assessment team was unable to find research on how clients or providers view these payments.

This kind of payment system is not used in other health related areas, but it is used in the education system. Families of rural school children are given food for keeping their children in school. This program has made a major difference in the numbers of rural children remaining in school.

Recommendations:

1. Conduct research to determine both the impact of the current incentive system and how the reduction of these payments might affect the current PLTM program.
2. Work with the National Technical Committee to see whether and how the payments can be converted to benefit the quality of the PLTM program.

3. ACCESS TO SERVICES

Communities served by NSDP are relatively disadvantaged compared to non-NSDP communities. They are poorer, less educated and have less access to modern commodities. They are also more geographically remote. Despite these differences, they have nearly comparable contraceptive use rates. In 2002, NGOs in NSDP had approximately 22.9 million customer contacts in which they delivered 28.3 million units of services, including over 10 million units of family planning services.

To get a detailed view of the range and quality of services in NSDP clinics, and to determine their physical, informational, training, and commodities needs, a facility assessment of 39 NSDP clinics was carried out for this report. Sites were evaluated using a standardized assessment tool. An equal number of facilities were selected from each NSDP region. Facilities that provide the widest range of family planning services were selected because these have the highest potential to expand their method mix to include a broad mix of PLTM.

The facility assessment found that NSDP clinics are generally well-operated and -equipped to provide quality services, including PLTM. They have high customer volume--higher in urban clinics than in rural. The share of family planning services among all services provided is higher in rural clinics, however (double that of urban clinics). Following NSDP policy, all the observed clinics have at least one paramedic trained to provide IUD services. Fifty-nine percent of facilities that provide NSV and 62 percent of those that provide tubectomy have at least one trained provider to assist in those procedures. Of 35 facilities that provide Norplant, a third have a trained provider to assist.

3.1 Where Services are Provided and by Whom

Since the start of NSDP, the number of clinics providing PLTM has increased as follows:

PLTM services available at clinic level

Services	# of clinics providing services July 2002	# of clinics providing services Sept 2003	# of clinics will provide services Sept 2004
Norplant	126 (45.3%)	166 (60%)	210
NSV	79 (28%)	99 (35.6%)	125
Tubectomy	38 (13%)	48 (17.5%)	58
IUD (% of satellite clinics providing)	371 (4.6%)	507(6.4%)	707

By the end of the NSDP, the program aims to provide direct PLTM services in its clinics in the following proportions: 100% of clinics will provide at least 2 methods (IUD and Norplant); 60% of clinics will provide at least 3 methods (IUD, Norplant, NSV); and 27% of clinics will provide all 4 PLTM methods (IUD, Norplant, NSV, tubectomy).

PLTM services are available in the 144 urban and 139 rural clinics affiliated with NDSP as follows: [need updated #'s]

PLTM available by type and sector

Method	UFHP clinics	RSDP clinics	Total
IUD	143	139	282
NORPLANT	112	21	133
NSV	62	26	88
Tubectomy	45	0	45

Although PLTM are more widely available, their use by NSDP customers has declined since the program began in 2002.

Number of PLTM customers by type and quarter

Services	Jul-Sept,02	Oct-Dec,02	Jan-Mar,03	Apr-Jun,03	July-Sept,03
IUDs	5088	4372	4530	4906	
Norplant	4423	3092	3249	1893	
NSV	3312	1580	946	163	
Tubectomy	312	203	146	99	

Clinicians of different levels provide PLTM in these clinics. IUD services are provided in all urban and rural clinics by trained paramedics. Norplant and sterilization services are provided in urban clinics by medical officers (doctors) trained to provide them, with trained paramedics assisting them. In rural clinics, Norplant and sterilization services are performed in special sessions by "roving facilitators," NGO medical officers, or through collaborative effort with local GOB officials, with trained paramedics of the respective rural clinics assisting. This is because rural clinics do not have doctors or medical officers on staff. The special sessions are organized by the rural clinics.

In many NSDP sites, facilities for sterilization services are underutilized.

3.2 Static and Mobile Services

To scale up PLTM services, NDSP must consider the different needs of rural and urban areas as well as the common problem of high turnover of skilled providers. Until that problem is addressed, the best option for increasing the availability of PLTM is to deliver them through a combination of static and mobile services.

Static services: Static services include comprehensive clinics and upgraded satellite clinics. There are 278 comprehensive clinics (CCs) and 373 upgraded satellite clinics (USCs) in NSDP's network. All clinics provide components of ESP services, but the range of family planning services offered varies greatly from clinic to clinic.

Comprehensive clinics operate full time and are staffed and equipped to provide full range of ESP services and all four long-term family planning methods. They serve as referral centers for other service

sites in the network. Each NGO has at least one comprehensive clinic. Selection criteria for CCs are:

- Staffed with a full time physician, paramedic (nurse) and counselor, provide full range of ESP services
- Standard layout for offering PLTM services
- Situated in areas within the assigned municipalities/zones/ward which are demonstrably poorly served by existing facilities
- Located in the areas to fill gap in existing customer coverage and avoid duplicating services already offered by the government, private or other NGO clinics
- Must be at least one kilometer from other ESP providers
- Located in a place accessible to customers in the catchment area
- Prominent directional signage so that the customers are able to identify the clinic location easily

Upgraded satellite clinics are high performing satellite spots that have been upgraded due to high customer volume. They also operate full time and are staffed by a part-time physician and a full time paramedic. They provide ESP services, including child health, reproductive health, communicable disease, and LCC. Usually only short-term FP methods are available at these sites, but in some clinics IUD and Norplant are also provided. Selection criteria for upgrading are:

- High performing satellite spot (at least 50 contacts per session, with full community participation)
- Rental house consisting of 2-3 rooms, with at least one toilet, and running water is recommended. One waiting space, one room for MO and one room for paramedic with the facility of per vaginal (P/V) examination.

Satellite teams consist of a paramedic and a service promoter (outreach person) who provide services at least once a week at location provided by the community. Satellite teams can provide only a limited number of health services and refer customers to clinics for additional services.

Mobile Services: To provide quality PLTM services from rural clinics where there is no physician on staff, the RSDP has used roving teams, in which a group of physicians provides mobile services in a special session in each facility. The roving team concept was proposed in the 2000 assessment report on sterilization services in Bangladesh by EngenderHealth, which then collaborated with Directorate of FP on a project with USAID in which they explored the approach in two districts Jenaidaha of Khulna and Nilphamary of Rajshahi. [Was the experience/result successful?]

Roving teams are certified by the Directorate of FP and consist of a physician from RSDP or the nearest GOB and NGO facility who is trained to perform tubectomy, NSV, and Norplant. From each selected site, one paramedic is trained to assist the roving team's physician during PLTM procedures. To date, twenty-six rural clinics have been upgraded to allow NSV and Norplant services to be provided in sessions scheduled based on customer flow and demand--typically bimonthly or quarterly. The GOB ensures that NGOs provide all NSV related medical surgical requisites (MSR) and other supplies. NGOs that are near GOB facilities with direct NSV service provision, good facilities and strong referral networks, also have the opportunity to train their coordinating office Monitoring Officer (QA) on NSV

Recommendations:

1. More static services are needed to address the huge needs of urban and peri-urban populations.
2. Skilled and trained mobile service providers are the best option for reaching all but those in a few major cities.
3. Proper follow-up of PLTM customers by local NGO staff is needed to ensure mobile services are effective.

3.3 Strengthening the NSDP Referral System

Both the UFHP and the RSDP have two referral systems - **internal referral** and **external referral**. In the internal referral system, depot holders (DHs) refer customers in need of critical services to the UFHP or RSDP service delivery points (the static and satellite clinics). Both projects introduced a referral slip to be used by DHs to involve them in identifying potential users of other ESP services in addition to pills, condoms and ORS. The referral slip is filled out by the DH and includes the reason for referral.

To encourage increased referral for clinic-based ESP services, and to encourage follow-up, the RSDP introduced a system for augmenting the DH's income. DHs received 50 percent of the service charges family welfare visitors (FWVs) collected from the customers referred by the DHs. At the end of each month the Office Assistant calculated the DH's share of revenues from the referral slips. In this way, referrals that were actually completed were verified. The DH earnings ranged from 13 to 200 Taka per month.

External referrals were made to a Thana Health Complex (THC), MCWC, district hospital, private clinic, or NGO clinic. These external referrals were for contraceptive methods or other services not offered in the particular UFHP or RSDP clinic, like sterilization, Norplant insertion, safe delivery, child health complications, pregnancy complications, or the management of family planning complications.

The external referral forms used by both projects provide a list of the reason(s) for referral, the type of service needed, and the location of the nearest referral site. A few Upazilas refer NSV, Norplant and tubectomy clients to their Upazila Health Center (UHC) for services provided by the GOB. The static and satellite clinics refer customers to the district hospital, MCWC, or private clinic/hospital for safe delivery, child health complications, and pregnancy complications.

The numbers of referrals made in each project were very high. During the last year of the project, the RSDP referred 4,322 customers for injectables, IUDs, Norplant or VSC, indicating a high need for these services to be offered in static and satellite clinics. In both projects, reliable data is available on the number of referrals **made**, but not on the actual number of referral services provided. Informal feedback was given to the service site making the referral through the depot-holders. Clinics observed during this assessment did have in place a system and protocols for referral. Supervisors currently monitor the numbers of referrals made by each service site. One of the composite indicators included in the NIPHP Quality Assurance Observation Checklist is the percent of NGO sites that comply with referral protocols. The individual indicators include:

1. The list of identified ESP referral centers is available at the static clinic
2. Referral slips are available
3. Referral slips are correctly filled where indicated (i.e., for cases that need services not available at the clinic)

Many of the pieces are already in place for a strong referral system to function at the community, clinic, and hospital levels. Protocols are in place, service providers have been trained on how and when to make referrals, and there are mechanisms in place to monitor selected aspects of the referral system. However, another observation made in this assessment is that NGOs often feel discouraged and constrained in referring customers, as the referral points are sometimes not correspondingly receptive to referred clients. The team conducting this rapid assessment did not have the opportunity to determine the quality of the services provided when customers are referred or whether the network of referral sites is adequate. Some of this information will be available once the NSDP mapping exercise has been completed.

Recommendations:

1. Identify the network of referral sites during the NSDP mapping exercise.
2. Formal feedback mechanisms from referral centers need to be ensured. Create standardized referral slips that can be divided into two halves. One half will be retained by the referring facility and the other half will be given to the referral facility. The two halves will be matched monthly to track the number of referrals completed within the NSDP.
3. Emphasize the importance of referral, who should be referred and how referral should be done during ESP training for NGO providers.
4. Orient NGO facility managers and supervisors to the rationalized service-delivery approach, including which referral facilities offer each type of service and the accessibility of these services to clients.
5. Include indicators in the NIPHP to monitor services provided through referral.
6. Work with the GOB facilities to monitor referrals made to the MOH facilities.
7. Each NSDP service delivery point where PLTM services are not available or are partially available should establish an effective referral network with service sites where they are available and where referred clients are welcome.
8. Coordinate with other family planning service providers for backup support.

3.4 Policies Affecting the Provision of Family Planning Services

There are three types of barriers that limit access to contraception. There are physical barriers, which limit access, such as the distance to a facility, the unavailability of transportation or the inability of women to leave their homes to seek services. There are time-related barriers such as the hours of operation of a clinic and the services available at the time of the visit. The goal is for families to be able to avail themselves of all services in one visit. The third type of barrier is a process barrier. Process barriers are scientifically unjustifiable procedures required for receiving contraception.

Bangladesh has come very far in reducing all of the barriers which limit access to contraception. Physical and time barriers have been greatly reduced under the NIPHP. Many policy barriers have been eliminated such as the requirement for an overnight stay following minilaparotomy. However, many policy barriers remain that limit access to contraception, especially PLTM. There are limitations on which cadre of provider is allowed to provide a method and on locations where methods can be provided. Sterilization services and Norplant can only be provided by a physician. Permanent methods and Norplant can only be provided in static clinics, although special consideration has been given for upgraded satellite clinics in urban areas. IUDs can now be provided by mobile or satellite clinics.

There are other policy barriers related to eligibility to receive a method. Only married women having at least one living child may use Norplant, injectables and IUD contraceptives. For female sterilization the client must have at least 2 living children and the second living child must be at least 2 years old. This policy makes access to postpartum sterilization more difficult.

There are policy barriers expanding what is normally included in “informed consent.” Written informed consent is required for IUD use. Clients must sign a form saying that they have been informed about other methods, have been informed of the disadvantages of IUD, have not been sterilized and are willing to have someone from the MOHFW use their name and address for evaluation and possibly even visit their house. In the case of Norplant, before insertion, the client must sign a form saying she has received spousal consent.

The reporting of sterilization services may only be done in a client's own Thana. Although theoretically a NSDP July 2002

client may receive sterilization services in another Thana, in practice they cannot because they must also pay for the service in their own Thana. This policy creates a barrier for clients who want to access the best sterilization service available, even if it means traveling to another Thana.

Norplant is still considered a new method, still in a trial phase in Bangladesh. Only the Mohammedpur Fertility Service and Training Center has been approved by the government to provide training in Norplant insertion, which severely restricts the number of providers trained to provide Norplant.

Recommendation:

There is a National Technical Committee that meets regularly to discuss policy recommendations. NSDP should work closely with this National Committee to prioritize key policy changes. NSDP can share the latest, up-to-date international data and information, and can offer to do the actual technical work involved, such as developing a simplified IUD consent form.

