# Assessment of Ipas Initiatives in the Institutionalization of Family Planning, Menstrual Regulation and Postabortion Care Services in Bangladesh

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**icddr,b**
**Ipas Bangladesh**

**30 September 2021**

Ipas BANGLADESH Partners for Reproductive Justice

icddr,b

# Report

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# List of Acronyms

| | |
|---|---|
| ANC | Ante-natal Care |
| BASA | Bangladesh Association for Social Advancement |
| BAPSA | Association for Prevention of Septic Abortion, Bangladesh |
| BCC | Behavior Change Communications |
| BNNRC | Bangladesh NGO Network for Radio and Communication |
| CCSDP | Clinical Contraception Service Delivery Program |
| Co-PI | Co-Principal Investigator |
| CPR | Contraceptive Prevalence Rate |
| CS | Civil Surgeon |
| DDFP | Deputy Director of Family Planning |
| DFID | The Department for International Development |
| DGFP | Directorate General of Family Planning |
| DGHS | Directorate General of Health Services |
| DH | District Hospital |
| DHIS-2 | The District Health Information Software-2 |
| DGNM | Directorate General of Nursing and Midwifery |
| DPM | Deputy Program Manager |
| ED | Executive Director |
| eLMIS | Electronic Logistic Management Information System |
| EVA | Electric vacuum aspiration |
| ESP | Essential service package |
| FBCC | Facility-based Behavior Change Communications |
| FCDO | Foreign, Commonwealth and Development Office |
| FP | Family Planning |
| FP | Focal Person |
| FWA | Family Welfare Assistant |
| FWV | Family Welfare Visitor |
| GoB | Government of Bangladesh |
| GO | Government Organization |
| HPNSDP | Health, Population & Nutrition Sector Development Program |
| HPNSP | Health Population Nutrition Sector Program |
| HR | Human Resource |
| IBAS ++ | Integrated Budget and Accounting System |
| IDI | In-depth interview |
| IUD | Intrauterine Contraceptive Device |
| KII | Key-informant interview |
| LARC and PM | Long-acting reversible contraceptives and Permanent Method |
| LD | Line Directors |
| LMIS | Logistic management information system |
| MCH | Medical College Hospital |
| MCWC | Mother and Child Welfare Centre |
| MFSTC | Mohammadpur Fertility Services and Training Centre |
| MM | Medical Monitoring |
| MNC&AH | Maternal, Newborn, Child & Adolescent Health |
| MoF | Ministry of Finance |
| MoHFW | Ministry of Health & Family Welfare |

| | |
|---|---|
| MOMCH-FP | Medical Officer Maternal Child Health and Family Planning |
| MR | Menstrual Regulation |
| MRM | Menstrual Regulation with Medication |
| MVA | Manual Vacuum Aspiration |
| NGO | Non-Government Organization |
| NTC | National Technical Committee |
| OCP | Oral Contraceptive Pill |
| Ob/gyne | Obstetrician/gynecologist |
| OGSB | Obstetrical & Gynecological Society of Bangladesh |
| OP | Operational Plan |
| OT | Operation Theatre |
| PAC | Post Abortion Care |
| PAFP | Post Abortion Family Planning |
| PI | Principal Investigator |
| PM | Program Manager |
| PNC | Post-natal Care |
| PPFP | Postpartum Family Planning |
| QFP | Quality Family Planning |
| RCOG | Royal College of Obstetrician & Gynecologists |
| RHSTEP | Reproductive Health Services Training Education Program |
| RMO | Residential Medical Officer |
| SC | Steering Committee |
| SCMP | Supply Chain Management Portal |
| SDG | Sustainable Development Goal |
| SDP | service delivery point |
| SOMCH | Sylhet Osmani Medical College Hospital |
| SSN | Senior Staff Nurse |
| ToT | Training of Trainer |
| UHC | Upazila Health Complex |
| UH&FPO | Upazila Health and Family Planning Officer |
| UIMS | Upazila Inventory Management System |
| VCAT | Values clarification and attitude transformation |

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# Executive summary


**Background**

To reduce the unmet need for contraceptives and strengthen the postpartum family planning (PPFP) and postabortion family planning (PAFP) services, Ipas implemented a project titled 'Family Planning in Bangladesh: Improving Quality and Access' briefly called QFP (Quality Family Planning) Project. The project activities were implemented during October 2016 - July 2021. This study aimed to assess the QFP project initiatives to strengthen family planning (FP), menstrual regulations (MR), and postabortion care (PAC) services and to assess the progress towards institutionalization of FP, MR and PAC services in Director General Health Service (DGHS) system.

**Methods**

An exploratory study was conducted for the assessment, using both quantitative and qualitative research methods. Three tiers of the health system, i.e. division, district, and upazila where Ipas interventions were implemented, were covered in the qualitative assessment. The qualitative data were collected between May and August 2021. Quantitative analysis was conducted using secondary FP, MR and PAC service data of Ipas on from 210 health facilities under the Directorate General of Health Services (DGHS), Directorate General of Family Planning (DGFP), along with selected facilities of the private and NGO sectors, across six administrative divisions of Bangladesh. The quantitative service data were collected by Ipas as during February 2017-December 2020.

**Key findings**

One of the major contributions of the QFP project of Ipas is strengthening of the PPFP and PAFP services in 135 DGHS facilities, 41 DGFP facilities, 19 private hospitals/clinics, and 15 clinics of the Reproductive Health Services Training and Education Program (RHSTEP). As a result of the QFP project, there has been 2.5 to 7 times increment in service provision (quantity of services) of intra-uterine device (IUD), implant, and tubectomy services in the DGHS facilities. The DGFP facilities had 10 times increment in the service provision of IUD and 5 times increment in service provision of each implant and tubectomy respectively. Although the private facilities contribute to a small share in the total provision of long-acting reversible contraceptives (LARC) and permanent methods (PM) (2.5% of the total LARC and PM services), the private facilities achieved 2 to 9 times increment in the related services. However, in the RHSTEP clinics, the increment in service delivery for IUD and implant was minimal. Most of the increments in the intervention facilities took place during the first 3 years of the project (2017 to 2019) and, in 2020, there was a decline across all services, which is likely to be due to COVID-19 pandemic.

The Ipas interventions also contributed to the increase in the service performance of short-acting FP methods, demonstrating 7 to 9 times increment in different short-acting methods in the DGHS facilities, and the corresponding changes in the DGFP and private facilities were 2 to 3 times and 2 to 4 times

respectively. However, for the RHSTEP clinics, the increment in service performance of short-acting FP methods was not noteworthy.

The QFP project of Ipas also demonstrated increment in the service performance of MR and PAC in the intervention facilities. In the DGHS facilities, there was a 2 to 3 times increment in MR and PAC services during 2017-2019. The corresponding changes in the DGFP and private facilities were 2 and 3 times respectively. However, the RHSTEP clinics showed low increment in these services over the lifetime of the project.

The findings from the determinant analysis after adjusting for potential co-variates and stratifying by type of facilities, confirmed improvement in acceptance of implant in DGHS, private and RHSTEP facilities; improvement in acceptance of tubectomy in DGFP and private facilities; and improvement in acceptance of IUD in private and RHSTEP facilities. The reason for lack of improvement in selected LARC and PM methods in DGHS and DGFP facilities are likely to be related to inadequate number of providers and frequent transfer of trained providers in the facilities under the respective directorates.

According to the qualitative findings, the successes achieved so far were possible due to key project interventions like; training of the service providers at health facilities on FP, MR and PAC services; introduction of policies for supply of FP commodities and logistics by DGFP to DGHS facilities assigned as service delivery points (SDPs), and direct allocation of Imprest fund to DGHS facilities, and facilitation of the management of the Imprest fund; developing reporting system for FP service reporting in HMIS of DGHS through DHIS-2; coordination among high-level stakeholders for enhancing collaboration among DGFP, DGHS, and other relevant authorities.

During the lifetime of the project, Ipas trained 1,219 service providers on FP, MR and PAC service provision. The quality of Ipas training was highly appreciated by the service providers, which was reported to be interactive and had allocated substantial time in practical sessions. However, due to workload and lack of service providers at public facilities, it was challenging to deliver the related services and maintaining quality.

Our respondents acknowledged that it has now been possible to get direct supply of the FP commodities and logistics for PPFP and PAFP in the inpatient department of the medical college hospitals (MCHs) and district hospitals (DHs) due to inclusion of DGHS facilities under the service delivery points (SDPs) of the DGFP. However, in health units of the upazila health complexes (UHCs), the SDP system is still not fully functional, and these facilities are dependent on the FP unit of the UHC for supply of FP commodities which often cause interruption in service provision, particularly in the evening and night shifts.

The QFP project successfully advocated for procurement of manual vacuum aspirators (MVAs) directly by DGHS. Although the DGHS facilities were previously mandated to provide PAC services, they did not have the procurement policy for buying the required commodities, like MVA for MR and PAC. According to the study key informant interviews (KIIs), along with other major policy changes such as permission of

Family Welfare Visitors (FWVs) to provide postabortion care services using MVA, introduction of MVA in DGHS facilities has resulted in reduction of unsafe abortion. It has been validated by our respondents that introduction of MVA, along with related training, contributed to the increase in service provision of MR and PAC. Ipas also introduced menstrual regulation with medicine (MRM) for MR and medical postabortion care (mPAC) for PAC, although its utilization is low (9.5% for MR and 0.2% for PAC) at the facility level. However, self- and unregulated use of MRM is likely to be high according to our respondents. Ipas's advocacy under the QFP project succeeded in incorporating the procurement of the MVA through the operational plan of the Government and also developed policy for local procurement of MRM. However, continuation of support from Ipas is needed for adaptation of the changes in the health system.