3.5 Infrastructure, Supplies, and Equipment

Infrastructure

Nationally, most facilities of the GOB and of several NGO sectors--NSDP and non-NSDP--have adequate infrastructure to provide PLTM, including sterilization services. This includes running water and electricity/generator/IPS, space for counseling and screening, adequate operation theaters, pre- and post-operative rooms, sufficient instruments, a scrubbing area, an instrument processing area, and proper infection prevention systems. In general, NGO sites are better organized than GOB sites, especially with respect to client flow. For example, GOB sites often lack a system for maintaining client confidentiality and privacy during counseling.

The facility assessment of 39 NSDP clinics carried out for this report collected data on the quality of the clinics' physical facilities, including the waiting area and the space for services. Using a composite indicator for the category of "physical facility," the assessment found that 90 percent of the clinics scored in the top quartile. The two most common weaknesses were not having materials available for customers to take away (39 percent of observed clinics) and not having a separate instrument processing area (18 percent of observed clinics).

Supplies

Local Thana health and family planning offices supply all family planning commodities. In both urban and rural sites, IUD and Norplant supplies are adequate. To ensure smooth supply of the Norplant implant in urban clinics, beginning in April 2001, it was procured by the UFHP centrally, then distributed to all UFHP sites that provide Norplant services, based on their requisitions. There is a functioning system to provide MSR needed for the services from the local Thana office. Though this system was generally working well, in a few sites there was an inadequate supply of MSR. However, these shortages were managed locally at the site and did not adversely affect services. The facility assessment found the availability and quality of supplies in the observed clinics to be good. Among the weaknesses were not having a revolving stool in the OT (21 percent of observed clinics), not having an OT light (13 percent), not having a screen for privacy (8 percent), and not having a functioning sink in the examination room/area (5 percent).

In both urban and rural sites, there was a lack of regular on-time reimbursement of imprest funds from the GOB to the private sectors. The Imprest Fund comprises: A fixed cash flow set aside for small immediate cash outlays, which is replenished periodically in accordance with the amount expended. The GOB uses NSDP July 2002

the fund for disbursement of the payments to the providers and customers of the PLTM services (i.e. sterilization, Norplant and IUD). The fund allows for making the payment and then seeking reimbursement once the allocated amount is exhausted. NGOs other than those within the NSDP network also receive money from the Imprest Fund to cover the spot payments that have to make for PLTM users and providers.

Instruments

The availability of essential PLTM equipment varies. In general, GOB facilities have adequate equipment and often even have spare items. Most of the NGO facilities are also adequately equipped. In UFHP clinics, IUD and tubectomy instrument kits are procured by the NGOs in adequate numbers as per GOB standards. The GOB provides sufficient Norplant insertion sets with the implants, but there is a scarcity of Norplant removal sets and NSV kits.

Previously, the MFSTC provided one set of Norplant removal forceps to each trainee to take back to their clinic. But recently, MFSTC has experienced a shortage of instruments, therefore trainees are not receiving Norplant removal sets. Moreover, these sets are not available on the local market. The NGOs are also facing problems with the unavailability of NSV kits. Good quality NSV instruments are not generally available; when they are, they are very expensive. After completion of training, AITAM provides 4 sets of NSV kits and MFSTC provides only 1 set of an NSV kit to each trainee, which is not sufficient.

When a special session for sterilization is held in a clinic or when mobile teams or roving physicians provide services, it is essential to have sufficient quantities of instruments.

Recommendations:

1. Ensure uninterrupted supply of logistics by facilitating regular coordination and discussion with the local as well as central level GOB offices
2. For clinics to successfully incorporate PLTM services, existing physical facilities need to be improved, especially in the rural setup. This includes arranging for sufficient physical facility for appropriately equipped Operating Theaters, availability of relevant logistics and MSR and ensuring availability of appropriately trained and skilled personnel for providing PLTM service. At present, the rural clinics do not have adequate physical facility (Operating Theater) and trained personnel for the purpose.
3. All facilities providing NSV and Norplant need to have an uninterrupted supply of high quality NSV instruments and Norplant removal sets.

4. QUALITY OF SERVICES

The quality of PLTM services available in the NSDP will ultimately determine whether the methods become more widely used. Although NDSP has a Quality Monitoring and Supervision System, it does not provide detailed information on the range and quality of RH and FP services available at each facility. For this information, the facility assessments were used. To examine the issue of provider training, the study team visited nine training organizations to assess them in the following areas: physical infrastructure and their capacity to organize and conduct training at the level required by NSDP; quality of training, including course curriculum and training materials; management and evaluation capacity, including the capacity to follow-up the performance of trainees and provide refresher guidance as needed; potential to expand training capacity, particularly with respect to training of trainers and providing the technical support that will be needed as NSDP expands services. Course directors and senior faculty were interviewed using a standardized questionnaire. Findings are summarized below.

4.1 Training

After two clinical contraception assessments in Bangladesh identified a dearth of trained surgical teams as a reason for the decline in clinical contraception, a concerted effort was made by the GOB, NGOs and CAs to institutionalize training capacity and increase the pool of master trainers. In the 1980s, the Bangladesh Association for Voluntary Sterilization (BAVS) conducted all PLTM training both for the GOB and NGOs. Since then, the following institutions have begun to provide training in clinical contraception:

1. Associates in Training and Management (AITAM)
2. Mohammadpur Fertility Services and Training Centre (MFSTC)
3. Bangladesh Association for Voluntary Sterilization (BAVS)
4. Marie Stopes Clinic Society (MSCS)
5. Population Services and Training Center (PSTC)
6. Concerned Women for Family Development (CWFD)
7. National Institute of Population Research and Training (NIPORT)
8. 13 medical colleges[†]

In addition, several more described below have the potential to provide such training.

Government Authorized Training Centers for PLTM

Government Authorized Training Institution	IUD	Minilaparotomy	NSV	Norplant
AITAM	Yes	Yes	Yes	No
MFSTC	Yes	Yes	Yes	Yes
Medical Colleges	Yes	Yes	Yes	No
BAVS	No	Practicum	Practicum	No
PSTC	Yes	No	No	No
CWFD	Yes	No	No	No
NIPORT (FWVTI)	Yes	No **	No	No
INHEALTH				

** In the past NIPORT provided training in Minilaparotomy.

[†] Dhaka Medical College, Chittagong Medical College, Sylhet Medical College, Mymensingh Medical College, Rajshahi Medical College, Rangpur Medical College, Barishal Medical College, Comilla Medical College, Bogra Medical College, Farindpur Medical College, Dinajpur Medical College, Khulna Medical College, and Salimullah Medical College.

Training Organizations

Associates in Training and Management (AITAM)

AITAM welfare organization is the primary organization training NGOs in clinical methods of contraception, including the IUD and male and female sterilization. It was established with USAID funding in 1991 mainly to provide training in components of ESP, including family planning clinical services training (FPCST), sterilization, and TOT on sterilization. AITAM provided 100% of the training for the NIPHP, including some of the public sector training. Currently it is the only NGO accredited and approved by the GOB to provide training in sterilization.

AITAM has 5 full-time trainers and a pool of part-time trainers available, all of whom are certified as “master trainers” using criteria established by the GOB. In addition, it has 20 resource trainers who do not complete training sessions, but as physicians who are experts in the subjects being taught, share their expertise with trainees. Most AITAM trainers are physicians, but some are paramedics who provide training in counseling and in assisting the surgeon during an operation.

AITAM built its own facility, which includes a clinic with indoor and outdoor space, training rooms, a pharmacy, a small laboratory for pathological testing, and residential accommodation for trainees. Its training rooms are well equipped and its operating theater has infection prevention facilities. It also has a microbus to transport trainees. The organization uses GOB-approved training materials supplemented with other training resources. Since the customer flow in its own clinic is not sufficient for training purposes, AITAM uses 11 other clinical sites in the public sector and NGOs for this purpose. It also provides technical support in sterilization to Kumudini Hospital and TOT in sterilization to LAMB Hospital.

AITAM's system for evaluating trainees is weak, and the organization is taking steps to address this. It needs to develop a system that can evaluate the training, the trainees, and the trainers. The organization also needs to increase the number of trainers in sterilization and ensure sufficient practical cases for trainees to be confident in their skills.

The Bangladesh Association for Voluntary Sterilization (BAVS)

BAVS was organized as an NGO in 1974 and began providing services in 1975. During the 1980's it opened 34 district clinics and performed over 200,000 sterilizations per year. By 1991, BAVS had trained 101 physicians in NSV. At that time BAVS was funded by USAID and received technical support from AVSC. During the years 1992 and 1993 BAVS, AVSC and USAID had a major disagreement over the organization of BAVS as a training organization. USAID requested that 5 members of the board be removed. The board of BAVS is elected and during the next election 2 of the 5 were removed, 2 were reelected and 1 was elected president of BAVS. At that point USAID discontinued funding for BAVS and the organization effectively shut down, no longer providing services. BAVS began clinical services again, opening 16 clinics in 1996. Since 1996 BAVS has provided more and more sterilization services, although it has not expanded from the original 16 clinics. During the 2000-2001 reporting year, BAVS performed 14,000 sterilizations, which is 30% of the country total.

As a service delivery organization, BAVS provides a full range of outpatient services. It also conducts deliveries in one of its 2 Dhaka clinics. BAVS has continued to provide training for the public sector and conducts clinical practicum training for Marie Stopes Clinic Society. AITAM also sends trainees to BAVS for clinical practicum. BAVS currently receives funding from UNFPA, through the GOB to train 104 physicians, 72 in NSV only and the rest in both NSV and Minilaparotomy. It has also been given a contract to perform 20,000 sterilizations on behalf of the GOB.

Mohammadpur Fertility Services and Training Centre (MFSTC)

MFSTC was established in 1974 as an NGO. In 1989, it was absorbed into the government structure. MFSTC currently trains both NGO and GOB providers. It has 7 full-time physician trainers, 6 part-time trainers and 5 staff nurses who assist in some of the clinical practicum training. It has 3 classrooms for training and is currently adding 2 more.

Like BAVS and AITAM, MFSTC also delivers services. It provides a complete range of MCH and FP outpatient services, but does not conduct deliveries. It provides pre-natal care, but refers patients to other facilities for deliveries. The MFSTC clinics serve as referral centers for contraceptive-related complications that occur at the Thana level. Minor complications are treated at the Thana level. Only more serious complications reach MFSTC through referral.

During the 2002, MFSTC trained 324 physicians in Norplant insertion and removal, 60 physicians in Mini-lap and NSV. It also trains 6-10 providers each month in contraceptive management training (CMT) which includes other methods of contraception. MFSTC faces several problems as a training organization (note that many of these problems are faced by the other training organizations; they were just not articulated as clearly).

- It is not able to provide training follow-up for new trainees. This is done by the NGOs themselves or by district-level government staff. It has recently developed guidelines for government supervisors to provide follow-up.
- Shortage of NSV equipment. The government allows it to provide 1 set for each trainee.
- It does not have a large enough client load for clinical practicum, so it uses other sites like Marie Stopes or BAVS.
- It sends some trainees to the medical colleges for clinical practicum, but trainees complain that they do not receive mentoring or support from the physicians at these centers, who have many other responsibilities.
- Before training any new trainers, it must receive approval from the Line Director for in-service training. This is not an easy process.
- Equipment is also a problem. It is required to follow the government bidding process and to accept the lowest bid. It is not allowed to specify equipment or supplies by brand, which means the equipment and supplies are often of poor quality.

National Institute of Population Research and Training (NIPORT)

Between 1992 and 1996 NIPORT managed the public sector training program. It conducted training in selected MCWCs, MFSTC and one medical college model clinic. However, this program was weak and was terminated in 1996. One training expert interviewed felt that NIPORT remains weak because its management is in the hands of non-medical staff and that it needs stronger clinical/medical leadership.

EngenderHealth

With funding from UNFPA, EngenderHealth supports the public sector in training in clinical methods of contraception, including sterilization and management of RTIs. It provides technical assistance, curriculum development and funds for training to 13 medical colleges and MFSTC. Of the 13 medical colleges, 8 have FP model clinics.

Concerned Women for Family Development (CWFD)

CWFD has a long history of clinical activities, of which training and skill development for different cadres of health professionals have been an integral part. The organization started clinical training in 1998 after reviewing the ESP curriculum. CWFD's training center has been approved and accredited by NIPORT, the government body responsible for this accreditation..

CWFD has 5 full-time and 2 part-time trainers, as well as 7 guest lecturers on different issues. It has good facilities for providing training, including two training rooms with open spaces for group work, and a dormitory with capacity for 15-20 trainees. The training unit has an overhead projector, slide projector, television, VCR, photocopier, computer, white boards, VIPP boards, and dummies. It also maintains a training reporting and monitoring system and a mechanism for pre- and post-test training evaluation. In relation to NSDP training requirements and identified areas, CWFD has a regular training program on HIV/AIDS communication and counseling, ORH, CSI, RTI/STD, Adolescent RH. CWFD has the infrastructure and with some support, could provide PLTM training. [

In addition to training, CWFD provides ESP services through 14 clinics, some of which are in Dhaka city. When needed, it can use these sites for practical sessions. In addition, CWFD signed an MOU with the Shisu Foundation, MSCS, and the Bandhu Social Welfare Society to use their sites for clinical practicum. CWFD also has a special HIV prevention program in Mymensingh, Tangail and Dhaka City through NSDP, which is working with high-risk populations. The organization developed an RTI/STI training curriculum with support from PRIME II and organized a TOT on HIV/AIDS, which needed to be developed further.