Another major change in policy as a result of Ipas advocacy under the project, was DGFP allocating Imprest fund directly to Medical Collage Hospitals (MCHs) and District Hospitals (DHs) and thus enabling distribution of incentives among the clients and the service providers for LARC and PM in DGHS facilities. Our respondents acknowledged that this fund transfer mechanism to some extent helped eliminate barriers in the disbursement of funds to clients and designated service providers at the MCHs and DHs. However, one major challenge in mobilizing Imprest fund is: lack of capacity of the managers and service providers at the health facilities in managing the Imprest fund effectively. Moreover, the upazila-level facilities of the DGHS and the private facilities are still not within the scope of the new system of Imprest fund management.

The QFP project of Ipas helped developing reporting system for FP service information using the MIS3 format and entering FP service statistics into DHIS-2. Which can help monitoring FP, MR and PAC service performance.

The QFP project also invested in developing and disseminating behavioral change communication (BCC) material for promotion of FP services; providing amenities for setting up FP, MR and PAC procedure room/corner; developing and distributing guidelines and protocols for maintaining quality services and providing registers for record-keeping.

**Conclusions and recommendations**

Most of the respondents acknowledged that the project initiatives undertaken by Ipas, strengthened the capacity of DGHS facilities to provide effective FP, MR and PAC services. However, for institutionalization of FP, MR and PAC services in DGHS facilities the study recommends (i) developing policies for in-service training of doctors, nurses and midwives on FP, MR and PAC services; (ii) training adequate number of service providers, along with the introduction of refresher training so that skilled providers are available; (iii) developing capacity of DGFP and DGHS to train service providers on FP, MR and PAC (iv) appointing a counselor at facilities for quality counseling; (v) exploring the reasons for non-functioning of the SDP supply system at the health unit of UHC and accordingly orient the relevant managers and providers for improving system efficiency; (vi) undertaking new studies to assess the barriers in use of MRM including user knowledge and practices; (vii) organizing additional orientation program for the

managers and service providers on efficient management of Imprest fund; (viii) bringing the upazila-level facilities of the DGHS and the private facilities within the scope of the new management system of the Imprest fund; (ix) developing BCC materials considering the fact that the most abortion cases come with incomplete abortion; (x) creating a platform where all the relevant stakeholders at supply-side can exchange thoughts and generate solutions on how to improve and sustain the current FP service delivery; (xi) scaling up the interventions under the QFP project to the remaining DGHS facilities.

Finally, for realizing the above recommendations in the national health system, continuation of Ipas's support is needed for another 2-3 years to enable transfer of learnings to the DGHS and to support DGHS to further improve their capacity to deliver quality FP, MR and PAC services and for ownership and accountability.

# 1. Introduction

## 1.1. Description of the QFP project of Ipas

With the FCDO funding, Ipas was assigned - to implement the project, 'Family Planning in Bangladesh - Improving Quality and Access' (QFP) during (October 2016– July 2021) with a goal to reducing the unmet need for contraceptives and thereby unwanted pregnancies and unsafe abortions in the country [1]. The project emphasized on delivering post abortion family planning (PAFP) and postpartum family planning (PPFP) services to women. It contributed to the Sustainable Development Goal (SDG) 3 – good health and well-being; the Government of Bangladesh's FP2020 commitments; and the 7th Strategic Objective of the 4th Health Population Nutrition Sector Program (HPNSP, 2017-2022) of Bangladesh. This program also contributed to the UK government's manifesto commitment to 'end preventable deaths of mothers, new-born babies and children in the developing world by 2030'[2].

Ipas with its four NGO partners[1], (RHSTEP, BAPSA, BASA, BNNRC) worked closely with both the Directorate General of Health services (DGHS) and the Directorate General of Family Planning (DGFP) to implement the program in selected facilities ranging from primary to tertiary in seven divisions namely Sylhet, Chattogram, Barisal, Dhaka, Rangpur, Rajshahi and Mymensingh of Bangladesh where unmet need for contraceptive, unwanted pregnancy and unsafe abortion was the highest. The project aimed to make inroads to a significant but neglected area of maternal health in Bangladesh: death and injury from unwanted pregnancy by improving availability of high-quality contraceptive services, menstrual regulation (MR), and post abortion care (PAC), educating and empowering women, men and adolescents to access services and advocating at the national and local level for improved reproductive health policies. Special attention was given to increasing the availability and utilization of long acting reversible contraceptive and permanent methods (LARC and PM). The project focused on increasing quality and access to family planning (FP), MR and PAC service through increasing number of DGHS facilities that agreed to provide these services, improving contraceptive quality standard of these facilities, initiating the above mentioned services within the facilities by providing training to the service providers, ensuring the trained providers are providing the services, increasing number of FP adopters along with long and permanent method users, ensuring these facilities are able to indent FP related commodities from DGFP regularly, introduction of Imprest fund[2] up to district hospitals, introduction of FP service reporting through District

[1] Reproductive Health Services Training and Education Program (RHSTEP); Bangladesh Association for Prevention of Septic Abortion (BAPSA); Bangladesh Association for Social Advancement (BASA); and the Bangladesh NGO Network for Radio and Communication (BNNRC)

[2] Imprest fund: For LARC and PM (IUD, implants, female sterilization), service providers performing the procedure and clients receiving the methods get incentives. This incentive is allocated from a fund that is known as Imprest fund.

Health Information System (DHIS-2)[3], developing guidelines for service provision and policy advocacy etc.

In the beginning, the program assumed that introducing FP and MR and PAC services within the program supported DGHS facilities, ensuring availability of commodities, training up the providers with relevant skills and overcoming policy barriers would surely increase number of women using contraceptives that would lead to maternal death reduction. After two years of implementation, the project realized the importance of resetting the target to increase access to quality family planning in the program supported DGHS facilities. Other than this, the program also aimed to health system strengthening to ensure quality family planning. Considering these issues, the program revised the log frame and theory of change and focused on building strong relationship with government body, technical assistance provision and investment that would bringing change in government policy, system and service delivery practice which would result in institutionalization of the program and lead to increased availability of quality FP service in DGHS facilities.

To increase and ensure FP service provision, FP acceptors, performance reporting, incentives provision through Imprest fund- Ipas focused on increasing the number of trained providers, improving medical standard of the facilities for service provision, ensuring logistics supply through indenting to DGFP, improving reporting mechanism, increasing number of facilities that can access Imprest fund, adding FP service provision in the job responsibilities of midwives and technical support provision. For this purpose, the initiatives undertaken by Ipas are: i) built capacity of the service providers on short acting FP methods, LARC and PM, MR and PAC service provision and counseling through training ii) train new providers through on-the-job orientation and established institutionalization of standard practice in tertiary, secondary and primary level facilities iii) developed various guidelines and protocols for clinical service provision and for the service delivery mechanism of the private sector facilities iv) renovated the facilities and developed, and used behavior change communications (BCC) materials v) ensured logistics and direct handling of Imprest fund by DGHS vi) advocated at policy level to recognize the program supported DGHS facilities as service delivery points (SDPs) that have ensured consistent logistics supply, performance and logistics reporting vii) advocated at policy level for direct handling of Imprest fund by the DGHS facilities viii) provided support to DGHS to build capacity for procurement of the quality MR and PAC device. ix) incorporated in DGHS supply management systems the procurement and supply of Manual Vacuum Aspiration (MVA).

Ipas also advocated to the National Technical Committee (NTC) chaired by the DG of DGFP and the DG of DGHS to expand the provision of MR, PAC, and FP including IUD services. Ipas also contributed in

[3] DHIS2: MIS-DGHS has established a web based data collection system called District Health Information System (DHIS, version 2) to collect routine health data from the government health facilities of Bangladesh.

forming a steering committee where the DG, DGHS is the Chair and a director from the DGFP is the Member Secretary for effective collaboration between the two directorates and the other stakeholders for guiding successful implementation of the planned interventions. The steering committee, with support from Ipas, was formed to make collaboration effective.

Other than these, Ipas conducted joint monitoring visits to facilities with Line Directors (LDs), Program Managers (PMs) and other officials of DGHS and DGFP to monitor implementation related issues for logistic supply, Imprest fund management issues and engagement of the local management in service delivery. In addition, Ipas conducted periodic monitoring visits to assess the quality of services, utilization of training and to put forward recommendations for improved quality.

Also, in collaboration with DGHS and DGFP, Ipas updated clinical protocols for MR, PAC and FP services with technical assistance from Obstetrical and Gynecological Society of Bangladesh (OGSB) and in some special cases from Royal College of Obstetricians and Gynecologists (RCOG) for improving quality of services. Ipas, in 2018 provided technical support to update of the National Family Planning Manual of DGFP. The manual was approved, printed and distributed by DGFP. Ipas provided technical assistance to DGHS and DGFP to develop an integrated register for FP services in DGHS facilities as well. During COVID-19, Ipas took special initiatives by using virtual platform for training, monitoring and follow-up to continue FP, MR and PAC services.

Purpose of this study is to validate Ipas's QFP Project interventions to understand how well it could achieve its goals, overcome the implementation related challenges and adapt the learnings in the national health system for sustainability.

## 1.2. Specific objectives of the study:

1. To document the role of Ipas program in developing and implementing
   - ✔ policies, guidelines and protocols for institutionalization of FP, MR and PAC services;
   - ✔ new policies in procurement of FP, MR and PAC related instruments and commodities by the DGHS facilities through the LMIS of DGFP;
   - ✔ new policies for flow of Imprest fund from DGFP to DGHS for incentives of the DGHS providers for FP, MR and PAC services;
   - ✔ capacity development activities and engagement of relevant health care providers in delivery of FP, MR and PAC services;
   - ✔ data flow channel for reporting of FP, MR and PAC service data from DGHS facilities to the HMIS based in the DGHS;
   - ✔ dissemination of renovation and facility-based behavior change communications (FBCC) activities at DGHS facilities for promoting FP, MR and PAC services;
   - ✔ interventions for crisis management including severe adverse events while providing FP, MR and PAC services;
   - ✔ coordination and collaboration among DGHS, DGFP and professional bodies for FP, MR and PAC service introduction/strengthening in DGHS and private sector
2. To document the role of each of the above interventions in creating positive environment in local and national levels for effective delivery of FP, MR and PAC services by health system strengthening through collaboration among the relevant stakeholders (DGFP, DGHS and private sector).
3. To determine the contribution of Ipas program to the FP (including Long Acting and Reversible Contraceptive (LARC) & Permanent Method (PM)), MR and PAC services in Ipas supported facilities in Bangladesh.
4. To identify the factors, enable and/or hinder the uptake of FP (including LARC & PM), MR and PAC services.
5. To identify the challenges in implementation of the above health system interventions of Ipas and gather suggestions from the stakeholders to overcome those for way forward.