CWFD expressed a need for TOT in TB, IMCI, PAC and EOC. The organization needs to develop a curriculum to sensitize providers to gender & sexuality issues and a tailor made 5-day course on STI geared to improving the performance of primary providers in this area.

Institute of Child and Mother Health (ICMH)

The Institute of Child & Mother Health (ICMH) was identified by the Technical Training Unit (TTU) of the Directorate General of Health Services (DGHS) as a lead training organization. Since 1993, it has organized approximately 236 batches of 34 different courses and workshops that trained 4599 participants. During 2002, it trained more than 2000 in 50 different programs. The demand for this venue is increasing rapidly.

ICMH's building has four big and four small training rooms and is centrally air conditioned. There is also a multipurpose conference with capacity for 600 participants. It also has dormitory facilities for more than 200 trainees at a time. The training complex has a practical demonstration facility with a client flow of 500 to 800 per day. There are 40 permanent trainers as well as external resource persons available for specific training needs. ICMH has an audio visual section with modern AV equipment including an overhead projector, multimedia projector, VIPP board, fax board, TV, and VCP. ICMH could be an important training venue for NSDP.

OGSB Maternity Hospital and Training Center

OGSB Maternity Hospital & Training Center has a training unit with good physical facilities for providing training and clinical services. In NIPHP, it provided safe delivery and ORH training. It has nine trainers in its training pool, six from OGSB and three from MCHTI, Azimpur. The trainers are good, confident and competent. OGSB also provides training to a GOB hospital, a Red Crescent hospital, and other organizations. It has all the necessary training equipment, including air conditioned training rooms, open space for group work for 12-15 participants, and dormitory facilities for residential training. Its safe delivery curriculum of was approved by NIPHP but not by the GOB. In its safe delivery curriculum, OGSB included the simplified version of the partograph. OGSB is ready to sign MCP and it is not doing any menstrual regulation in their training center.

Population Services and Training Center (PSTC)

This organization has a long history of clinical activities, including training. Its training activities encompass skill development for its own workers, as well as providing training to different cadres of health professional of different organizations. PSTC has good facilities for providing training, including

training rooms with open space for group work, a dormitory with capacity for 22, enabling it to offer in-house training. The training unit has an overhead projector, slide projector, television, VCR, photocopier, computer, white board, and VIPB boards. It doesn't have a multimedia projector.

PSTC provides ESP services in its clinics and can use these sites for practical sessions. It also has access to other clinics for this purpose. It has five full time trainers, 17 resource persons and 15 guest speakers in its training pool. All are experts in different areas with very good experience. In relation to NSDP training requirements PSTC has a regular training program. As a partner organization of PRIME, it was responsible for conducting training activities for NIPHP. PSTC has accreditation for CMT and ORH training. PSTC expressed interest in providing sterilization training, but will need accreditation from GOB to do so.

Radda MCH-FP Centre

Radda MCH-FP Centre has good facilities for providing training, including a training room with open space for group work and dormitory facilities for 20-25 people that enables it to offer in-house training. The training unit has an overhead projector, slide projector, television, VCR, photocopier, computer, and white board. It has the potential to organize training on CSI and ORH. It does not have accreditation for IUD training and as such cannot offer CMT. For clinical practicum, Radda uses its own clinics. It also has access to other clinics. Client flow in its clinics are as high as 500/day, half of which are infant and child health patients.

Radda has 12 trainers and 15 other trainers listed in their training pool. It expressed a need for TOT on RTI/STI, TB, IMCI, PAC and EOC. After receiving this TOT, it could provide training to others in these areas. Radda needs to improve its reporting system.

Lamb Hospital

Lamb Hospital has a well-equipped training center consisting of two training rooms, a resource room, a 100-seat classroom, and two 20-seat classrooms. It has a 40-bed dormitory facility and full- and part- time trainers, who are very effective. Three of its trainers received TOT in SD, and two received training in NSV.

The hospital has 50,000 outpatients, 2200-2500 normal delivery, 350-400 C/S and 250-300 postabortion cases per year. Lamb performs NSV and tubectomy, including postpartum tubectomy, and provides training in safe delivery, with first aid EOC for trained TBAs, community health workers and doctors. It provides IMCI as a part of ESP services. The hospital has also different courses including TOT, EOC short course, courses for GOB physicians, basic clinical training and training for community physicians. It uses different training modules from various organizations, but produced its own Village Health Volunteer curricula. It also has its own pictorial card and other pictorial BCC material on sanitation and other topics.

Training for safe delivery, PLTM, and PAC can be organized in the hospital, and it has a higher delivery, sterilization, and PAC client flow than other facilities. The hospital is in the process of getting approval from the GOB to provide sterilization training. Lamb was not included in the previous NIPHP program. Building the capacity of this hospital for the provision of quality training would open up new possibilities. NSDP is planning to diversify training outside Dhaka and Lamb Hospital could be considered for that.

Ad-din Hospital

Ad-din hospital has 206 beds, with another 100 under construction. It has outdoor, indoor, diagnostic, nutrition and referral services. It also has a training cell, ambulance service, pharmacy, and emergency services. It has a staff of 266 and a very high client flow. Because it receives referrals from all of Dhaka City and other parts of the country, it has more caesarian section patients than normal delivery patients. It has at least 6-10 delivery patients per day.

The hospital has many specialists but it doesn't have TOT for conducting training. This organization could be developed as one of the NSDP training institutes. It has a hospital and training facilities in Jessore, which can be used for training outside Dhaka.

InHealth

InHealth has two regional offices in Rangpur and Mymensingh (which will move to Jamalpur very soon) and works in five districts--Sherpur, Jamalpur, Lalmonirhat, Gaibandha and Kurigram. It has training programs in community support systems, infection prevention, and sterilization. InHealth is a sister organization of MSCS and can utilize MSCS's 44 clinical facilities for practical demonstration. Half of these clinics are in Dhaka and half are outside.

Some experts from MSCS with lot of experience in training may be involved in the training activities of InHealth. The team was informed that InHealth provides sterilization training in collaboration with EngenderHealth. It has its own trainers but initially trainers from MSCS provided them with technical assistance and back up support. InHealth could potentially be another new training organization for NSDP subject to developing its capacity to fulfill the requirements of NSDP training needs.

Method Training

IUD

Paramedics are certified to perform IUD insertions and removals after taking the basic family planning course, Family Planning Clinical Services Training (FPCST), formerly known as Contraceptive Management Training (CMT), which was the first training offered to them under NIPHP. EngenderHealth (EH) organized and assisted in this training initially, and PRIME/INTRAH began to provide technical assistance for it in September 2000. EH also supported AITAM in conducting all of the FPCS training, though two other training institutions used by the NIPHP are also recognized by the GOB: Population Services and Training Center (PSTC) and Concerned Women for Family Development (CWFD). PSTC provides FPCS training to ADB-funded clinic staff.

Norplant

Mohmedpur Fertility Services Training Center (MFSTC) only training center offering training in Norplant nationally to both the NGO and government sectors. It is also the GOB training center for all the long-term methods in Dhaka. The center offers all FP methods and also manages complications referred from a wide geographical area. It does not conduct deliveries but has infertility and laboratory services. All methods except condoms are provided free of cost.

The center has a 5-day training for Norplant. NGOs pay for the training while it is free for the GOB. Four trainers from the center received TOT from Indonesia.

Sterilization

MFSTC and 12 medical colleges offer a 21-day training called "Strengthening Clinical Contraception and RTI/STI Management." The course is funded by UNFPA technical support is provided by EngenderHealth. A curriculum has been developed and trainers trained to conduct this course.

MFSTC and BAVS have also recently received World Bank funding for services in the NGO sector and INHEALTH has applied for certification for training in PLTM from the GOB and is awaiting a response.

AITAM, with assistance from EngenderHealth, has been conducting an 18-day training in Tubectomy and NSV for NGOs, using the government curriculum. All UFHP service providers received this training. It has only 2-3 permanent staff that can provide training in sterilization, but for each course it has a pool of

resource persons and trainers. AITAM has an MOU with MFSTC, MSCS, BAVS service delivery sites to provide practical training, as they do not have sufficient clients. Master trainers have been trained from other service delivery institutions such as Lamb Hospital, FPAB, Shimantik (Community Health Action Program).

Training Accomplishments and Needs of UFHP and RSDP [date]

Method	TRAINED			TO BE TRAINED		
	UFHP	RSDP	TOTAL	UFHP	RSDP	TOTAL
IUD	144	139	283	0	0	0
NOR	74	21	76	38	137	175
NSV	50	26	70	62	119	181
TUB	43	0	43	69	139	208

Issues Involved in Expanding Training

Training Requirements for PLTM: The GOB has set clinical requirements for certification in PLTM. The following table illustrates the requirements by method. In addition to the practical requirements the GOB has also set the number of hours of theory required. The comprehensive VSC training is 21 days, which includes 54 hours of theory and 66 hours of practicum (total 120 hours). The 8-day NSV training includes 21 hours of theory and 27 hours of practicum (total 48 hours). The 12-day tubectomy training includes 33 hours of theory and 39 hours of practicum (total 72 hours). In addition to these GOB requirements, some courses have set additional numbers of required procedures, while others have required that the trainee be judged “competent” performing each procedure before certification is given.

Clinical Requirements for Trainee Certification

Method	Number of Times Trainee Must Observe a Procedure	Number of Times Trainee Must Assist in a Procedure	Number of Times Trainee Must Satisfactorily Perform a Procedure
IUD	10	10	10
Norplant Insertion	5	5	5
Norplant Removal	5	5	5
Tubectomy	10	10	10
NSV	5	5	5

Caseload for Clinical Practicum: The biggest issue identified by every training organization is ensuring an adequate client load during the clinical practicum. Clinical practicum sites used by training organizations are not necessarily designed as practicum sites and trainers often have to “make do” with whatever is available at the site.

Follow-up of Trainees: None of the training organizations visited had an efficient system for follow-up. In most cases, training organizations relied on the government Family Planning Clinical Supervision Team (FPCST) to provide training follow-up. Ideally trainers should follow-up the trainees they have trained. If this cannot be done, a more formal link between the trainee and FPCST must be made. FPCST must receive information for each trainee, on both his or her weaknesses and strengths. Trainees must be linked to the FPCST immediately following training. Trainees who aren’t supported often never provide the services they were trained to provide, especially in the area of PLTM.

Number of Trained Trainers: There are few trained trainers in Bangladesh, and of the ones identified as trainers it is not clear what actual training or certification they have received. It seems that many are identified as trainers because they are providing training, not because of their certification as trainers.

Equipment: NSV equipment is very expensive. AITAM provides 4 sets of NSV equipment for each trainee to take back to their clinic. MFSTC is only able to provide 1 per trainee. When mobile teams or roving physicians provide PLTM services, days are organized for each method. Many sets of equipment are used on these days.

Anatomical models are necessary for clinical training. Trainees must be proficient at performing a procedure on an anatomical model before performing the procedure on a patient. AITAM has several Zoe models, MFSTC has none. Every organization providing training in PLTM needs a Zoe model for practicing mini-lap (these can also be used for IUD insertion), a special male model for NSV and a Norplant training arm.

Recommendations:

1. Maximally utilize all training organizations while planning for the expansion of training. Mentor the FPCST in PSTC and help standardize and improve the quality of the practical training site.
2. Standardize all practical training sites and master trainers. (Some resource persons who are not trainers are used in the training courses.)
3. Develop an adequate mechanism for training follow-up, including comprehensive guidelines for training follow-up. Review the guidelines developed by MFSTC for government supervisors providing training follow-up, to see if these might be suitable.
4. Visit the Medical College training sites and Lamb Hospital to assess suitability as decentralized training sites for training.
5. Visit InHealth to assess suitability as a training organization and also find out about the process for application for government approval for training in PLTM.

4.2 Clinical Standards and Guidelines

According to the Maximizing Access and Quality (MAQ) initiative of USAID and its collaborating agency partners, family planning/reproductive health service protocols and guidelines ideally include information on informed choice, privacy and confidentiality, counseling, infection prevention, technical competence, appropriate eligibility criteria, follow-up protocols and removal of inappropriate barriers. Service protocols and guidelines should be in accordance with current accepted international norms for service delivery. Service protocols and guidelines should be developed through a participatory process involving stakeholders such as policy-makers, supervisors, service providers and international partner organizations.

Following the development of service protocols, a systematic strategy for dissemination and implementing them should be developed. Organizations involved in service delivery should make sure that service providers are trained in the use of the guidelines and that these guidelines are available at the clinic level. It is also the responsibility of service delivery organizations and the public sector to assure that the resources necessary to put guidelines into practice are available. These include necessary equipment, supplies, and contraceptives.

The previous government standards and guidelines were developed in 1992. Various circulars were added throughout the years.

The Ministry of Health and Family Welfare convened a Family Planning Manual Review Committee in 2001. The Quality Improvement Partnership and EngenderHealth supported the development of national standards and guidelines and the reviewers represented numerous partner organizations. The manual was written for service providers and covers each contraceptive method as well as counseling and infection prevention. It contains a section on emergency contraception management as well as a very detailed

section on non-scalpel vasectomy (NSV). The manual includes some of the most recent government policy changes related to contraception, as well as the latest WHO guidelines on medical eligibility for contraceptive use. It also includes the latest additions in the field of contraception, the female condom, the Lactational Amenorrhea Method (LAM) and the use of emergency contraceptive pills.