# 2. Methodology

This is an exploratory study comprising of both qualitative and quantitative research methods along with document review. Objectives 1, 2 and 5 have been addressed qualitatively and through document review. The rest of the objectives have been addressed quantitatively. The assessment covered all the three tiers of the health system i.e. division, district and upazila level, where Ipas intervention was implemented. The service centers have been selected purposively by taking the performance of clinical contraceptives into consideration so that the factors contributing to the success and challenges of Ipas intervention could be documented through this assessment.

## 2.1. Document review

A thorough review of the Ipas project related documents including annual reports, periodic progress reports, review reports were conducted as listed below.

1. Business case Improving Access to Quality Family Planning (QFP) in Bangladesh
2. QFP narrative proposal
3. Revised logframe for QFP project
4. Quarterly reports (Year 1 to year 5) of QFP Project
5. Annual review 2017, 2018, 2019 and 2020 of the program “Family planning in Bangladesh-improving quality and access”
6. Client exit interview (CEI) 2017, 2018 and 2019 of the program “Family planning in Bangladesh-improving quality and access”
7. Social Behavioural Change (SBCC) baseline and midline report of the program “Family planning in Bangladesh-improving quality and access”
8. Training strategies for the service providers under DGHS (doctors, OB/GYN, consultants, nurses, midwives) for postpartum family planning (PPFP)
9. Training strategies for the service providers under DGHS (doctors, OB/GYN, consultants, nurses, midwives) for family planning, menstrual regulation (MR) and post abortion care (PAC) services
10. Achievement beyond the logical framework of QFP program

The document review helped understand the details of the intervention developed and related barriers in implementation of the planned intervention; need for health systems adjustment for effective delivery of the intervention; process of developing and implementing new policies; changes taking place after implementation of new policies etc. The findings of the document review have been aligned with the qualitative findings.

## 2.2. Study sites (qualitative)

For the qualitative part, the study collected data from four medical college hospitals (MCHs), four district hospitals (DHs) and four upazila health complexes (UHCs) under DGHS including two private medical college hospitals from four divisions. The areas have been selected purposively considering the performance of clinical contraceptives (see **Figure 1** and **2**) so that the factors contributing to success and challenges of Ipas intervention can be documented through this assessment.

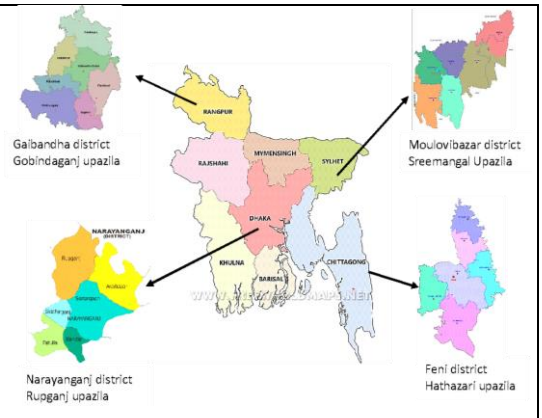


**Figure 1: Study sites (qualitative)**

## 2.3. Qualitative data collection and sampling

This study collected qualitative data through in-depth interviews (IDIs) and key informant interviews (KIIs). Under the direct supervision of the study PI and Co-PI, three female research officers with degree and experience in social science studies were trained and engaged in data collection activities. A week-long training on the data collection tools and interviewing techniques of qualitative research was conducted before starting the actual data collection. Further, field testing of the IDI and KII interview guidelines were done before data collection commenced. All data was collected between May-June, 2021. All IDIs and KIIs were audio-taped and transcribed verbatim into Bengali. All findings were directly written in English from Bengali transcription by the investigators.

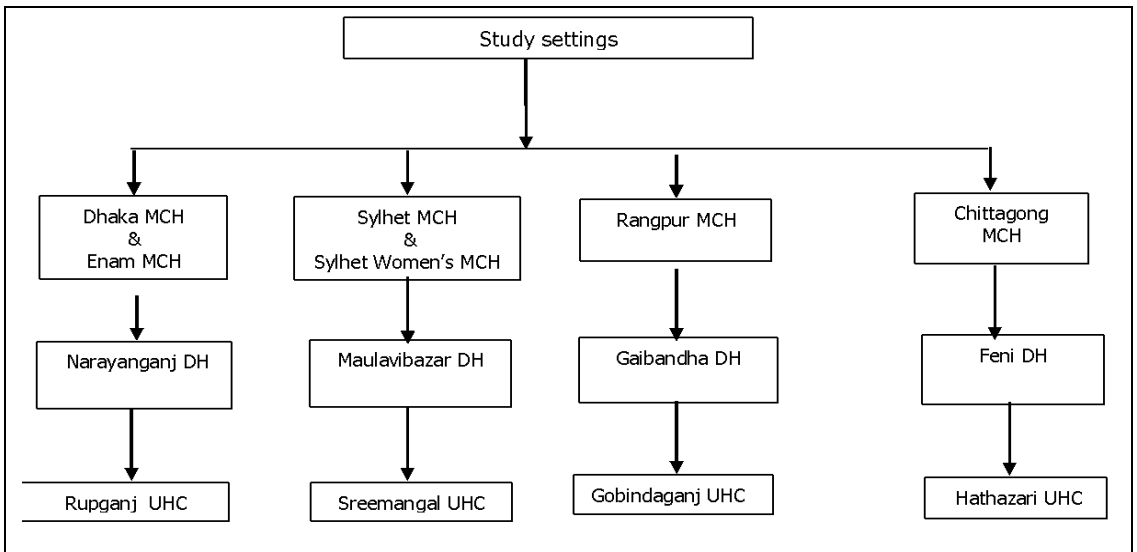


**Figure 2**: **Study settings (qualitative)**

### 2.3.1 IDIs and KIIs

We have conducted 78 interviews comprising of 32 KIIs and 46 IDIs selected from DGHS, DGFP, private and NGO sectors at different levels of the health system as shown in **Table 1**. IDIs were conducted to collect information from service providers which included doctors, nurses, midwives, accountants, and statisticians. KIIs were conducted with Directors, Line Directors, Program Managers, Deputy Program Managers, Civil Surgeons (CSs) and Deputy Directors of family planning (DDFP) at district level. Main topics discussed in IDIs and KIIs are described in **Table 2.** During the planned data collection period, due to country-wide lockdown for COVID-19 pandemic, in order to minimize the risk of transmission of infection, most of the interviews were conducted through using virtual platforms such as Zoom and over phone as per the convenient time and date of the study participants. The interviews lasted approximately 50 minutes to 1 hour and were audio-taped. Non-randomized, purposive sampling was used to identify the respondents. After obtaining consent, we interviewed the participants.

**Table 1: List of the study participants for IDIs and KIIs**

| Diff. level | Area | Qualitative interview done | | | |
|---|---|---|---|---|---|
| | | **Group for KII** | **Total KII** | **Group for IDI** | **Total IDI** |
| Central level | | DGHS (LD/PM/Deputy Program Manager (DPM)<br>DGFP (LD/PM/DPM)<br>NGOs & others:<br>[RHSTEP Executive Director (ED); BAPSA (ED); OGSB (President/focal person); FCDO (Health Advisor); Ipas (ED)] | 16 | Trainer (GO/NGOs) | 5 |
| Divisional | Dhaka | Head obstetrician/gynecologist (Ob/gyn); Head ob/gyn pvt. | 2 | Doctor, Obgyn<br>Focal Person (FP)<br>Senior Staff Nurse (SSN);<br>Account officer | 4 |
| | Rangpur | CS; DDFP; Doctor- Head of ob/gyn | 3 | Doctor- Head of ob/gyn;<br>Focal person (SSN); SSN;<br>Account officer | 4 |
| | Sylhet | DDFP; Doctor, Head ob/gyn; Doctor- private hospital | 3 | Doctor-ob/gyn; Focal person (SSN); SSN;<br>Account officer | 4 |
| | Chattogram | Doctor; Head of Ob/gyn | 1 | Doctor- obgyn<br>Focal Person (SSN); SSN | 3 |
| District | Narayanganj | (CS is not informed well and DDFP post vacant) | 0 | Doctor, Residential Medical Officer (RMO); Doctor- Ob/gyn; Focal person (SSN); SSN; Account officer; Statistician | 6 |
| | Gaibandha | DDFP | 1 | Doctor- Head of Ob/gyn<br>Focal Person SSN | 3 |

| | | | | | |
|---|---|---|---|---|---|
| | Moulvibazar | DDFP;<br>Hospital Superintendent | 2 | Doctor- Head of Ob/gyn;<br>Focal person (SSN); SSN;<br>Statistician | 4 |
| | Feni | Doctor- Head of Gynae | 1 | Doctor- (Superintendent);<br>Focal Person/Family Welfare Visitor (FWV); SSN;<br>Account officer; Statistician | 5 |
| Upazila | Rupganj | Medical Officer Maternal Child Health and Family Planning (MOMCH-FP) | 1 | Doctor ob/gyn;<br>Focal person (SSN) | 2 |
| | Gobindaganj | - | 0 | Focal Person (Midwife) | 1 |
| | Srimongol | Upazila Health and Family Planning Officer (UH&FPO); MOMCH-FP | 2 | Doctor, ob/gyn<br>Focal person (SSN) | 2 |
| | Hathajari | - | 0 | UH&FPO; Doctor-ob/gyn;<br>Focal Person (SSN) | 3 |
| **Total** | | | **32** | | **46** |

**Table 2: Topics discussed with IDI and KII participants**

| IDI | KII |
|---|---|
| 1. Information related to LARC and PM service delivery from the relevant facility<br>2. Flow of Imprest fund from DGFP to DGHS for incentives of the DGHS providers for FP, MR and PAC services<br>3. Procurement of FP, MR and PAC related instruments and commodities by the DGHS facilities through the LMIS of DGFP<br>4. Data flow channel for reporting of FP, MR and PAC service data from DGHS facilities to the HMIS based in the DGHS<br>5. Promotional activities and site readiness of DGHS facilities for providing quality FP, MR and PAC services<br>6. Interventions for crisis management including severe adverse events while providing FP, MR and PAC services | 1. FP, MR and PAC service delivery related policies, guidelines and protocols related information<br>2. FP, MR and PAC service delivery relevant logistic and equipment supply<br>3. Provision of incentives from DGFP to relevant DGHS service providers from the Imprest fund related information<br>4. Technical skill training activities of relevant service providers<br>5. Incorporation of relevant data from DGHS facility into HMIS database<br>6. Promotional activities for quality FP, MR and PAC service delivery<br>7. Intervention for crisis management while providing FP, MR and PAC services to the clients<br>8. Coordination and collaboration with DGHS, DGFP and other relevant institutions for FP, MR and PAC services and sustainability |

### 2.3.2 Assessment of promotional activities and site readiness regarding FP service delivery within the facilities

A total of seven health facilities were visited, covering from three divisions (Dhaka, Rangpur and Sylhet) except Chattogram. These facilities were purposively selected considering high and low performance for FP, MR and PAC service utilization to capture the enabling factors and barriers in related service provision. The observations documented family planning related promotional activities in terms of BCC materials and site readiness for FP, MR and PAC services.

## 2.4 Quantitative data and variables

### 2.4.1. Study sites

All FP service data (secondary), from the Ipas supported 210 facilities across 6 divisions, collected during February 2017 – December 2020 by Ipas was used to demonstrate the uptake in intervention, to examine utilization, trends and to identify factors of short acting, LARC and PM, MR and PAC services (**Table 3**).

**Table 3: Distribution of different Ipas intervention facilities from where secondary FP service data collected**

| Site Type | Number of facilities n=210 |
|---|---|
| Medical College Hospital (MCH) | 15 |
| District Hospital (DH) | 35 |
| Upazila Health Complex (UHC) - Health Unit | 85 |
| Upazila Health Complex (UHC) - FP Unit | 31 |
| Mother and Child Welfare Centre (MCWC) | 10 |
| Private MCH/Hospital/Clinic | 19 |
| RHSTEP Clinic | 15 |

### 2.4.2. Data description

Secondary data collected from the Ipas program was checked for inconsistencies (like missing values only 0.1%) and then cleaned manually and finally for FP service data 8,78,177 cases and MR and PAC services 1,73,084 cases were used for further analysis.

## Variables

Utilization of LARC and PM methods (Yes or No), Utilization of IUD (Yes or No), utilization of implants (Yes or No), utilization of tubectomy (Yes or No), utilization of MR, utilization of PAC, age of the clients in years (<=19 years, 20-24 years and >=25 years), project year (Year 1: Feb'17-Dec'17, Year 2: Jan'18 -

Dec'18, Year 3: Jan'19-Dec'19 and Year 4: Jan'20-Dec'20), study site type (district hospitals (DH), medical college hospitals (MCH), mother and child welfare centre (MCWC), private MCHs/hospitals and, upazilla health complexes-FP units, upazilla health complexes-Health units, and RHSTEP clinics), site category (primary, secondary and tertiary), provider type (doctors, nurses/midwives, FWVs/SACMO/paramedics), adoption of Ipas training (trained and untrained), patient type (interval, postpartum and post-abortion), and client type (adopters, changers/continuers).

## 2.5 Analysis

### 2.5.1 Qualitative analysis

Three major steps were followed to analyze the qualitative data. At the first step, transcripts were prepared during the course of the data collection from audio recorded files. Secondly, codes were developed based on review of transcripts. These codes were done deductively and grouped into categories. Finally, in the third step, the researchers developed themes that expressed the content of data from each of the grouped codes. Coding categories was derived from initial research themes, as well as emerging concepts. Thematic analysis was conducted based on relevant findings on barriers in introducing FP, MR, and PAC including LARC and PM services and strategies to overcome the barriers to ensure those services in DGHS facilities. The data analysis process was iterative which involved concurrent data collection and analysis. The narrative data from the interviews was summarized in the form of word text files. A team approach was employed to minimize individual biases. A total of ten main dominant themes appeared and reappeared. Data analysis was done manually based on themes and sub-themes. The following **Table 4** is presenting the themes and sub-themes according to the study findings.

**Table 4: Themes and sub-themes based on the responses**

| |
|---|
| **Theme-1: Service delivery and service uptake**<br>**Sub-theme:**<br>✓ *Extending service provision and accessibility from out-patient department to in-patient department*<br>✓ *Contribution of counseling to motivate clients for short acting and long-acting family planning (FP) methods*<br>✓ *Long-acting and reversible contraception and permanent methods (LARC and PM)*<br>✓ *MR and PAC service delivery*<br>✓ *Challenges for service providers* |
| ***Theme-2: Impact of training on skills and attitude of service provider*** |
| **Theme-3: The mobilization of Imprest fund**<br>**Sub-theme:**<br>✓ *The challenges in mobilizing the Imprest fund* |
| **Theme-4: Management of logistics and equipment** |
| **Theme-5: Services and logistics reporting mechanism** |

| |
|---|
| **Theme-6: Promotional activities and site readiness**<br>**Sub-theme:**<br>✓ *FP service promotion*<br>✓ *FP, MR and PAC procedure room*<br>✓ *Guidelines and protocols*<br>✓ *Service register books* |
| **Theme-7: Guideline and protocols** |
| **Theme-8: Crisis management including severe adverse events while providing FP, MR and PAC services**<br>**Sub-theme:**<br>✓ *Training on management of adverse effect or complication of FP, MR and PAC services*<br>✓ *Experience of managing the clients who had FP, MR and PAC related adverse event/complications*<br>✓ *Dealings with public when managing clients those had adverse event* |
| **Theme-9: Collaboration, coordination and support**<br>**Sub-theme:**<br>✓ *Bridging the gap for the collaboration between DGFP and DGHS*<br>✓ *Supervision and Monitoring* |
| **Theme-10: Sustainability** |

## 2.5.2 Quantitative analysis

Descriptive analysis was done to explore relevant socio-demographic study variables of the study participants for all QFP Project intervention facilities. Distribution by facility type was checked for overall FP methods, short-acting methods, LARC and PM, MR and PAC services.

We have reported 'trend in FP service provision' to assess the performance of a facility in terms of quantity of services provided over time. It has been defined as the percentage of specific FP service provided from a specific type of facility over time.

Also calculated 'acceptance rate of FP method' to assess the ability of a facility in promoting a specific FP method. It has been defined as the proportion of clients accepting a specific FP method among the total number of FP clients in a facility within a specified time period.

Logistic regression analysis was done for identifying factors associated with different LARC and PM by type of facilities adjusted for different co-variates. Statistical significance of results was defined as p-values of <0.05. Quantitative data analysis was done by SPSS V.20.

# 3. Qualitative findings

## 3.1. Service delivery and service uptake

To improve quality of and access to FP, MR and PAC services, the QFP Project focused on: family planning for postpartum and postabortion clients, accessing facility delivery and abortion care at the DGHS facilities by those who would potentially be in need of contraceptives. The project also emphasized on reducing unsafe abortions; hence, attempted to improve MR and PAC service provision in these facilities. Throughout the project period, Ipas gradually extended its support to 210 facilities (MCH=15, DH=35, UHC health unit=85, UHC FP unit=31, MCWC=10, Private MCH/clinic=19, RHSTEP clinic=15), trained 1,219 service providers (doctors, nurses, and midwives) who provided services to 721,106 clients for FP method adoption after child delivery or abortion and provided MR and PAC to 155,033 clients and contributed to improved service utilization [1].

Before the Ipas intervention, the FP services to the PPFP and PAFP clients at the DGHS facilities in different layers of the health system were very limited. In some of the MCHs, there were model clinics from where both short- and long-acting FP services were available. However, in the obs/gyne department of MCHs, there were no supply of FP commodities and logistics for the PPFP and PAFP clients. Although a family welfare visitor (FWV) in the DH was assigned to provide short-acting methods from outpatient department and to supply FP commodities and logistics to the inpatient care providers for PPFP and PAFP, this mechanism did not work very well. In the health unit of UHC, there was no provision of FP services at the inpatient department for PPFP and PAFP as well. To strengthen the FP services to the PPFP and PAFP clients, the QFP Project of Ipas has taken initiative for direct supply of both short- (OCP, condom, injectables) and long-acting (IUD, implant) methods at the inpatient department of MCHs, DHs, and health unit of the UHCs.

The in-depth interviews with service providers helped us understand the process of service delivery and uptake and how the output of the project had been possible to achieve. In terms of FP services, the service providers attributed that they deliver both services which include short-acting (pills, condoms, injectables) and long-acting (IUD, implants)/permanent FP method (tubectomy). The health service providers further articulated that they offer a full range of FP methods to the clients.

In this regard, one nurse of a DH has given the following explanation in her own words:

*“When we counsel the clients, we sit with the family planning method-related leaflets in front of the clients so that they can know about all the methods.”*

The service providers particularly mentioned that they suggested clients for accepting any long-acting method if she had two children or more.