The national standards and guidelines are referred to as the Family Planning Manual and should be available in every RSDP and UFHP facility. The presence of this manual is monitored through the use of the NIPHP Quality Assurance (QA) Observation Checklist. Although this checklist monitors the presence of the manual, it does not measure the actual use of the manual. RSDP technical staff report that although the manual is present in every clinic, it is not well utilized. Clinic staff often ask for information already contained in the manual when beginning the process of expanding to new methods.

Recommendations:

1. Increase the use of the Family Planning Manual by making it more user-friendly, including adding job aids and checklists, and provide on-the-job training to clinic staff on its use.
2. Disseminate specific simplified PLTM standards to NGOs.
3. Use the manual to scale up PLTM use.
4. Continue to support dissemination of the manual.
5. Any training material, job aids, or checklists developed under NSDP should be developed in accordance with this manual.
6. New information such as the revisions currently being made to the WHO Eligibility Criteria should be disseminated through the GOB MOHFW policy circulars. NSDP will be responsible for disseminating to all the clinics under the project.

4.3 Monitoring and Supervision

[This section does not seem to relate directly to PLTM, but rather to monitoring and supervision of NSDP in general. It should be made more pertinent to PLTM or deleted. Also, the recommendations are too long.] I agree that this section should be deleted. It just does not fit into the story-board, even if we slash it and tailor it.

Effective supervision and monitoring is a key to success for any program. NSDP will establish eight Regional Offices to ensure maximum technical assistance to its supported NGOs and Upazilas in order to help them improve their capability in scaling up long term FP services in phases. On the top of that, it has different poles of expertise to ensure the quality of services. Now, each Regional Office has a professional with management and technical expertise. NSDP will provide PLTM services from all sites of 24 urban and 18 rural NGOs.

Monitoring will provide a picture of what is going on in the planned program. The provision of TA begins where monitoring ends. NSDP monitors the supervisory activities of NGO Managers/Monitoring Officers. Progress has been made because monitoring skills have been transferred to NGO staff at NGO headquarters and field.

The NGO headquarters and their field level staff will receive TA. The route of TA will not be straightforward and direct, neither is the sequence. In cases when NGOs have field and headquarters offices located in the same geographic region, the Regional Office will occasionally provide TA simultaneously to the NGO headquarters and field staff, but in most cases, it will be provided directly to the field staff. In such cases, coordination among Regional Office, NGO headquarters and field becomes easier. In cases when NGOs have headquarters offices in Dhaka, NSDP headquarters will provide TA directly to the NGO headquarters staff. Coordination with the Regional Office and the field staff

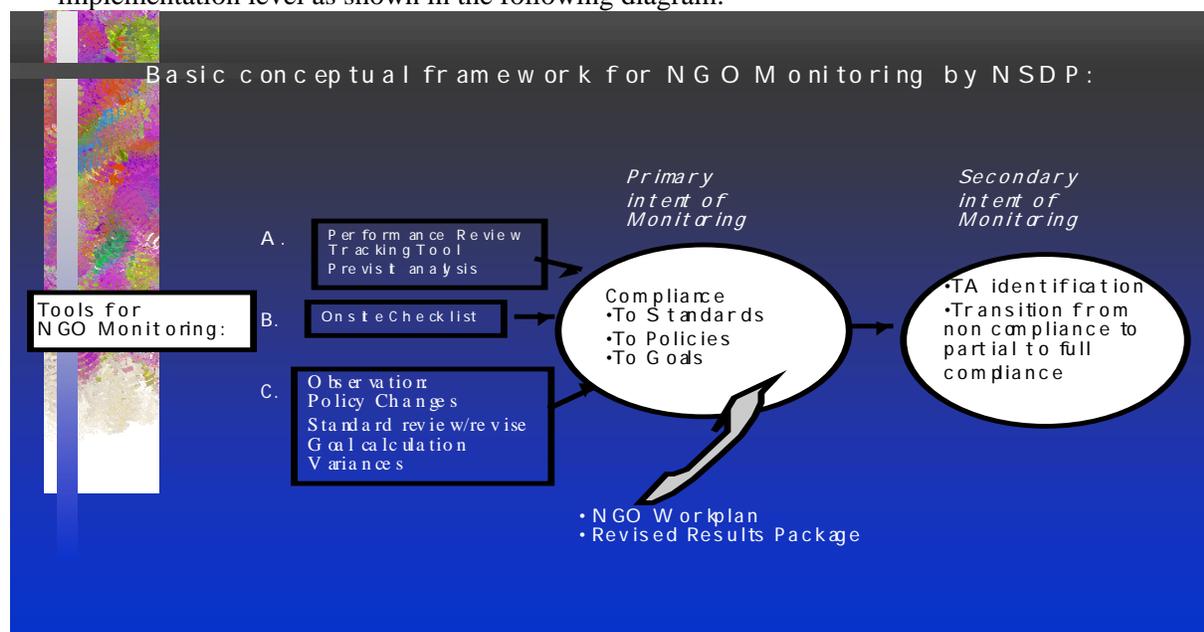
sometimes becomes a problem in these cases. Similarly, coordination between Regional Office and the Dhaka-based NGOs can become difficult.

Recommendations:

- 1 NSDP needs to develop a routine monitoring and supervision system that spreads responsibility for performance review across all levels of program implementation. NSDP can take lessons from NIPHP program where we have undertaken a process to gradually move the majority of the routine supervision and monitoring responsibilities from the Dhaka NSDP office, through the Regional Offices and NGOs, into the hands of the individual service delivery sites at the upazila level. So, under NSDP monitoring activities will be developed and conducted more by the NGOs than ever before, with technical assistance provided by NSDP and the Regional Office as needed.

- 2 In NSDP, monitoring and technical assistance needs to be worked in a cyclical process. The Technical Officers will begin with an assessment/review of implementation status of different tasks, as per the workplan and the progress made/achieved as of date. Without direct involvement in the project implementation, the regional office persons help improve the capability of NGOs and project sites in delivering ESP. To introduce the new service delivery system in the NSDP needs to set and develop step-by-step Monitoring strategies. Thus, NSDP will develop a routine monitoring and supervision system that will spread responsibility for performance review across all levels of program implementation. Initially, NSDP will be undertaken a process to gradually move the majority of the routine supervision and monitoring responsibilities from the Dhaka NSDP office, through the Regional Offices and NGOs, into the hands of the individual service delivery sites. Then, the NGOs will conduct monitoring activities more than ever before, with technical assistance provided by NSDP and the Regional Office as needed.

- 3 Considering the diversity of the program, NSDP should develop a step-by-step supervision strategy in which NSDP first receives TA from partners, then makes appropriate adaptation for NSDP and then transmit them to the NGO recipients, both at the NGO headquarters and NGO field implementation level as shown in the following diagram:



- 4 Monitoring and supervision activities need to be conducted on a regular basis by field staff, with extra emphasis placed on follow-up visits to sites with special needs. Monitoring visits will be planned based on the need – the lower performing sites get the highest priority in receiving monitoring visits, and more frequently than the higher performing sites. This system helps to assure that concerns are identified and addressed over time. For targeted TA and monitoring, especially for the low performing sites, NSDP regularly analyses the number of customers served at static. Monitoring visits in general cover issues such as quality, MIS, finance and administration, and other areas in need of assistance.
- 5 There should be a comprehensive set of monitoring tools to monitor quality and BCC activities under NSDP. With the exception of BCC tools specially developed by BCCP, all tools are being used by NGOs to monitor their activities at the field levels. Besides the above-mentioned tools, there will be self-monitoring tools that will be used by the NGO at their sites for decision making.

4.4 Client-Provider Interaction and Counseling

The importance of the interaction between provider and client in attempting to raise awareness of PLTM cannot be underestimated. A client may receive information--including BCC messages--about PLTM from many sources, but it is in the presence of the provider that the client will ultimately choose a method. Given the misinformation and social stigma surrounding PLTM, providers have to take an active role in educating clients, while making sure to answer their concerns. The exploratory study of client perceptions of PLTM found that a barrier to choosing PLTM is relinquishing control over one's method to a provider. This and other identified concerns should be addressed in counseling sessions.

The facility assessment carried out for this report examined client-provider interaction and counseling in 39 NSDP clinics. Overall results were good, even though it was one of the weaker areas of performance. Among the weaknesses were the provider not using visual aids (26 percent of clinics), not encouraging the customer to ask questions (26 percent), not learning the customer's opinion about a method being discussed (26 percent), not explaining the range of methods offered in the facility (17 percent), not asking if the customer has a preferred method (17 percent), and not providing key information on the method chosen by the client (14 percent).

Recommendations:

4.5 Infection Prevention

The strict adherence to effective infection prevention practices is essential for the provision of all permanent and long-term methods of contraception. Infection prevention standards and protocols must be strictly adhered to in the preparation of equipment and the operating theater, during the procedure and in the processing of instruments, gloves and linen. Safe waste disposal practices must be implemented for the disposal of sharp items like needles and surgical blades and for medical waste.

The Facility Assessment Tool used in this rapid assessment of PLMT includes indicators of decontamination, the cleaning of instruments, high level disinfection, sterilization, hand washing, barriers, the use of antiseptic solutions, the handling of specimens, infection prevention procedures used in the operating room, and the disposal of sharps and medical waste. The assessment found infection prevention practices and capacity in the 39 observed NSDP clinics to be generally good, but also identified some weaknesses. These include: not wiping down the examination with chlorine between clients (36 percent) not labelling buckets and solutions (31 percent), not washing hands between customers (23 percent), and incorrectly sterilizing instruments (21 percent). The NIPHP Quality Assurance (QA) Observation

Checklist has 26 separate indicators for infection prevention.

Infection prevention received a strong focus during the RSDP and UFHP projects. Training materials were developed, appropriate equipment and supplies were brought in, training was provided and infection prevention practices were systematically improved, monitored, and evaluated. This careful attention has paid off in both urban and rural clinics. Assessment team members, both those with experience in Bangladesh and those with international experience in improving infection prevention practices, were impressed with what they saw. Infection prevention standards were available in each clinic and strictly followed. Each staff member interviewed was able to explain the procedure correctly and in most cases, understood why the procedure needed to be performed in a certain way. The appropriate equipment has been provided and sufficient supplies of items like chlorine powder, Savlon, soap, and latex gloves are available. One key element in the improvement process is that supervisors and clinic managers have been trained in infection prevention. This training of supervisors and clinic managers is an essential, but often forgotten element in the process.

Visits to more clinics at different levels will be needed, but it is clear that the current system for improving infection prevention practices can work. This process of improvement should continue to be strengthened under the new project.

Recommendations:

1. The appropriate infection prevention procedures must be in place for each PLTM added to a facility's method mix, **before** the new method is added.
2. Continue training, using the current training curriculum and skills checklists for infection prevention, but develop infection prevention job aids to support the training efforts.
3. Continue monitoring infection prevention practices using the NIPHP Quality Assurance (QA) Observation Checklist.
4. Ensure that adequate equipment and supplies continue to be available as the number of sites offering PLTM expands.
5. Ensure that as PLTM training expands to different provider cadres that training in infection prevention is included.

4.6 Surgical Complications and Deaths

Sterilization related mortality has decreased dramatically over the years from 5.77 per 100,000 in 1982 to 1.68 per 100,000 in 1999 according to information provided by the Directorate of Family Planning, MOHFW. Of the 118 sterilization-related deaths that occurred in Bangladesh between 1982 and 1992, 62 of these were caused by tetanus. Tetanus toxoid immunization, small surgical incisions, bandaging of the incision, careful client instructions, and better infection prevention practices have eliminated tetanus-related deaths. The few deaths that now occur can be attributed to infection or bleeding, or in the case of female sterilization, to unintended injury to internal organs or depressed respiration or blood pressure due to anesthesia.

Sterilization Related Mortality in Bangladesh 1990 – 2002

Year	Vasectomy Procedures Performed	Tubectomy Procedures Performed	Vasectomy Related Deaths	Tubectomy Related Deaths	Total Sterilization Deaths	Sterilization Deaths per 100,000 Procedures
1990	67,372	122,780	0	12	12	6.3
1991	74,525	95,606	0	10	10	5.8
1992	54,175	75,505	0	3	3	2.2
1993	41,259	69,727	0	3	3	2.7
1994	34,566	56,318	0	3	3	3.2
1995	10,809	48,222	0	3	3	5.6
1996	7,981	37,024	0	1	1	2.2
1997	9,858	47,282	0	0	0	0
1998	16,981	51,258	0	2	2	2.9
1999	17,700	41,671	0	1	1	1.7
2000						
2001						
2002						

Source: MOHFW: Directorate of Family Planning

When a sterilization related death occurs, the Medical Officer responsible for conducting the surgery is required to immediately inform the Deputy Director, Family Planning, who in turn, is required to notify the Director of MCH services within 24 hours. Within 48 hours the District Technical Committee, whose members include the Civil Surgeon, Deputy Director of Family Planning; the Project Director BAVS; the Principal from the Family Welfare Visitors' Training Center and MOCC, investigate the death. They are required to submit a report of their investigation to the Director of MCH services within 72 hours of the death. Failure to complete any of these steps within the allotted time results in disciplinary action taken against the Deputy Director.