In this regard, one doctor (service provider) of a UHC stated:

*"If the client does not have any child or one child, we normally counsel for short-acting method. We also counsel her to take another child after 2 to 3 years later; for those who already have 3 to 4 children, we tell them not to take anymore child as it is risky for their health. So, we try to convince them to adopt a long-acting method. Otherwise, we offer them all the methods. If the client wants to take short-acting method, we provide short acting method, if the client wants to take a long-acting method, we provide her a long-acting method."*

The service providers reported that the clients were more inclined to adopt short acting methods during the time of the COVID-19 pandemic. The reasons were explained by the service providers during interviews. They reported that a significant number of clients during the COVID-19 pandemic were afraid of visiting hospitals for ANC, PNC, delivery and other maternal health-related care. The service providers further added that they had difficulty in counseling the clients to adopt FP methods as the clients were not visiting hospitals during the pandemic. They further reported that the clients were more inclined to adopt short-acting FP methods during the COVID-19 pandemic. The stated reason was that the clients were afraid of visiting healthcare facilities during the COVID-19 pandemic. Further, the service providers acknowledged that this resulted in more incomplete abortion as the clients used self-medication for MR outside the formal healthcare setting. They added that the clients, in some cases, came to the hospital for PAC service during the COVID-19 pandemic when the abortion was incomplete due to taking non-prescribed medication at home. The healthcare providers also mentioned that compared to other times, PAC service had increased during the COVID-19 pandemic as the clients were not visiting hospitals for MR services due to the fear of getting infected with COVID-19.

In this regard, one doctor of an MCH said:

*"During COVID-19, clients are taking more short-acting method (pills). Clients also do not come for ANC check-ups right now. We are getting PAC clients more now. On an average, we now get 10-15 PAC clients during the time of corona. Now, clients are more afraid of visiting hospital. Instead, they take abortion pills and get admitted here with incomplete abortion."*

### 3.1.1. Extending service provision and accessibility from outpatient to inpatient department

The DGHS service providers reported that FP services were not provided at the inpatient department of the DGHS facilities prior to the QFP Project. Rather, the FP service was being provided by the DGFP-assigned personnel at the outpatient department of the DGHS facilities. Hospital personnel further explained that the DGHS personnel were previously not involved in delivering FP services, neither were they trained to provide FP services, except for FP-related emergencies or referred cases from outpatient department or from other facilities. The service providers attributed that it became possible for the first time because of the QFP Project to provide FP services to the inpatients, particularly to those who were

admitted for the facility delivery or for the PAC service. They opined that it fostered strengthening of the FP service provision at the DGHS facilities.

In this regard, one nurse from a DH said:

*"We could not provide any family planning service to the clients who were admitted at the hospital for delivery before Ipas started to work with us. The services were available at the health facilities only for outpatients. Now, we are providing FP-related services to our inpatients who visit our health facilities. So, obviously, it has increased our services. Now, we directly can provide the method."*

According to the service providers, the QFP Project trained them to provide services on FP, MR, and PAC, which enabled them to deliver these services to the indoor clients. They further explained that before the QFP Project of Ipas, they couldn't provide these services due to the lack of training which hindered indoor FP service provision. Moreover, it indirectly affected overall delivery of the FP service. The service providers further mentioned that the training was a necessary condition to begin postpartum and postabortion FP (PPFP and PAFP) services at the indoor. The hospital personnel admitted that the QFP Project of Ipas trained up doctors, nurses, and midwives at the DGHS health facilities on short- and long-acting FP methods. In particular, they reflected that doctors were trained on providing IUD and implant, and the nurses and midwives were trained on providing IUD, performing MVA (for MR and PAC service) and on providing short-acting methods, like pills, condoms, and injections.

Nurses and midwives mentioned that their knowledge on FP service was inadequate prior to the training given by the QFP Project. They acknowledged that the training helped them learn about both short- and long-acting FP methods and capacitated them to provide these services. This, in turn, increased the accessibility to services.

One nurse of a UHC said:

*"We did not have any knowledge about FP methods. Now, we know four types of methods. We now can deliver services related to FP methods according to client's choice."*

The key informants reported that the improved accessibility to FP services during the project period could be attributed to: (i) counseling clients during ANC check-ups and following up after delivery; (ii) counseling clients during the time of admission for abortion care and following up after the abortion.

One policy implementer of the DGFP stated:

"*This is where QFP Project focused. Previously, we did not follow up clients for adopting methods, neither we were aware that the clients had left the facility already who might never come back for FP services. The project motivated the service providers to go an extra mile to stick to the clients from the beginning to end of her required service and then following her up for adoption of methods."*

### 3.1.2. Contribution of counseling to motivate clients for short- and long-acting FP methods

Most of the service providers reported that training by Ipas contributed in improving their counseling skills for motivating the clients for adoption of FP methods, particularly for the long-acting ones. The providers discussed that the project emphasized on clients' counseling where a provider would counsel the clients on short- and long-acting methods, its procedure, advantages, and the side-effects. In addition to that, the Imprest fund provided incentives to the clients, which act as a compensation to the client for the time spent and the indirect cost they would be bearing for selecting LARC and PM. The service providers further explained that counseling on the above-mentioned issues helped clients in adopting a method, specifically a long-acting one. According to the service providers, the counseling service of the program succeeded to improve acceptability of FP methods among the clients to a great extent.

In this connection, one doctor of a DH stated:

*"Earlier, we only performed female sterilization in the inpatient department. There was one counselor at the outpatient department for family planning services. The counselor, sometimes, provided short-acting methods. The program assigned a counselor whose sole responsibility was to counsel clients for both types of methods. When she started the counseling, we could see a huge change in the acceptance of IUD among clients. In 2017, it was 115 and, in 2018, it was 299. This change has happened due to the counseling service provided by the counselor."*

Service providers also mentioned that they never counseled inpatients for adopting FP services before the Ipas interventions. After implementation of the project, more emphasis was given on counseling the clients to motivate towards making decision about using an FP method, at least for short-acting ones if they could not be motivated for long-acting ones.

In this regard, one nurse of an MCH said:

*"I counsel the mothers during pregnancy, during delivery, and postpartum to ensure that none of them misses the counseling service. We supply of Apon and Sukhi pills as well as PP-IUD and female sterilization after surgery. I counsel my clients not to take child within two years after having a child. I provide FP methods as per the choice of the clients. If clients prefer to have implant, our doctors provide them implant according to their choice."*

To facilitate counseling, Ipas had provided a service facilitator to extent support for implementation of QFP Project in different DGHS facilities. In some facilities, these service facilitators had been engaged in counseling, and they (service providers of facilities) used to call them 'counselor'.

### 3.1.3 Long-acting reversible contraception and permanent methods

From our IDIs and KIIs, we came to know that only tubectomy service was available after cesarean section at the DGHS facilities before the QFP Project interventions. At that time, this service was not possible after normal delivery. The respondents also mentioned that it has been possible to provide all types of FP services to clients after the initiation of the QFP Project intervention, particularly to those who are admitted for delivery or PAC services. They opined that it fostered strengthening of the service provision for long-acting reversible contraceptives and permanent methods (LARC and PM) at the DGHS facilities as well.

One nurse from a DH said:

*"Before Ipas started to work with us, we could not provide any family planning-related service to the clients who were admitted at the hospital for delivery. Previously, only the short-acting methods were available at the health facilities from outpatient department. Now, we are providing FP services with special emphasis on LARC and PM to the inpatients as well. So, obviously, the QFP Project has enhanced the FP service provision in the DGHS facilities."*

Key informants mentioned that an important goal of the project was to increase service delivery and acceptability of LARC and PM. According to them, acceptability of LARC among clients had been low, particularly for IUD which had the lowest acceptance rate in Bangladesh. Ipas interventions had helped improve acceptance of IUD.

One program manager from the DGFP central level said:

*"IUD-use in Bangladesh is nearly 6%. Other Muslim countries, like Jordan and Syria, have 40% IUD-use rate. It was becoming difficult to increase IUD-use rate here in Bangladesh. However, because of the Ipas's activities on family planning and emphasis on long-acting FP methods, IUD-use is improving."*

Another key informant also stated that policy advocacy done through this project ensured improved quality of service delivery as well as accessibility by enabling doctors and nurses to provide FP services.

Although service providers stated that counseling played a major role in motivating women for adopting long-acting methods, however, religious stigma, women's limited decision-making power, misconception about FP methods, particularly about IUD, remains as barriers to accepting and adopting IUD.

One nurse of an MCH stated:

*"Many are afraid of taking IUD, thinking that a foreign body be inserted inside the body. Most of the time, husband also refuses. Those who come with the mother-in-law always say if there is such a foreign body inside her body, she may not get Janaja (funeral ritual) after death. So, some superstitions still exist."*

The service providers further reported that they are still trying their best to clear clients' misconceptions about long-acting methods, keeping their counseling training in mind.

In this regard, one doctor of a UHC stated:

*"We then counsel them by giving example, such as while patients with heart disease go through a surgical operation and need to have ring-like device, their funeral is performed. If you die with device, your funeral will also be done. We try to counsel them this way."*

The service providers also reported that if any woman faces any side-effect of IUD or implant, they discuss it with other women in the neighborhood, and it has serious impact in the community, particularly in rural areas. After hearing these issues, other women in the neighborhood do not want to use it and also suggest others not to take these methods.

One doctor of a DH said:

*"Generally, clients come to us with serious health problems after taking an IUD. They also face serious obstacles from their family members, especially husband and mother-in-law. The clients are taking IUDs but they are coming after a few days with complications to take it out. In many cases, they face problems, like getting the IUD stuck in the wall of the client's uterus. When this happens, the doctor needs to widen the cervix with medicine and use forceps to pull it out. When a client shares this experience with her relatives and neighbors, she hugely influences other women not to accept IUD."*

As per our document review, acceptance rate of other long-acting methods, like implants was also low--according to the client's exit interview in 2019 while about 47% of the clients were counseled for taking implants and only 7% accepted it [3]. Several healthcare providers reported that they could not perform more than 5 to 6 implants per month. They recognized lack of manpower as one of the reasons for low uptake of Implants. According to them, as implant is provided by doctors who are in duty, mostly in the morning shift, however, the related services are not available in the evening and night shifts. Another reason for the low rate mentioned by the service provider was client's complaining attitude and fear of the method.

One doctor (obs/gyne) working in MCH said:

*"When a client is informed that there will be cessation of menstruation after having implant, they wrongly perceive that it will do harm to their health by accumulation of wastes within the uterus causing different diseases."*

In this connection, another nurse of a DH said:

*"The clients ask: what will happen if they cannot be pregnant after 3 years of the use of implant. They have misconception that even after removal of implant, they may not become pregnant."*

### 3.1.4. MR and PAC service delivery

According to our respondents, the DGHS service providers were reluctant to provide these services, although DGFP service providers started providing MR services since 1979.

In this regard, one KI of the DGFP said:

"*A negative attitude existed among the DGHS service providers or among the gynecological society members regarding MR and PAC service. The service had its very own demand and even Government itself was providing the service. But the service provision was highly stigmatized among the service providers, and they did not want to deliver these services."*

Key informants further reported that doctors could perform surgical MR of clients who had eight weeks of pregnancy according to the previous regulation, and paramedics (i.e. nurses and midwives) could perform surgical MR of clients who had six weeks of pregnancy. Clients whose pregnancy period exceeded this time period could not seek care that led them to choose an unsafe abortion option.

Possibly for the above-mentioned reasons, clients did not have proper accessibility to MR and PAC services in earlier times before the Ipas interventions. The QFP Project played a crucial role in increasing clients' accessibility to MR and PAC services and in reducing unsafe abortion through advocating for the extension of the regulation on time restrictions for performing surgical MR. This policy advocacy contributed in extending the time period for performing surgical MR up to 12 weeks of pregnancy for doctors and up to 10 weeks for nurses and midwives.

The key informants further reported that bringing this change was possible because of Ipas's introduction of MVA and MRM-kit to the health systems of Bangladesh through this project.

Regarding MVA, one policy advocator mentioned:

*"The syringe (MVA) Ipas brought is highly effective. The syringe is big and with a long line cannula; with this, it is possible to terminate pregnancy up to twelve weeks. Earlier syringes were not built to terminate a twelve-week pregnancy; those could be used for terminating pregnancy up to eight weeks."*

According to our key informants, medical MR--a new addition to MR service provision had been introduced by Ipas for the first time.

In this regard, one key informant of the DGFP mentioned:

*"We work in a traditional way. We, sometimes, lack innovation. Ipas advocated for medical MR during various meetings and provided technical support to develop the guideline for medical MR."*

According to our document review, although the use of medical MR has increased in the last few years (3% in 2017, 5% in 2018, and 8% in 2019) [3-5], its use remains low. Still most MR and PAC clients seek care through MVA procedures (81% in 2017, 86% in 2018, and 72% in 2019) [3-5], although its use has decreased over time.

### 3.1.4.1. Attitude of the peer service providers regarding MR services

The key informants reported that a key contribution of the project was motivation of the service providers to provide MR and PAC services. For this purpose, Ipas introduced values clarification and attitude transformation (VCAT) as a tool in their training modality to understand provider's attitude regarding the service provision. The service providers who received training from Ipas acknowledged that the training transformed their negative attitude towards these services.

In this regard, one doctor of a DH said:

*"To ensure the MR and PAC service in Bangladesh, in particular to motivate and change the attitude of the service providers, the training by the Ipas program contributed immensely. It also helped improve the quality of and accessibility to MR and PAC services."*

Some respondents reported that the service providers who did not receive training and were not involved in MR and PAC service provision, sometimes, put pressure on trained providers not to provide these services for religious reasons. These untrained service providers also believed that providing this service is not a respectful job for the doctors. So, it would be good if all doctors and nurses at the health facilities receive training on knowledge, attitudes, and practices.

One doctor of a DH said:

"*My colleagues who did not receive training on MR and PAC try to demotivate me not to provide these types of services from religious perspective. They believe that providing FP services should not be the job of doctors. These are lower-grade work and should not be performed by doctors."*

### 3.1.4.2 Consumption of non-prescribed MRM-kit at different gestational weeks

Most service providers, managers, and key informants expressed their concerns about the availability of MRM-kit without a prescription. Most clients buy the MRM-kit from a nearby pharmacy as it does not require a prescription. In many cases, the clients come to a health facility for PAC service when the abortion remains incomplete after use of the kit. All the respondents suggested that further awareness-raising campaign is necessary against the sale of non-prescribed MRM-kit.

One doctor from a UHC said:

*"Clients randomly collect MRM-kit from the medicine shop without any prescription, even during the 5$^{th}$ month of pregnancy. I have seen many who took it without doctor's prescription. So, it needs awareness campaign on how to stop clients taking these tablets."*

### 3.1.5. Challenges for service providers

#### 3.1.5.1. Workload

In in-depth interviews, most service providers and managers mentioned that inadequate human resources already imposed a great workload on their shoulder, hampering their quality of services. Further, the additional responsibilities of FP service provision (counseling and performance of procedures) led to burnout and inefficient service delivery even when they wanted to deliver the service properly.

One manager of a district hospital echoed the issue of workload, thus:

*"Our senior staff nurses are so busy. They are busy in managing emergency and delivery clients. They do not have the scope of spending time to counsel a client to adopt FP method. If they get busy to provide counseling service, they cannot provide emergency service, and the attendants will get angry if the emergency service is delayed. In fact, our nurses do not get time to take breathe. As hospital superintendent, I always see that my nurses are running after patients."*

#### 3.1.5.2. Problem in human resource retention

A problem reported by our respondents is the transfer of trained manpower for which the continuation of services is greatly hampered.

Regarding this, one program manager of the DGFP said:

*"One problem in the health sector is that the doctors do not continue serve for long after having training. Either they go for a higher course or get transferred. For that reason, even after providing training, the benefit is not fully achieved."*

## 3.2. Impact of training on skills and attitude of service providers

The nurses and midwives informed that training helped them develop skills for providing short- and long-acting FP methods as well as MR and PAC services. The doctors, nurses, and midwives also informed that training provided a good span of time for practical sessions, which was unique compared to training organized by other development programs. Along with practicing on models/dummies, the trainees performed IUD/implants on real-time patients. Practical sessions helped develop a sense of confidence among them to perform procedures correctly.

One service provider (doctor) of a DH said:

*"Certainly, my confidence has increased after training. Now, I have been authorized to provide the service. I could do this earlier also but it was not legal for me to deliver the service as I didn't have training. Now, I have the training. Earlier, I was always worried whether I could do the job successfully! The training significantly improved my confidence and skill."*

Training also influenced their ability to handle complications that might occur for service provision. Providers stated, they did not face any difficulty to perform since they got the relevant training. If any complication occurred, they were confident to manage it by their own.

Trainers' friendly attitude also helped them to be comfortable enough to ask questions on execution of service. This enriched their knowledge on performance.

In this regard, one doctor of an MCH said:

*"The quality of training was unique. As a junior doctor, I had a lot of interest to learn, could ask the trainers as many questions as I had. As the training was conducted in an FP service center, there were plenty of clients who brought an opportunity to practice on both dummies and real clients."*

Respondents also informed that training helped change their attitude and perceptions about MR, PAC, and overall FP service provision. They put efforts to provide the service properly, keeping in mind the patient's comfort, particularly while providing IUD or performing MVA.

One of the nurses from UHC reported:

*"Earlier, I used to get really annoyed that I did not have time to listen to her (client) about problem related to the FP issues. I used to tell them to go to the FP officer for service. Now, the service is being given here in the ward of the hospital. Now, I know that I have to listen to her. I must give her time to understand her problems. Now, I do not get annoyed; rather, I go to her (admitted client) frequently. The training has made me sympathetic toward her."*

Asking about how the program training could do better; most respondents replied that arranging refresher training would help them more. All of them emphasized on the importance of refresher training, saying: even being trained, the lack of practice might result in losing the skill.

In this regard, one nurse of a DH said:

*"Had there been the provision of refresher training, it would be very helpful because day-by-day, not only the techniques are being upgraded but also there may be gradual lacking in our skills. The refresher training may help us fill up the gap."*

## 3.3. Mobilization of Imprest fund

A significant contribution of the QFP project for promoting LARC and PM FP methods was policy advocacy for direct operationalization of the distribution of incentives from the Imprest fund by the DGHS facilities.

For four types of methods (IUD, implant, sterilization, and recanalization), service providers performing the procedures and the clients receiving the methods get incentives. These incentives are allocated from

a fund that is known as Imprest fund. Before 2019, incentive for the DGHS providers and clients was functional under the DGFP. At that time, collecting incentives from the DGFP was no less than a hassle. Both providers and clients needed to submit the related bills to the upazila FP office for further processing. This processing was lengthy and time-consuming. Trade-off between collecting the incentives and time spent to collect that incentive were not satisfactory. This was the reason why service providers were reluctant to motivate clients and to provide these services. Similarly, clients who were already uninterested in LARC and PM services became more unwilling to get these services.

To motivate the service providers and to encourage the clients, and at the same time to ease the system of incentive collection, the Ipas program intervened via advocacy to modify the Imprest fund-related policy. As an outcome of this advocacy, Ministry of Finance (MoF), Ministry of Health and Family Welfare (MoHFW), DGFP and DGHS agreed upon to modify the running concept of Imprest fund and developed a new provision of Imprest fund in 2019 where the DGHS facilities can handle Imprest fund directly to provide incentives to the providers and clients.

The new process of the fund allocation and mobilization is electronically operated to make the fund (an advance amount of Tk. one lakh) available at the facility's bank account using the IBAS++ (Integrated Budget and Accounting System) software. The facility accountant then provides the fund to focal person who has been assigned for providing money to the clients and service providers. Focal person is responsible to provide clients' incentives, immediately after they receive the method. The care providers, on the other hand, submit a monthly bill to the focal person on the number and types of LARC and PM services they have provided. In both the cases, the focal person collects signatures from providers and clients against the bills as an acknowledgement that all parties have received the amount. To get the next allocation, the facilities submit request for re-allocation of fund. This fund transfer mechanism resulted in positive move to disbursement of the funds among clients and all designated personnel of the health facilities in a well-organized and timely manner.