In case of a family planning related death, the District Technical Committee authorized the concerned Medical Officer to make a spot payment of Tk. 5,000 to the husband or wife of the deceased. Staff at every facility is responsible for maintaining a register of complications. However, these registers are rarely filled in. NGO staffs are fearful of reporting complications and side effects to the GOB. They are afraid they will be punished or the facility closed in case of a severe complication. So, few side effects are reported. During client exit interviews, the assessment team found that although client counseling had included most aspects of good counseling, it had not included information about side effects, how to recognize complications, or where to go in case a complication occurred.

Although sterilization is only provided to couples with at least 2 living children, there have been situations in which one or both of these children have died, leaving the couple childless or with only one living child. In 1999, the government approved a program for recanalization for both male and female sterilized clients who have lost children. Vasectomy recanalization is offered at MFSTC. Female tube recanalization is offered at Bangabandhu Shaikh Mujib Medical University, BIRDEM Hospital, MFSTC, The Institute of Mother and Child Health and the Sher-e-Bangla Medical. All of the facilities are located in Dhaka, except the last, which is located in Barisal.

Complications related to the use of long term and permanent methods do occur. They are rare, but as the numbers of clients receiving PLTMs increases, so will the number of complications. In order to keep the rate of complications low and have those complications that do occur treated quickly and expertly, the following recommendations should be considered:

Recommendations:

1. Counseling training for PLTM conducted under the NSDP project should emphasize counseling on side effects, the recognition of complications, and where to seek care if complications occur.
2. Clinic managers and supervisors should be oriented on the proper use of complication registers.
3. NSDP should work with the GOB to develop policies that support the reporting and treating of complications, making NGOs partners in the effort.
4. Competency-based training on the provision of PLTM should include management of side effects and complications.

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Appendix A: Service Statistics

Year	URBAN					RURAL					NSDP				
	IUD	Norplant	Vasectomy	Tubectomy	TOTAL	IUD	Norplant	Vasectomy	Tubectomy	TOTAL	IUD	Norplant	Vasectomy	Tubectomy	TOTAL
2001	9,727	15,389	6,272	1,528	32,916	10,876	474	631	26	12,007	20,603	15,863	6,903	1,554	44,923
2002	8,878	17,812	7,411	1,548	35,649	11,397	2,034	999	27	14,457	20,275	19,846	8,410	1,575	50,106
2003	7,553	6,665	905	432	15,555	11,471	1,651	478	19	13,619	19,024	8,316	1,383	451	29,174
2004	6,622	9,771	727	514	17,634	10,870	2,333	411	43	13,657	17,492	12,104	1,138	557	31,291

Appendix B: Equipment Requirements by Service

List of necessary MSR for 100 IUD Cases

SI No	Name of articles	Unit	Need for 100 cases	Need for 15% complications
1	Absorbent Cotton (100 gm. Packet)	Packet	20	5
2	Chlorohexidine Gluconate Cetrimide Solution (1 liter bottle)	Bottle	5	1
3	Tab Paracetamol (500 mg.)	Tablet	(for 20 cases) 200	150
4	Iron Tab. with folic acid (Ferrous fumerate 200 mg + folic acid BP 0.20 mg.)	Tablet	6000	
5	Cap. Doxycycline (100 mg.)	Capsule	0	210
6	Tab. Ibuprofen, 400 mg.	Tablet	(For 80 cases) 480	90
7	Rubber Gloves 6.5" (sterile)	Pair	100	15

List of necessary MSR for 100 (One Hundred) women Norplant Insertion or Removal

SI No	Name Items	Measurement	Required for 100 cases
1	Inj. Xylocaine (1% lignocaine hydrochloride USP) 50 ml. Bottle	Bottle	15
2	Surgical Blade	Pcs	100
3	Disposable Syringe (5 c.c)	Pcs	100
4	Gouge than (20 yards)	Than	1
5	Absorbent cotton (100 gm. packet)	Packet	5
6	Elastomeric Matrix Dressing (2"X4")	Pcs	110
7	Rubber gloves 7" (starial)	Pair	110
8	Uristix	Pcs	100
9	Chlorohexidine Gluconate Cetrimide Solution (1 liter)	Bottle	5
10	Povidon Iodine Solution, 100 ml.	Bottle	10
11	Tab. Paracetamol , 500 mg.	Tablet	1000
12	U – Forceps	Set	4 per center

List of necessary MSR for 100 (Hundred) Tubectomy Cases

SL No	Name of Items	Unit	Required for 100 cases	Required for 15% follow-up complications
	Medicines			
1	Inj. Atropine Sulphate, 0.6 mg	Ampoule	110	-
2	Inj. Promethazine Hydrochloride 12.5 mg	Ampoule	110	-
3	Inj. Pethidine Hydrochloride BP, 25 mg Pentazocine 30 mg.	Ampoule	110	-
4	Inj. Xylocaine (1%) Lignocaine Hydrochloride USP 1%, 50 ml.	Vial	50	-
5	Cap. Amoxyciline Trihydrate BP 500 mg. strip/blister	Capsule		315
6	Tab. Diazepam (5 mg.) strip/blister	Tablet	250	-
7	Tab. Paracetamol 500 mg. strip/blister	Tablet	1,000	150
8	Iron Tab. with Folic Acid (Ferrous Fumerate 200 mg + Folic Acid BP 0.20 mg)	Tablet	2,200	-
	Surgical items			
9	Absorbent Cotton (100 mg.)	Roll	25	10
10	Catgut Sterilized (Serial 1-0) 1x60" (152 cm.)	Pcs	110	-
11	Chlorohexidine Gluconate Solution BP 7.5% W/V + Cetrimide BP Solution 15% W/V (Hospital Concentration), 1 liter	Jar	5	1
12	Cutting Curved Needle	Pcs	10	-
13	Cutting Straight Needle	Pcs	5	-
14	Curved round body Needle	Pcs	10	1
15	Gauge 20 yards	Roll	5	1
16	Surgical Gloves (Surgeon, Latex Rubber, sterile, disposable, size -6.5"	Pair	100	15
17	Surgical Gloves (Surgeon, Latex rubber, sterile, disposable, size -7"	pair	100	15
18	Gloves Powder	Kg	1	-
19	Disposable Syringe (Sterile) , 10 c.c, with Needle in blister packet	Pcs	110	-
20	Disposable Syringe (Sterile) , 5 c.c, Needle with blister in packet	Pcs	110	-
21	Povidon Iodine Solution, 1 Liter	Bottle	8	2
22	Sharee	Pcs	100	-
23	Scissors straight	Pcs	2	-
24	Surgical Blade (sterile, Stainless steel) Size-10	110	-	-
25	Uristix GP-2 (Glucose : Protein equivalent)	Pcs	100	-
26	Tallquist Book	Book	2	-
27	Disposable Lancet, Sterile	Pcs	100	-
28	Elastomeric Matrix Dressing (sterile, extra thin CGF 4"x4")	Pcs	100	15
29	Elastomeric Matrix Dressing (sterile, extra thin)	Pcs	100	15
30	Atraumatic Catgut (0)	Pcs	10	-
31	Gown for Client	Pcs	20 per center	
32	Pajama – Panjabee (Shirt) for Surgeon and Assistant	Set	10 per center	
33	Autoclave Testing Tape	Roll	1 per center	
34	Uterine Elevator	Pcs	5 per center	

List of necessary MSR for 100 (Hundred) Vasectomy Cases

SL No	Name of Items	Unit	Required for 100 Cases	Required for 15% Follow –up Complications
	Medicines			
1	Inj. Xylocaine (1%) Lignocaine Hydrochloride USP 1%, 50 ml	Vial	10	-
2	Cap. Amoxiciline Trihydrate BP 500 mg Strip/Blister	Capsule	-	315
3	Tab. Paracetamol 500 mg Stip/Blister	Tablet	1,000	150
4	Iron Tab. with Folic Acid (Ferrous Fumerate 200 mg . + Folic Acid BP 0.20 mg)	Tablet	-	-
5	Tab. Vitamin B Complex (Thiamine Monotraste USP 5 mg, Riboflavin BP 2 mg. Pyridoxin Hydrochloride BP 2 mg, Nicortinamide BP 20 mg.)	Jar	5	1
	Surgical Requisites			
6	Absorbent Cotton (100 gm.)	Roll	25	10
7	Catgut Sterilized (Serial 1-0) 1x60" (152 cm)	Pcs	110	-
8	Chlorohexadine Gluconate Solution BP 7.5% W/V + Cetrimide BP Solution 15% W/V (Hospital Concentration), 1 Liter	Jar	5	1
9	Cutting Straight Needle	Pcs	5	-
10	Gauge (20 yards)	Roll	2	1
11	Surgical Gloves (Surgeon, Latex Rubber , Sterile, Disposable, Size – 6.5 ")	Pair	100	15
12	Surgical Gloves (Surgeon, Latex Rubber , Sterile, Disposable, Size – 7 ")	Pair	100	15
13	Gloves Powder	Kg	1	-
14	Disposable Syringe (Sterile), 5 c.c. Needle with blister packet	Pcs	110	-
15	Povidon – Iodine Solution, 1 Leter	Bottle	8	2
16	Scissors Straight	Pcs	2	-
17	Surgical Blade (Sterile, Stainless Steel) Size – 10	Pcs	110	-
18	Uristic GP – 2 (Glucose : Protein equivalent)	Pcs	100	-
19	Tallquist Book	Book	2	-
20	Lungi	Pcs	100	-
21	Disposable Lancet, Sterile	Pcs	100	-
22	Condom	Pcs	2000	-
23	Gown for the client	Pcs	20 per center	
24	Pajjama-Punjabee (Shirt) for Surgeon and Assistant(s)	Set	10 per center	
25	Autoclave Testing Tape	Roll	1 per center	
26	Euterin Elevator	Pcs	5 per center	

Appendix C

Standards and Requirements for Facilities providing Sterilization

In Bangladesh, both GOB and private sector facilities use the “Family Planning Manual,” published by the Health and Family Welfare ministry, as their reference for clinical standards and guidelines. According to this reference, standards for sterilization services are the following:

1. Sterilization services must include the following:

- Appropriate and adequate information and proper counseling
- Informed consent
- Screening, physical examination and laboratory test as per GOB checklist
- Arrangement of local anesthesia and analgesia
- Follow the surgical technique
- Post operative care
- Post operative follow up
- Proper management of post operative side effects and complications

2. Minimum requirements for sterilization

- Availability of sterilized instruments and logistics in the OT
- Operation theater should be clean and within the restricted area
- Only trained physicians / surgeon are allowed to performed sterilization
- There should be a trained assistant (physician/ paramedic/ nurse /FWV) in the OT to assist the surgeon
- Another paramedic/FWV should be in the OT to monitor the vital signs
- The door, windows, and ventilator of the OT should be closed
- Emergency medicine, oxygen cylinder, and sucker machine should be functioning
- The staff of the OT should have training in emergency management

3. Physical facilities of the clinic

Facilities providing sterilization should have 5 separate rooms, including:

Reception room for history taking & counseling. This room should have:

- Chair and table for the counselor and customer
- “Client description form for sterilization acceptor”(includes general information of the customer, physical and laboratory examination finding, informed consent, pre and post operative monitoring record, operation note, discharge note and follow up note.)
- Job aid and other logistics

Physical examination room with laboratory facilities. This room should have:

- Chair and table for the provider
- Sphygmomanometer & stethoscope
- Thermometer
- Weight and height measurement machine
- Spot light and torch light
- Examination table
- Instrument for PV examination
- Soap, running water and chlorhexidine cetrimide solution
- Test tube and Uristix for testing urine sugar
- Logistic to detect blood Hg%

Pre-operative room. This room should have:

- Bed, mattress, bed sheet, rubber sheet and mosquito net

- Water, soap, bucket, towel
- Toilet & bathroom facility

Operation theater with adjacent space for autoclaving. An OT room should have:

- Source of adequate light
- Paint the lower half of the window panes with white color or cover half of the windows with curtains
- The door and windows of the OT should be closed or covered with net
- The OT should have mosaic (tile) floor and wall (up to 7 feet)
- OT instruments and list of emergency medicine

An autoclaving room/area should have:

- Autoclave and autoclave tape
- Autoclave monitoring chart
- Surgical drum, instrument, gloves, syringe, and covered tray for the instrument
- Tray cover and trolley cover
- Gas burner or kerosene stove
- Sterilizer
- Material for cleaning of instrument
- Material for decontamination of instrument
- Table or shelf to dry up the instrument
- Hanger for gloves
- Utility gloves, mask and cap

A scrubbing area should have:

- Hand washing space with elbow tap basin and running water

Postoperative room. This room should have:

- Toilet and tap or tube, well water
- Bed, mattress, bed sheet, rubber sheet, and mosquito net
- Sphygmomanometer & stethoscope, thermometer and torch with battery
- Medicine such as Amoxicillin, paracetamol and vitamins
- Access to emergency medicine
- Stool and bedside table

Appendix D

Personnel and scope of activities for sterilization procedure

Only doctors trained in sterilization can perform these operations because they are able to take necessary steps if an emergency arises

A physician or trained nurse or paramedic or FWV is needed to assist the surgeon

Nurse/ FWV/Paramedic:

Another trained nurse or FWV is needed to monitor vital signs, i.e., blood pressure, pulse rate, and respiration of the client in the OT during operation, and to inform the doctor about the condition of the patient

Necessary staff training is needed (including use of essential medicines and equipment) to meet any emergency

A day before the surgical operation, a trained FWV or Medical Assistant or paramedic, a nurse should be in charge of keeping linen drum, equipment, syringes, needles, drapes and cotton balls etc, prepared

A trained nurse, FWV, or trained paramedic should run the OT during the surgical procedure, as necessary. The OT in charge will be a nurse in the Upazilla Health Complex and should have the responsibility of the operation theater

The trained FWV, medical assistant, or paramedic should take the client history, record body weight, body temperature, and blood pressure, do PV examination and give pre-medication, and perform pre-operative monitoring. She/he will ensure that the informed consent goes with the client to the OT and is also back to the postoperative room duly filled in.