In this regard, a nurse of a DH mentioned:

*"Earlier, I needed to go to MCWC to collect incentive. Processing of the bill was tedious. Now, we get the incentive directly from the facility. Clients also get their incentives instantly after having IUD or implants. Earlier, they could not get it on time and, sometimes, needed to spend Tk. 200 to Tk. 300 to come from home for collecting the incentive. No one would like to spend Tk. 200 or Tk. 300 to collect Tk. 173."*

According to our document review, the project has been successful to enable 166 of the 210 DGHS facilities supported by Ipas to access Imprest fund directly [1], which has benefitted and motivated both service providers and clients.

A doctor of an MCH stated:

*"We now get incentives regularly. Government has allocated an advance of Tk. one lakh. We get the incentives from that allocation. When the billing process is done, we and clients both get our portions. We*

*do not have to worry about how the clients would get her portion of the incentive later on. This is a huge change."*

### 3.3.1. Challenges in mobilizing the Imprest fund

Some service providers (IDIs) mentioned: in the absence of fund, sometimes, they required to provide incentives to clients from their own pocket. Sometimes, clients accused the service providers of cheating when they could not provide the money. Sometimes, the service providers even did not get the incentives on time.

In this regard, one doctor working in an MCH said:

*"For a long time, the FP service providers are giving incentives to clients from their own pocket. I believe it should be changed. Why the care provider has to spend own money for clients' incentive? What if I say that she (provider) makes the bill purposively without delivering the service! Why do I have to spend my money? What is the guarantee that I will get it back?"*

Lack of confidence and trust was also found to be existing in between the fund administrator and care providers. A number of fund managers also added they had been doubtful if the correct client had gotten the incentive since the handling of Imprest fund at the facility is done by the focal person (assigned doctor and nurse).

One fund manager of a DH said:

*"Sisters submit vouchers for performing implant, female sterilization, and IUD. They make a copy of it and keep one copy with themselves and submit another copy to the account's office. Cash is supposed to be handled by cashier. It is not the senior stuff nurse's job. How come she does the billing! There is a gap. I am unaware of what actually they are doing with the money."*

The service providers had suspicion against the fund administrators at the facility level regarding accounts settling.

One nurse of a DH opined:

*"Imprest fund is currently sanctioned by the DGHS. There are issues that I may not be able to state properly. But for the last one=and-a-half year, we are not getting our incentives. We are delivering these services but not getting the incentives."*

In addition, the key informants reported that many facilities up to district hospital level could not develop the capacity to handle Imprest fund yet. Lack of orientation on fund management was reported as a reason for unwillingness to operate the Imprest fund.

One policy implementer from the DGHS central level said:

*"Many facility managers or supervisors still do not understand the proper way of utilization of the Imprest fund, its mechanism, how to get the advance, bill adjustment, or audit facing, etc."*

On the other hand, upazila health complexes are still not enjoying the benefits of this new Imprest fund. This is also true for private health facilities. Service providers at UHC and private facilities have also to collect incentives from the DGFP. From IDIs of private facilities, we could know about their dissatisfaction for not including them in the new provision of Imprest fund management. Moreover, some of the private service providers at their own discretion charges from the clients for different LARC methods.

One doctor from a private health facility stated:

*"We are not getting any incentive, we never got any incentive. Neither Ipas has ever oriented us with this Imprest fund. Earlier, we have delivered IUD, Implant services free of charge. But now we have decided to charge Tk. 300 for implant. Although we are still working out to come to a consensus on how much to charge for these services since we are not getting incentives*."

## 3.4. Management of logistics and equipment

Prior to the QFP Project of Ipas, the health facilities under the DGHS were not covered by service delivery point (SDP) of the DGFP. At that time, the pregnant women used to be treated like other general patients and had to buy tickets for care-seeking. After the Ipas interventions, a special arrangement has been made for the pregnant and PNC-seeking women to directly access the ANC/PNC corner to get pregnancy care as well as PPFP-related services.

According to our respondents, only one FWV was available to provide FP services from outpatient department before the QFP Project intervention in the DGHS facilities (district hospitals). The FWV used to provide mostly the short-acting FP methods and counsel for LARC and PM for PPFP and PAFP. For the related services, she had to collect the required FP commodities and logistics from the designated upazila FP office. However, that was not adequate for full range of supply of FP commodities from the DGFP in a sustainable manner. On the other hand, the doctor at the inpatient department had to collect the method (to provide IUD to a CS patient) from this FWV. As the FWV was assigned to serve at the outpatient department, there was always a gap in coordination between the FWV and the care providers at the inpatient department for FP-related commodities and services. Consequently, LARC and PM services were provided in a very limited scale to the CS patients.

To ensure sustainable supply of FP commodities, the project advocated at policy level to bring the DGHS facilities under the Service Delivery Point (SDP) model of the DGFP. This means: similar to the DGFP facilities, the DGHS facilities would also receive FP, MR and PAC-related commodities (both long-acting and short-acting) directly from the DGFP. As outcomes of this policy advocacy, the DGFP started supplying all related commodities (pills, condoms, injectables, IUD, implants, MRM) to the DGHS facilities directly that have become the SDPs and would deliver FP services. As a result of ensuring supply of FP

commodities and logistics, the doctors and nurses at the DGHS facilities now can provide LARC and PM to the delivering women (both normal and CS) and PAC clients from the inpatient department.

In support of this, one key informant from central level said:

*"Before the Ipas intervention, the doctors of health department used to say that they want to provide IUD to the mothers after delivery but cannot do so due to lack of supply. As a result of Ipas intervention, the FP-related commodities and logistics have been made available at the MCHs and DHs from the upazila FP store. Now, the doctors in these facilities can easily provide LARC methods to their clients as PPFP and PAFP."*

Although the DGHS was mandated to provide PAC services, it did not have the procurement policy for buying related commodities like MVA which is used for surgical PAC and surgical MR. The project provided the MVA during the project phase. At the same time, it advocated at policy level for direct procurement of MVA by the DGHS and succeeded to incorporate it in the procurement policy of the Maternal, Newborn, Child & Adolescent Health (MNC&AH) operation plan. Ipas also advocated for local procurement of MRM by the facilities that were supposed to provide MR and PAC services, keeping account of the essential service package (ESP) document that stated public facilities at each tier that was supposed to ensure availability of MVA and MRM. The facility budget could be utilized to procure MRM (medical MR commodities) as per the need.

Through policy advocacy, the QFP Project of Ipas created an enabling environment for sustainable supply of logistics that ensured postpartum and postabortion FP services at indoor of the DGHS facilities. The logistics supplied by the DGFP and received by the DGHS were kept documented in the standard inventory tools and periodically monitored for ensuring its control and compliance. The capacity of the healthcare providers and relevant officials of the DGHS was built through programmatic technical assistance for logistics and reporting management of the supplied logistics. As a result, the designated persons of the DGHS facilities collected logistics from the DGFP stores, managed inventory, stored these, and reported the service-related and logistics data to the DGFP through MIS3 reporting. Currently, a total of 125 DGHS facilities supported by the project have become SDPs and are regularly accessing supplies from the DGFP through software-based Inventory Management Systems [1].

Asking about regular supply and quality of these commodities to our respondents, we were informed that Ipas project worked proactively to ensure consistent logistic supply by maintaining quality.

In this connection, one service provider (doctor) from a DH said:

*"They [Ipas's QFP Project coordinators] always ask us if we need anything before we request them for logistics. They are very helpful in this regard. The quality of the logistics is also good. In particular, the MVA is very good. I do not perform evacuation curettage anymore. I use MVA procedure. They give us one set of each. If the instrument becomes useless, they replace it immediately. There was never a shortage of commodity supply."*

A doctor from a private facility stated:

*"Now I get these stuff (commodities) from Ipas very easily. A few days back, I did not have MRM-kit. When I asked for it, they had sent it immediately. Whenever something is out of stock, I can get it immediately after requesting for it. This is one advantage. Sometimes, the MVA syringes get tight and become difficult to loosen without lubricant. I looked for it everywhere in the market but could not find it. After requesting for it, along with 2 sets of MVA, I got 6 sets of lubricants for each MVA set."*

A few respondents also mentioned that, sometimes, the supplies are stored at the central level and, sometimes, some commodities got damaged due to improper handling by the care providers. The service providers suggested that there is a need to train all on how to handle the equipment.

One nurse of an MCH stated the situation thus:

*"We have got all kinds of support and logistics from Ipas. In 2017, Ipas has provided some MVA syringes. We are using these instruments in our OT and gyne ward. Some of those got damaged. Instruments were fine when we received those but the way I have got the training, not all have the same on how to open these or how to use these. Sometimes, it happened that some were damaged during cleaning of the instruments by the ward boys."*

At the health units of UHCs, the care providers need to collect required FP commodities from FP unit of UHC on case-by-case basis and cannot maintain a stock of LARC commodities. For this reason, care providers at the health units of UHCs could not deliver LARC services as PPFP and PAFP during busy hours, especially at the evening and night shifts.

On a different note, we have found through interviews (i.e. IDIs) that there was a lack of knowledge among service providers about how to acquire commodities in absence of Ipas. Although multiple policy guidelines have been endorsed and circulated that outlining the supply mechanism, the study participants (i.e. IDIs) stated that they did not know what would happen to logistics issue in absence of Ipas. Some have informed that they may not be able to get required commodities on time, which will lead to shortage of supply and hamper smooth running of service delivery.

One nurse of a DH said:

*"Along with commodities, Ipas also provides us stationeries for documentation (registers). If they do not provide these stuffs anymore, we have to get these ourselves. We do not know where to get these from. We also do not know if there is any government procedure to collect these."*

## 3.5. Services and logistics reporting mechanism

As the facilities get logistics support and Imprest fund from the DGFP, these facilities were required to provide performance and logistic-usage reporting to the DGFP. Our discussion with the respondents revealed that the following types of reporting are mainly done:

- Report on logistics related to short- and long-acting methods, distribution, and performance, using MIS3 form for the DGFP
- Report on service statistics related to family planning in DHIS2

To make logistics data available online, the DGHS hospitals can now report back to the DGFP, using monthly reporting form MIS3 under the Supply Chain Management Portal (SCMP) of the Ministry of Health and Family Welfare (MoHFW). The key logistics data that are available in the MIS3 include opening balance, receipt, distribution and closing balance.