A trained FWV, medical assistant, or paramedic should be on duty for monitoring pulse rate, respiration, and blood pressure, and recording them

Aya/Peon:

The OT peon or technician shall assist the OT nurse and or FWV during autoclaving

Aya (female aids) shall be in charge of wiping and cleaning of the OT room (no broom sweeping allowed)

Aya will clip/ trim the hairs at the site of the surgical procedure by scissors (not shaved by blade); assist the client to put on the gown and before going to the OT to assist the client urinate and evacuate bowel

The aya will assist in looking after clients in the post operative room

17. [For those who have adopted the method in the past] Did you have any complications?
Yes No [Skip to Q 19]

18. What complications?

19. Do you feel that you received enough information from the provider (about the method) prior to your acceptance of the method?
Yes No

20. Do you now feel comfortable with the method?
Yes No

21. Do you have any concerns? Yes No [End interview]

22. What concerns?

BCC information

23. Have you recently heard/seen about this method (the one you have adopted) through:

Television	Yes No
Radio	Yes No
Billboard/poster	Yes No
Leaflet/brochure	Yes No

24. Have you recently heard about the method from:

Clinic	Yes No
Depotholder	Yes No
Service Promoter/ Community Mobilizer	Yes No

**Permanent and Long Term Clinical Methods (PLTM)
Facility Assessment Tool**

**NGO Service Delivery Project
July 2002**

Clinic Assessment Guide

NGO Service Delivery Project (NSDP)

Introduction

This assessment guide is designed to help the Permanent and Long Term Clinical Methods (PLTM) assessment teams collect detailed information on the range and quality of reproductive health and family planning services available at a given facility. NSDP intends the guide primarily to be used as a needs assessment instrument, for determining what the physical, informational, training, and commodities needs of new facilities are. This needs assessment also provides essential baseline information and this assessment guide can be used later, to examine changes and the impact of program interventions..

Determining minimum requirements for a health facility is a difficult task. Given the great differences in contexts and availability or resources, there is no simple means for quantifying quality of care and services. This assessment guide can help NSDP and its grantees determine what each facility needs in order to improve the quality of services, design appropriate interventions, and plan for the addition of permanent and long term methods of contraception. The guide allows observers to look at key areas of facilities and note which areas require improvement.

Using This Assessment Guide

Discussing Objectives: Before starting to fill out the individual sections of this guide, it is extremely important that the assessment team discuss the objectives of the assessment with facility staff and supervisors. The assessment team leader should explain clearly how and why the assessment will be done, emphasizing that the assessment guide is designed not to find fault, but to identify needs and areas where improvements can be made.

Completing the Guide: Complete only the sections of the guide which

are relevant to the facility and the services it provides. The sections do not need to be completed in a particular order. For example, if there are clients at the facility, complete those sections which require observation of clients receiving services. The management section is generally best left to the end.

Filling out the Data Collection Forms:

- For each section, fill in the information requested, using the ratings given at the start of each section. In many cases the same rating system is used to measure quality, frequency, or quantity.
- Consider whether a team or an individual will be most appropriate, and decide who will collect the data for different sections.
- Take into account the routine of the service providers and try to make data collection as unobtrusive as possible.
- Be as objective as possible - if a team is collecting data, it is important that you agree on definitions and ratings before beginning the data collection.
- Consider timing – which sections require clients, which sections can be completed when there are no clients.
- Be flexible – it may be impossible to complete the whole guide at one time. You may have to wait to observe some procedures.
- Just observe, do not discuss procedures with services providers.
- Use the comments/recommendations column – these observations often provide the useful information.

Using the Information: Go over the data with facility staff, looking at each section and interpreting the data as a whole. Discuss which areas show the greatest strengths and weakness and how care and facilities could be improved. The assessment tool can provide baseline information for planning, prioritizing, and decision-making. However the guide may be used in a number of other ways:

- as an ongoing monitoring tool
- for annual evaluations
- for designing training opportunities
- for developing workplans
- as a self-assessment tool for staff

Organization of Assessment Guide

This guide is organized according to the sections listed below. Each section begins with some introduction about why the information is being collected, why the topic is important, and how the observations/data collection should be carried out.

- I. General Background Information
- II. Client Volume and Range of Services Provided
- III. Personnel
- IV. Observation of Recordkeeping & Treatment Protocols
- V. Observation of Rooms, Equipment & Commodity Storage
- VI. Observation of Infection Prevention Practices
- VII. Observation of Counseling Practices
- VIII. Assessment of Provider Clinical Skills/Performance
 - Physical assessment
 - General family planning service provision practices
 - Norplant implants
 - IUD counseling and history
 - Interval IUD insertion
 - Postpartum IUD insertion
 - Interval Minilaparotomy
 - No Scalpel Vasectomy (NSV)
- IX Observation of Clinic Management

Clinic Assessment

I. General Background Information

This section is designed to provide general information about the facility, its size and location, as well as details of the assessment process.

Date of Visit:

Name of Facility:

Location:

Type of Facility: Rural _____ Urban _____ Other _____

NGO:

Staff Interviewed:

Person Conducting Interview and Observation:

II. Client Volume and Range of Services Provided

This section is for gathering information on client volume and the range of services provided. High quality care includes offering an appropriate range of services. While some facilities may initially only be able to offer a limited number of services, expanding services is an important aspect of quality improvement. Additionally, in order to maintain and improve the quality of services, service providers should have experience in the provision of all the family planning methods offered at the clinic. All service providers should be capable of providing as many family planning methods as is appropriate for their level of training. At least one staff member trained to provide family planning services should be available all the time at each facility.

Using the facility record books, record the following reproductive health statistics for one month. If statistics vary greatly from month to month, collect 3 months worth of information and record an average for a 1 month period. Any additional comments or recommended actions should be noted in the “Comments/Recommendations” column.

Service Provided	No. of Clients	Comments / Recommendations
Family Planning Services		
Pill (Combined or Progestin Only)		
ECP		
Injectables (DMPA)		
IUD		
LAM		
Condoms / Spermicides		
Foaming Tablets		
Norplant		
Minilaparotomy		
No Scalpel Vasectomy (NSV)		
Reproductive Health Services		
Counseling for Family Planning		
Counseling for STD/RTI		
Treatment for STD/RTI		
Antenatal Care		
Deliveries		
Postpartum Care		
Infant Health Care		
Growth Monitoring/Well baby Examination		
Immunization		
Pregnancy Test		
Treatment of Incomplete Abortion		
MR		
Referral		

IV. Observation of Recordkeeping and Treatment Protocols.

This section is designed to provide information on how the facility keeps track of the services provided and clients. It is important to keep accurate records of clients and services, in order to assess clients' health against their medical history. Client records should be stored in such a way that they may be easily retrieved. Records should be accurate and complete, including information on complications and deaths.

Review the facility's recordkeeping system and rate the record keeping on the following scale:

- 1 = Poor or Rarely / Never 2 = Average or Sometimes
 3 = Good or Routine / Always N/A = Does not apply / Not observed

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

General Recordkeeping	Rating	Comments/Recommendations
Is a client medical record used in the clinic?		
Is the client given a card to record his/her visits to the facility?		
Is there a system for filing clients' record and retrieval?		
Can records be retrieved easily?		
Is the required data entered by the end of each day?		
Are the following records accurate and complete?		
• Informed Consent Form		
• Medical History		
• Physical Examination		
• Record of Counseling Session		
• FP Method Chosen		
• Number of FP Supplies Given		
• Referral Form		
Is the contraceptive method used listed?		
Is there a registration book?		
Is the collected data reviewed and analyzed? If so, by whom?		
Are complications related to contraceptive use reported? If "Yes", to Where?		

V. Observation of Rooms, Equipment, and Commodity Storage

The questions in this section are designed to provide information on the physical aspects of the facility, including space for services, utilities, equipment, supplies, and commodities. Whenever possible, facilities should have dedicated spaces or rooms for a waiting area, private counseling area, private examination room, operating room, recovery area, training room, a room for processing contaminated instruments, and an appropriate method for disposing of medical waste. Facilities should also have certain basic amenities such as electricity, running water, adequate lighting, and functioning sinks and toilets. Sufficient supplies of equipment for the provision of reproductive health services are also very important to the availability and quality of services. Procedures and facilities for storing commodities and contraceptive supplies must be adequate.

Recognizing that wide variations in context and resources available lead not only to significant differences in physical structures, utilities, and equipment, but also to unique solutions to the challenges posed by insufficient resources, it is particularly important to include comments and observations in this section. For example if a facility has no running water, make a note of how instrument cleaning and hand washing is carried out; if there is no electricity, list alternative light sources used.

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

- 1 = Inadequate, not present 2 = Adequate facility or supply
 3 = Good facility or good availability N/A= Not observed, Not applicable

Room/Area	Rating	Comments/Recommendations
Separate room for the processing of equipment		
An appropriate place for the disposal of medical waste		
Multi-purpose operating room		
Isolated operating room for VSC		
Recovery area		
Laboratory		
Training room		
Outpatient Clinic	Rating	Comments / Recommendations
Waiting Room area with seating for all clients		
Waiting area is protected from rain		
Private counseling area		
Private examination room		

A separate area for processing instruments?		
<i>BCC</i>		
IE&C material / posters is visible		
IE&C material/posters appropriate for clients		
Materials are available that the client can take away		
There is an adequate supply of client materials		
Summarize how BCC materials are being used in the clinic		

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

- 1 = Poor quality, insufficient supply of item 3 = Good quality, supply of item
2 = Adequate quality and supply N/A= Not observed, Not applicable

Does the site have:	Rating	Comments / Recommendations
Sign with clinic working hours		
Signs directing clients to services inside the clinic		
Electricity		
Running water		
Functioning sink in examination rooms/area		
Adequate lighting		
An adequate supply of water		
Toilet for clients		
Equipment for decontamination of instruments		
Supplies for cleaning instruments		
Hot air oven, autoclave or boiler		
IUD insertion/removal kits available		
Norplant implant insertion/removal kits		
Minilap kit available		
NSV kit available		
Examining table		
Instrument trays		
Instrument table		
OR light		
Sphygmomanometer		
Stethoscope		
Gooseneck lamp		
Chairs for counseling		
Revolving stool		
Screens (for privacy)		
Linens		
Drapes		
Gloves		

Does the site have:	Rating	Comments / Recommendations
Safe needles and Syringes		
<p>Please note any additional equipment and supplies needed</p>		

Rate the facility's commodities storage procedures, facilities, and supplies using the following rating scale:

- 1 = Inadequate, not present, needs renovation
- 2 = Adequate facility
- 3 = Good facility
- N/A= Not observed, Not applicable

Mark contraceptive stock-outs with a "1" in the appropriate "Rating" box, to indicate an inadequate system for supplies.

The following systems are in place:	Rating	Comments / Recommendations
Inventory of equipment and commodities		
Storage system according to commodity expiration dates		
Supplies maintained in good condition		
Expired contraceptives are destroyed		
System for ordering (reordering) supplies		
Is the storage facility protected from damage by:		
Rain		
Sunshine		
Rats and pests		
Did supplies of any contraceptive methods run out during the past three months?		
Combined pills		
IUDs		
Condoms		
Injectables		
Norplant Implants		
Progestin Only Pills		
Spermicides		
Other:		

It is important to ascertain whether the amount and condition of contraceptive supplies are sufficient to provide family planning services on an ongoing basis. Perform a rough count of the total number of contraceptives in stock in the storeroom for each method supplied, and note the number below, along with any other comments or recommendations.

Contraceptive Method	Quantity in Stock	Comments / Recommendations
Combined Pills		
Progestin Only Pills		
Condoms		
Spermicides		
IUDs		
Injectables		
Norplant		

In the box below, describe the supply flow of contraceptives. Who supplies the contraceptives? Is this facility responsible for supplying to other facilities? Identify any problems related to the flow of contraceptives.

VI Observation of Infection Prevention Practices

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

Enter the appropriate rating from the list below into the "Rating" column of the monitoring chart. Please note the name of the person observed on this worksheet. Note any further remarks in the "Comments/Recommendations" column.

- 1 = Poor or Rarely/Never 3 = Good or Routine/Always
 2 = Average/Sometimes N/A = Does not Apply/Not Observed

Task	Rating	Comments / Recommendations
<u>Decontamination</u>		
0.5% chlorine solution available		
Instructions for mixing chlorine are present		
Buckets and solutions are labeled		
Wears rubber gloves		
Places <u>all</u> instruments in chlorine solution for 10 minutes immediately following procedure		
Mixes chlorine solution correctly		
Wipes down exam table with chlorine between clients		
Cleaning of Instruments		
Completely disassembles instruments and/or opens jaws of jointed items		
Washes <u>all</u> surfaces with soap and water and a brush or cloth until visibly clean		
Thoroughly cleans serrated edges		
Rinses all surfaces with clean water		
Wears rubber gloves		
Cleaning equipment & supplies available		
<u>High Level Disinfection (HLD)</u>		
<i>Boiling</i>		
Completely submerges items in water		
Starts timing when boiling begins		
Keeps at rolling boil for 20 min.		
Air dries equipment		
Boiled items removed using HLD forceps		
Stores items in HLD container		
<i>Chemical</i>		
Immerses items completely		
Instruments submerged for 20 min.		
Rinses items with boiled water		
Stores items in HLD container		
Sterilization		

Task	Rating	Comments / Recommendations
<i>Autoclaving</i>		
Wraps instruments		
Arranges packs loosely in autoclave		
Puts holes in drums in open position		
Sterilizes for 30 min. for wrapped items at 121°c (250° f) and 106 kPa (15 lbs/in ²)		
Stores items in a sterile container		
<i>Dry heat</i>		
Puts loose instruments on trays		
Begins timing after set temperature has been reached		
Uses standard time/temperature 170° C (340° F) - 60 minutes 160° C (320° F) - 120 minutes 150° C (300° F) - 150 minutes 140° C (285° F) - 180 minutes 121° C (250° F) – overnight		
Stores items in a sterile container		
<i>Chemical sterilization</i>		
2% glutaraldehyde freshly made		
Soaks in covered container 8-10 hours		
Rinses items with sterile water		
Stores items in a sterile container		
Asepsis hand washing		
Soap available		
Clean towel available		
Staff wash hands correctly for 15 seconds with running water		
Staff wash hands between clients		
Barriers		
Linen is clean		
Paper or linen is changed between clients (if possible)		
Exam table is wiped down with chlorine solution at least once daily		
Sterile gloves are changed between procedures		
Gloves are put on properly		
Gloves are disposed of properly		
<u>Storage and Disposal</u>		
Antiseptic solutions are labeled		
Pickup forceps are stored in a dry HLD container		
Used needles and syringes are immediately disposed of in a special container		
HLD or sterile equipment is stored in a dry sterile or HLD container		
Handling specimens		
Clean gloves worn when obtaining or handling specimens		

Task	Rating	Comments / Recommendations
Spills of blood or other bodily products are cleaned up immediately with 0.5% chlorine solution		
IP Procedures in the Operating Room		
Is the environment clean?		
Are restricted areas respected?		
Is the surgical team preparation adequate?		
Is the patient prepped adequately?		
Is decontamination of equipment done promptly after surgery?		

VI. Observation of Family Planning Counseling Practice

This section is for information on family planning counseling practices. Client counseling is an essential component in the provision of reproductive health services. Counseling must be a standard training component and clinic staff must be adequately trained in counseling.

Please indicate if the counseling practices listed below are properly discussed using the following rating system. Please note who was observed on this worksheet.

- 1 = Poor information/counseling skills infrequently performed
- 2 = Adequate information/counseling skills sometimes performed
- 3 = Good information/counseling skills routinely performed
- N/A= Not observed, Not applicable

Counseling Practice	Rating	Comments / Recommendations
Visual and auditory privacy is acceptable for counseling		
Client is greeted in a respectful manner		
Uses language the client can understand		
Communication between client & provider is interactive		
Explains range of methods offered in the clinic		
Learns the client's opinion about FP methods		
Encourages the client to ask questions		
Asks client information that will help determine suitability of the method (age, number of children, birth date of last child, whether she wishes to space or limit pregnancies)		
Asks if the client has a preferred method		
If the client has a preferred method, asks what she knows about the method and if she wants to discuss other methods that may be suitable for her		
If the client has no preferred method, inform her of methods which may be appropriate for her given her reproductive goal and other needs		
Allows client to receive their chosen method if medically eligible		
Describes benefits and risks		
Discusses effectiveness		
Uses visual aids		
Provides key information on method chosen <ul style="list-style-type: none"> - How to use - Signs to watch for - When to return 		
Gives accurate information when client expresses incomplete or incorrect information		
Tells client to return if s/he has any concerns		

VII. Assessment of Provider Clinical Skills/Performance

This section is for collecting information on provider clinical skills. Whenever possible providers are observed conducting a physical assessment, providing various family planning methods, and providing antenatal, postnatal and infant care. Since some clinic staff may act as trainers and preceptors, their clinical skills must meet certain uniform standards. Key indicators of technical competence may be used to determine whether clinic staff need further training.

Enter the appropriate rating and note any further remarks in the "Recommendations" column. Please note who was observed on this worksheet.

1 = Poor or rarely/never 3 = Good or routinely/always
 2 = Average/sometimes N/A= Does not apply/Not observed

Task	Rating	Comments / Recommendations
Physical assessment		
Provider makes client comfortable and gives feedback during and after the examination		
Privacy is ensured during examination		
Provider follows correct steps in conducting the physical examination		
Abnormal and normal findings are documented in client record		
Method provision		
For every method prescribed, guidelines are followed concerning:		
Indications or precautions noted from a client's history and physical examination		
Screening using a screening checklist		
The client's choice of method & informed consent		
Instructions provided to the client on method use		
Information provided to the client about potential side effects		
Provision of supplies		
Client record documentation of method prescribed		
Norplant implants		
Provider informs client that menstrual pattern will change		
Provider informs client that implants should be removed after 5 years		
Provider informs client that implants can be removed anytime she desires		
Provider explains side effects which may occur		
Provider explains that client should return for follow-up visit or if she experiences any of the following: - pain or pus at the insertion site - heavy bleeding - severe abdominal pain - expulsion of implants - delayed menstrual periods after long interval of regular		

Task	Rating	Comments / Recommendations
periods - migraine headaches, repeated very painful headaches, or blurred vision		
Provider takes a history for implant use which includes: - missed period - jaundice, liver disease - unexplained vaginal bleeding - breast lumps/cancer - breastfeeding under 6 weeks		
Provider explains Norplant insertion/removal procedures		
During insertion procedure provider does the following: - washing hands - wears sterile gloves - cleans the arm with antiseptic solution - infiltrates the insertion site with Lidocaine - inserts implants close to the skin (not deeply into the tissue) - palpates the implants upon completion of insertion - decontaminates instruments following procedure - washes his/her hands following the procedure		
- provider properly disposes of needle and syringe		
IUD Counseling and History		
Provider informs client that the Cu T380A can remain in place for 10 years		
Provider explains possible side effects of IUD		
Provider obtains medical history including: - active, recent, or recurrent pelvic infection - pregnancy, known or suspected		
Provider explains IUD insertion/removal procedures		
Provider informs client that she should return for follow-up visit or if she experiences any of the following: - late period (pregnancy, abnormal spotting, or bleeding) - infection exposure or abnormal discharge - not feeling well, fever, or chills - string missing, shorter, or longer		
Interval IUD		
Position of the uterus is determined during bimanual examination		
Visualize vagina and cervix prior to insertion during speculum exam		
Tenaculum is applied to align the uterus		
Traction is applied to align the uterus		
A sterile sound is used to determine uterine depth and to check the position of the uterus		
IUD is loaded into applicator maintaining its sterility		
IUD is inserted using the withdrawal method for CU T380A		
Pre- & post- instruction on IUD insertion given		

Task	Rating	Comments / Recommendations
Post-use instruction and follow-up appointment		
<u>Minilaparatomy</u>		
<u>Provider informs client that the sterilization is permanent</u>		
<u>Provider explains possible side effects which may occur</u>		
<u>Provider obtains medical history which includes:</u> <ul style="list-style-type: none"> - problem with reproductive organs - missed period/pregnancy - date of last delivery or date of last menstrual period - recent delivery complications - Unexplained vaginal bleeding - P.I.D. within the last 3 months - STDs - Any chronic diseases - Drug allergies - Current medications - Heart disease - Bleeding disorders - Active infection - Acute lung disease 		
<u>Provider asks how the client was recruited</u>		
Provider asks to make sure the sterilization is voluntary		
<i>Preoperative Procedures</i>		
Do clients have to visit several times prior to getting the service?		
Was an adequate physical examination done?		
Were laboratory tests, both blood and urine, done?		
10 mg. Diazepam given 45 min. before operation		
What medications are given just before the start of the operation, on the OR table. Please list medications and dosages.		
<i>Surgical Procedure</i>		
Operation site is cleaned adequately		
Correct dosage of lidocaine is infiltrated into skin, fascia, sub-fascia and peritoneum		
Physician waits 2-3 minutes before beginning the operation		
The abdomen entered safely, protecting the bowel and other organs?		
The fallopian tubes identified, retrieved and occluded in a safe and atraumatic manner?		
Each tube followed to the fimbrial end to confirm that it is the Fallopian tube?		
The uterine elevator used?		
Tubal hooks used?		
What tubal occlusion technique is used?		
<i>Patient Monitoring</i>		
Client comfort maintained during surgery?		

Task	Rating	Comments / Recommendations
Someone talks and reassures the client during the operation		
Handling during surgery is gentle		
Are vital signs monitored every 5 min. during surgery?		
Is the client monitored every 15 min. during the first hour in the recovery room?		
Is the client given post-operative written and verbal instructions?		
<i>Emergency Preparedness</i>		
Is operating emergency equipment satisfactory? -Is staff knowledgeable about emergency drugs?		
<i>General Condition of Operating Facility</i>		
-Are facilities and equipment adequate? -Is general surgical equipment in working order? -Is sterilization equipment in good working order?		
<i>Records and Reporting</i>		
-Are records of the operation complete? -Are complications reported? How?		
<i>Postoperative Instructions and Care</i>		
The patient is given instructions on : - How to care for the incision - How to keep the incision clean - Physical exercise (no heavy lifting for 3 weeks) - What side-effects to expect - What to do if complications occur - Where to go for emergency care - When to seek medical attention (fever, bleeding, excessive pain, the presence of pus or swelling)		
The client is given paracetamol and iron/vit B tablets and instructed on how to taken them		
The client is advised to return to the clinic to have her stitches removed after 7-10 days		
<u>Vasectomy</u>		
Provider informs client that the sterilization is permanent		
Provider explains possible side effects which may occur		
<u>Provider obtains medical history which includes:</u> - problem with reproductive organs - STDs - Any chronic diseases - Drug allergies - Current medications - Heart disease - Bleeding disorders - Active infection - <u>Acute lung disease</u>		
Laboratory tests are performed including: - Haemoglobin		

VIII. Facility Management and Supervision

This section provides information on various key aspects of clinic management . It focuses on the areas of clinic management that improve access to and the quality of services, such as; job descriptions, service delivery guidelines, information systems, protocols for dealing with complications, referral and supervision.

Enter the appropriate rating. In this section, observations and remarks are also particularly important.

1 = Poor/rarely/never/not available
2 = Average/Sometimes

3 = Good/Routinely/Always
N/A = Does not apply/not observed

Area	Rating	Comments/Recommendations
<u>Organization</u>		
Service delivery standards and guidelines available and followed		
1. The following systems are in place and functioning: <ul style="list-style-type: none"> • referral system • management information system (MIS) • logistics management system • supervisory system • financial management system 		
Administrative procedures are written, available, and followed		
If there is a complication or death related to sterilization is there a method of reporting? If so, describe the procedure of reporting, follow-up and remedial action		
Human Resources		
Clearly written job descriptions for all staff		
Information		
Information system in place and utilized		
Information needed by management for reporting and decision making is accessible (available, timely)		
Supervision		
Supervisors provide regular on site visits. Indicate how often		
Supervisory visits are documented		
<u>Referral</u>		
Explain how the referral system works. Is there a way to verify whether the client has actually gone to the referral facility and whether the client received care at the referral facility.		

Appendix G: Quality Assurance (QA) Observation Checklist

National Integrated Population and Health Program (NIPHP)

Quality Assurance (QA) Family Planning Observation Checklist

Identification:

1. Name of the Clinic & address: _____ District: _____

2. Name of the NGO: _____ Date of Visit: ____/____/____

3. Name of the Team Members:
 1. Name: _____ Organization: _____

 2. Name: _____ Organization: _____

Please circle the responses as appropriate

Composite Indicator: Percent of NGO sites that comply with physical facility and equipment and supply standards			
1. Site complies with minimum standards for space:			
▪ Private space for counseling	Yes	No	NA
▪ Private space for physical examination	Yes	No	NA
▪ Waiting space available	Yes	No	NA
▪ Toilet facilities	Yes	No	NA
▪ Running water available	Yes	No	NA
2. All spaces are clean and well maintained	Yes	No	NA
3. Clinic/ site facility has appropriate BCC material displayed on the walls and available as job aids in the respective provider's rooms, including:			
▪ Framed posters	Yes	No	NA
▪ Flip charts (BCCP developed FP Flip chart)	Yes	No	NA
▪ Comprehensive Family Planning chart/Tiaht chart	Yes	No	NA
▪ Contraceptive display board and tray	Yes	No	NA
4. On the day of the visit, the site has adequate supplies for at least one customer for each of the following contraceptives (circle NA if the service is generally not provided):			
▪ Condoms (12 pieces)	Yes	No	NA
▪ Oral pills (3 cycles)	Yes	No	NA
▪ Injectables (1 vial)	Yes	No	NA
▪ IUDs, if service provided at clinic (1 IUD)	Yes	No	NA
▪ Norplant implants, if service is being provided at clinic (1 set of (6) implants)	Yes	No	NA
Composite Indicator (Continued): Percent of NGO sites that comply with physical facility and equipment and supply standards			
5. On the day of the visit, the clinic site has working equipment & supplies for at least one customer for long term family planning methods, i.e. IUD and Norplant and permanent contraception procedures (for clinics offering these services, circle NA if the service is generally not provided):			
▪ IUD instrument set	Yes	No	NA
▪ Norplant instrument set	Yes	No	NA
▪ Tubectomy kit	Yes	No	NA
▪ NSV kit	Yes	No	NA
6. On the day of the visit, the clinic site has working equipment for patient care as follows:			
▪ BP instrument	Yes	No	NA
▪ Stethoscope	Yes	No	NA
▪ Thermometer	Yes	No	NA

▪ Measuring tape/any scale that can measure height	Yes	No	NA
▪ Weighing machine	Yes	No	NA
▪ Torchlight	Yes	No	NA
▪ Examination table	Yes	No	NA
▪ Autoclave or IUD sterilizer or boiling equipment per guidelines	Yes	No	NA
7. Emergency preparedness equipment and supplies are available for sites providing long term contraceptive methods NORPLANT and sterilization services (will not apply to all sites, circle NA if the service is generally not provided):			
Emergency drugs:			
▪ Injection Atropine Sulphate 0.6 mg (2 ampoules)	Yes	No	NA
▪ Injection Promethazine HCL 25 mg (2 ampoules)	Yes	No	NA
▪ Injection Adrenaline (1: 1000) (2 ampoules)	Yes	No	NA
▪ Injection Hydrocortisone 100mg (with distilled water) 2 vials	Yes	No	NA
▪ Injection Naloxone 0.4 mg (five ampoules)	Yes	No	NA
▪ IV fluid 5% DNS & 5% DA (500 cc) 2 bags or bottle with IV set (2 sets)	Yes	No	NA
Emergency equipment			
▪ Ambu bag and air way tube	Yes	No	NA
▪ Oxygen therapy unit	Yes	No	NA
▪ Suction unit	Yes	No	NA
▪ Foley's catheter	Yes	No	NA
▪ Atromatic catgut	Yes	No	NA
Composite Indicator (Continued): Percent of NGO sites that comply with physical facility and equipment and supply standards			
▪ Laparotomy set	Yes	No	NA
▪ Torchlight (3 battery)/charger	Yes	No	NA

Composite Indicator: Percent of service providers demonstrating compliance with counseling standards												
	C/CA			P1			P2			MO		
1. Auditory and visual privacy maintained	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
2. Provider gives information to the customer about requested service	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
3. During counseling the provider does the following:												
▪ Responds to questions	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Listens to customers' concerns	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
4. Provider assesses if customer has any other service needs (assesses missed opportunities according to guidelines)	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
5. Provider uses service specific job aids during counseling				Yes	No	NA	Yes	No	NA	Yes	No	NA
6. Provider uses service specific BCC materials for customers during counseling	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
7. Provider confirms that customer understands what was communicated during counseling	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
Comments:												

Composite Indicator: Percent of service providers providing family planning services in accordance with quality standards									
Client provider interaction	P1			P2			MO		
1. Provider provides counseling for family planning customer using GATHER steps	Yes	No	NA	Yes	No	NA	Yes	No	NA
2. Provider discusses other methods available in addition to customer's desired method	Yes	No	NA	Yes	No	NA	Yes	No	NA
3. Provider confirms that customer is eligible for method through appropriate screening and physical examination using the ESP card	Yes	No	NA	Yes	No	NA	Yes	No	NA
Comments:									

Condom	Observe	Case S		Observation			Observe	Case S	
	P1			P2			Counselor		
1. Provider demonstrates correct use of condom, emphasizing on the following	Yes	No	NA	Yes	No	NA	Yes	No	NA
<ul style="list-style-type: none"> ➤ How to put condom on erect penis ➤ How to avoid air entering at the tip of the condom ➤ How to remove the condom after intercourse 									
2. Provider explains what to do if a condom breaks during use (advice for emergency contraceptive)	Yes	No	NA	Yes	No	NA	Yes	No	NA
<ul style="list-style-type: none"> ➤ Tab. Sukhi – 4 Tabs. Within 72 hours of unprotected coitus and 4 Tabs. after 12 hours OR Tab. C-5 – 2 Tabs. Within 72 hours of unprotected coitus and 2 Tabs. after 12 hours 									
Condom	Observe	Case S		Observation			Observe	Case S	
	P1			P2			Counselor		
3. Provider tells the non-contraceptive benefits of condom	Yes	No	NA	Yes	No	NA	Yes	No	NA
Comments:									

Pill	Observe	Case S		Observation			Observe	Case S	
	P1			P2			Counselor		
1. Provider explains how to take the pill appropriately	Yes	No	NA	Yes	No	NA	Yes	No	NA
2. Provider explains what to do in case of a missed pill	Yes	No	NA	Yes	No	NA	Yes	No	NA
3. Provider provides advice about pill including the following:	Yes	No	NA	Yes	No	NA	Yes	No	NA
<ul style="list-style-type: none"> ➤ Side effects ➤ Warning signs ➤ Next visit 									
Comments:									

Injectable	Observe	Case S		Observation			Observe	Case S	
	P1			P2			MO		
1. Provider demonstrates competence in steps of injection according to guidelines									
<ul style="list-style-type: none"> ▪ Disinfects injection site (upper-outer portion of deltoid muscle or gluteal muscle) using Rectified Spirit/Hexisol 	Yes	No	NA	Yes	No	NA	Yes	No	NA
<ul style="list-style-type: none"> ▪ Does not waste medicine during removal of air bubble from the syringe (ensure the dose of 1cc) 	Yes	No	NA	Yes	No	NA	Yes	No	NA
<ul style="list-style-type: none"> ▪ Inserts sterile needle deep into the selected site at right angle 	Yes	No	NA	Yes	No	NA	Yes	No	NA
<ul style="list-style-type: none"> ▪ Does not massage the injection site and tells customer not to massage or rub the site 	Yes	No	NA	Yes	No	NA	Yes	No	NA
2. Providers ensures proper storage/disposal of used syringes and needles	Yes	No	NA	Yes	No	NA	Yes	No	NA
3. Provider provides advice about Injectable including the following:	Yes	No	NA	Yes	No	NA	Yes	No	NA
<ul style="list-style-type: none"> ➤ Side effects ➤ Warning signs ➤ Due dose of next shot 									
Comments:									

IUD	Observe	Case S		Observation			Observe	Case S	
	P1			P2			MO		
1. Provider obtains informed consent from IUD customer	Yes	No	NA	Yes	No	NA	Yes	No	NA
2. Provider demonstrates correct procedure for inserting IUD according to guidelines									
▪ Uses sponge holding forceps and three cotton balls for vulval wash	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Inspects the cervix and vagina for any discharge/ulcer/ friability	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Properly does a bi-manual exam to exclude any contraindication	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ If customer is fit for IUD, grasps the cervix properly at 2 and 10 o'clock position by tenaculum	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Inserts the uterine sound properly and determines the depth and direction of the uterus	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Loads the IUD in the inserter properly following non-touch technique	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Before inserting, adjusts the blue guard properly and fix it	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Wears new pairs of sterile gloves on both hands after loading the IUD	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Inserts the IUD by withdrawal technique	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Cuts the thread keeping 3 - 4cm long	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Checks for bleeding	Yes	No	NA	Yes	No	NA	Yes	No	NA
3. Provider provides post-procedure advice including the following	Yes	No	NA	Yes	No	NA	Yes	No	NA
➤ Side effects									
➤ Warning signs									
➤ Follow-up within 1 month									
➤ Checking of thread									
Comments:									

Norplant	Observ	Case	Observation	Observ	Case	
	P1		P2	MO		
1. Provider obtains informed consent from Norplant customer				Yes	No	NA
2. Provider demonstrates correct procedure for inserting Norplant according to guidelines						
▪ Administers local anesthesia (1% Lidocaine/2% Jasocain)				Yes	No	NA
▪ Introduces the tip of the trocar beneath the skin slowly and without any resistance upto the distal mark keeping its tip upwards and loads the implant through it				Yes	No	NA
▪ Carefully places six implants in position one by one through withdrawal technique				Yes	No	NA
▪ Pulls out the trocar after inserting the last implants and applies pressure with a piece of gauge for one minute to stop bleeding				Yes	No	NA
3. Provider provides post-procedure advice including the following:	Yes	No	NA	Yes	No	NA
➤ Side effects						
➤ Warning signs						
➤ Follow-up within 7 days						
Comments:						

Tubectomy:	Observe	Case S		Observation	Observe	Case S	
	P1			P2	MO		
1. Provider obtains informed consent from sterilization customer					Yes	No	NA
2. Provider demonstrates correct procedure for conducting sterilization							
▪ Ensures evacuation of bladder before entering into O.T.					Yes	No	NA
▪ Administers local anesthesia (1% Lidocaine) in layers about one inch above the pubic symphysis along the median plane					Yes	No	NA
▪ Makes the appropriate incision by layers till reaching the peritoneum					Yes	No	NA
▪ Before incising the peritoneum, ensures that bladder or bowel is not trapped in it					Yes	No	NA
▪ Confirms the tubes before ligating them by identifying the fimbriae					Yes	No	NA
▪ Ensures hemostasis through the procedure					Yes	No	NA
3. Provider provides post-procedure advice including the following:	Yes	No	NA		Yes	No	NA
➤ Side effects							
➤ Warning signs							
➤ Follow-up within 7 days							
Comments:							

NSV:	Observ	Case	Observation	Observ	Case	
	P1		P2	MO		
1. Provider obtains informed consent from sterilization customer				Yes	No	NA
2. Provider demonstrates correct procedure for conducting sterilization						
▪ Identifies, isolates and fixes vas deferens under median raphe at the junction of middle and upper third of the scrotum				Yes	No	NA
▪ Provides perivasal block				Yes	No	NA
▪ Occludes the vas using fine silk				Yes	No	NA
▪ Ensures hemostasis				Yes	No	NA
3. Provider provides post-procedure advice including the following:	Yes	No	NA	Yes	No	NA
➤ Side effects						
➤ Warning signs						
➤ Follow up after 3 days						
➤ Use condom for first 20 ejaculation						
Comments:						

Composite Indicator: Percent of staff demonstrating compliance with infection prevention standards												
Infection Prevention	Observe			Demo			Observe			Demo		
	Clinic Aide/Aya			Paramedic			MO					
1. Provider washes hands before and after examining each customer							Yes	No	NA	Yes	No	NA
2. Provider washes hands after touching body fluids, mucous membranes, or broken skin	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
3. Provider washes hands after handling soiled instruments	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
4. Provider demonstrates correct preparation and use of the following:												
▪ 5% Savlon solution	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
➤ Before making dilution looks at the strength of Savlon and prepare 5% dilution accordingly (i.e. 1 part of savlon + 19 parts of water for 100% strength and 1 part of savlon + 7 parts of water for 40% strength)												
▪ 0.5% chlorine solution	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
5. Provider demonstrates appropriate decontamination and cleaning of instruments as per guidelines including:												
▪ Wears protective attire (masks, utility gloves) during instrument processing	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Soaks all soiled items in 0.5% chlorine solution immediately after use	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Ensures decontamination of instruments for 10 minutes after immersing the last item	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Cleans soiled floors and table tops using 0.5% chlorine solution between procedures	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Submerging instruments under the surface of the water while scrubbing and cleaning	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Cleans decontaminated items using detergent powder and gentle brushing	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Rinses instruments thoroughly in running water	Yes	No	NA	Yes	No	NA	Yes	No	NA	Yes	No	NA

Infection Prevention	Observe	Demo		Observe	Demo		Observe	Demo	
	Clinic Aide/Aya			Paramedic			MO		
6. Provider demonstrates correct use of autoclave for sterilizing instruments (for clinics using autoclave) including all of the following:									
▪ Opens and unlocks all jointed instruments, wrapping the sharp points and cutting edges with gauge or cotton	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Does not pack the container tightly	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Keeps the steam control valve open for four minutes after the hissing sound begins	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Starts the timer after pressure reaches 15 pounds or temperature reaches 121°Celsius	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Maintains pressure at 17-19 pounds or 1.20-1.35 kg for 30 or 20 minutes depending on items being autoclaved by controlling stove flame (gas operated) or by releasing some steam through the steam control valve using a wooden stick (electric operated)	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Keeps the autoclave dry when not in use	Yes	No	NA	Yes	No	NA	Yes	No	NA
7. Provider demonstrates correct use of boiling (where applicable) including all of the following:									
▪ Opens or unlocks all jointed instruments before submerging	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Completely submerges all objects to be boiled, keeping at least 2.5 cm or 1 inch of water above the instruments	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Boils instruments for 30 minutes after rolling boil begins, using the timer to record time when rolling boil begins	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Does not add or remove any object or water after timing starts	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Immediately after 30 minutes, removes objects with previously boiled/HLD forceps and stores in an HLD container	Yes	No	NA	Yes	No	NA	Yes	No	NA
8. Provider demonstrates compliance with waste disposal standards									
▪ Sharp objects are disposed of in non-penetrable container	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Utility gloves used during handling contaminated waste	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Pours liquid waste (0.5% Chlorine solution, Savlon solution etc.) down a utility drain or non-septic toilet	Yes	No	NA	Yes	No	NA	Yes	No	NA
▪ Burns contaminated waste daily in the incinerator / burn and bury in pit if incinerator is not available	Yes	No	NA	Yes	No	NA	Yes	No	NA
Comments:									