To report FP-related service statistics in DHIS2 since the end of 2020 (i.e. November/December), the DGHS hospitals have started entering monthly FP service data in DHIS2. However, some respondents mentioned that the statisticians did not get any formal training from Ipas in this regard yet. However, Ipas oriented them on how to incorporate FP-related data and whether the service providers had faced any difficulty regarding uploading of the data, Ipas provided them the technical support. Statisticians also mentioned that the report was required to be signed by in-charge of the respective health facilities before entering data online, using DHIS2 (DGHS-MIS).

Our respondents (i.e. statisticians) in IDIs have confirmed that they were also being summoned at each monthly meeting. According to the service statistics, the service providers were instructed to increase performance or keep maintaining the service delivery.

Along with the IDI respondents, our key informants also have informed that Ipas has done a good job in the management of reporting. As a result of this intervention, under-reporting of FP, MR and PAC services have decreased significantly compared to the earlier times, they have succeeded in bringing discipline in the management of reporting as well.

In this connection, one manager of the DGFP said:

*“Earlier, if 10 women had taken postpartum family planning, I might have known about it 15/20 days later but when Ipas started their project, the same information we have been getting just the next day. I am getting the report just on time. I think this is an optimization of reporting.”*

## 3.6. Promotional activities and readiness of site

By visiting selected facilities, the study team observed that Ipas also had done some promotional activities and readiness of site for FP, MR and PAC services. As promotional activities, they have provided some BCC materials in ward and outdoor of the facility. Ipas had also set up MR corner, counseling corner in some of the facilities and supplied logistics, such as sterilizer machine, speculum, sponge forceps, tray, drum, table, cabinet, and screen for privacy. The study team visited Dhaka, Sylhet, and Rangpur sites. The hospital management allocated separate rooms/corners for the MR and PAC-related services. Study team had found separate MR and counseling rooms at different study sites. As Ipas-run project was focused on tertiary-level facilities, the BCC intervention was more comprehensive in these facilities. The details of the promotional activities observed by the study team are presented below.

### 3.6.1. Promotion of FP service

The BCC materials mainly inform about all types of FP methods and the procedures. These BCC materials are board-mounted and hung on the walls of the facilities. Some posters describe all types of FP methods (short, long, and permanent) in one sheet, and some posters were found to portray a single method in a single sheet. These single posters show details of the methods, like eligibility to take the method, availability, and benefits, etc.

<table>
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<tr>
<td>Ipas’s BCC materials at the main entrance of Rangpur Medical College Hospital</td>
<td>Ipas’s BCC materials at the entrance of Gyne Ward of Maulvibazar District Hospital</td>
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| | |
|---|---|
|  |  |
| Ipas's BCC materials at the corridor of Labor Room of Dhaka Medical College Hospital | Ipas's BCC materials at the main entrance of Osmani Medical College Hospital, Sylhet |

In addition, BCC materials were also found in different places of the health facilities by the study team. These places include: patients' waiting space, stairs, door of the lift, inside the lift, nurse's duty room, etc. Some direction signs toward gyne ward were also found in the hospitals. However, many of the BCC materials (posters) were torn out.

| | |
|---|---|
|  |  |
| Some posters hung on walls are torn out | |

| | |
|---|---|
|  |  |
| Ipas's BCC materials at the patients' waiting space of Gyne Ward in Rangpur Medical College Hospital | Ipas's BCC materials on stairways to Gyne Ward Rangpur MCH |

## 3.6.2. FP, MR and PAC procedure room

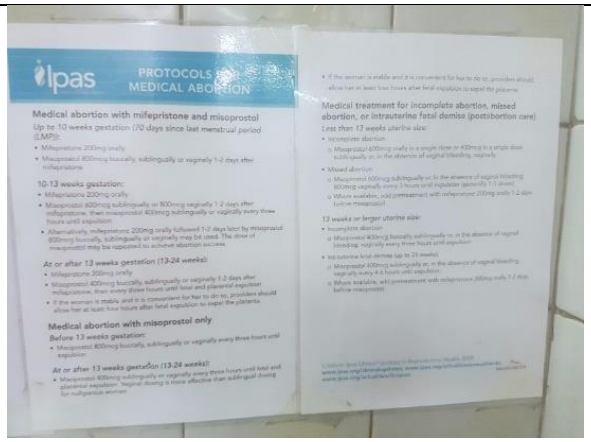
We found a separated counseling corner established by Ipas at Maulvibazar District Hospital. The corner was made in such a way that privacy and confidentiality of the client can be maintained. Ipas furnished the counseling room with necessary furniture, like chairs, table, stand-fan, register, shelf, and BCC material inside the room. According to the government protocol, a curtain to serve as a room-divider to separate the corner from the traditional service space if a separate room cannot be provided. Therefore, a dedicated room or space was not found in the district and medical college hospitals.

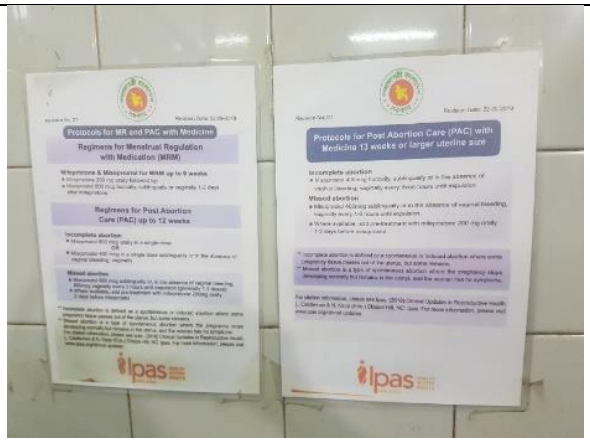
The study team also found a separate MR and PAC room called 'MVA Room' in Dhaka Medical College Hospital. This room is placed in the Gyne Ward and located near the OT. Inside this room, logistics and equipment were available, arranged by Ipas project, that included spotlight, sterilized drums containing instruments, cotton, gauze, etc. The room was also furnished and equipped with AC.

| | |
|---|---|
|  |  |
| BCC materials in front of the counseling room of Maulvibazar District Hospital | A separate MR and PAC room at Dhaka Medical College Hospital |

## 3.6.3. Guidelines and protocols

There were some protocols related to MR and PAC services in the labor room and in the doctor's corner. Several protocols were also found in DMCH on medical abortion; MR, and PAC with medicine (regimens for MRM and PAC up to 12 weeks); PAC with medicine 13 weeks; PAC with medication mPAC up to 12 weeks; PAC at or after 13 weeks, etc.




Different types of protocols on the walls of Labor Room and Doctor's Corner of Dhaka Medical College Hospital

## 3.6.4. Service registers

To keep the record of FP-related services provided from the hospitals, there were some registers (FP register and MR-PAC register) given by the Ipas-run project. The service providers regularly updated the records on those registers.


FP register of a private medical college hospital


MR-PAC register of a private medical college hospital

## 3.7. Guidelines and protocols

Key informants reported that the project had provided technical support for producing guidelines on the usage of MRM, extending the gestational week for performing surgical MR, modifying the Government-approved MR and PAC guidelines, etc. Recently, the MCH unit of the DGFP has decided to update and combine all of their previous guidelines on MR and PAC service and develop a comprehensive national guideline for MR and MRM. Ipas has provided its technical input in this guideline through this project. The project also helped in updating, modifying, and planning/developing the existing guidelines (i.e. existing guidelines of the Clinical Contraception Service Delivery Program (CCSDP) of the DGFP).

In connection with this, one key informant from the DGFP central level said:

*"Ipas helped us develop policy. They helped us develop MRM national guideline. Ipas helped us develop technical curriculum, including fixing the dose of medicine. They provided us international guidelines. They suggested to use information from international guidelines to prepare the national guidelines."*

One key informant from the DGFP said:

*"We have several guidelines, and Ipas helped us develop them. Ipas took initiative to upgrade the FP manual, and they helped us print them. They helped develop registers where the performance of FP activities is currently being recorded."*

Other than this, as found through document review, Ipas has developed standard clinical guidelines on postabortion care, postpartum family planning, and postabortion family planning in the context of Bangladesh [6]. Ipas also developed guideline, protocols and reporting mechanism for the private sector for FP service delivery [1]. They also have provided technical input to update national family planning manual [7].

## 3.8. Crisis management, including severe adverse events while providing FP, MR and PAC services

### 3.8.1. Training on the management of adverse effects or complications in FP, MR and PAC services

Our respondents communicated that Ipas has trained them on the management of complications and adverse events related to FP, MR and PAC services by following the Family Planning Manual and other training materials developed by Ipas. In this regard, all the related measures to be taken were elaborately explained by the trainers.

In this connection one nurse of a DH said:

*"During training, we were told that, sometimes, bleeding may occur while providing IUD. In such a situation, we have been asked to seek help from doctor. For some cases, there may be missing string of IUD, for which ultrasonography may be required."*

A gynecologist of an MCH who completed training of trainers (ToT) course said:

*"While I was in ToT in Dhaka, we were trained how to manage FP method-related problems. We participated in discussion on the management of complications. For example, we were oriented with guidelines to follow in case of perforation of uterus for IUD."*

During our visit, we asked the respondents to show if they had any guideline on crisis management. However, no guideline was readily available with them to show.

### 3.8.2. Experience of managing the clients who had FP, MR and PAC-related adverse effects/complications

Our respondents shared some of their practical experiences on the management of complications in patients arisen during FP, MR and PAC service provision.

One nurse from a UHC said:

"Sometimes, the clients cannot bear the pain while providing MVA; some also gets fainted. In such a situation, I check *the pressure, give saline and pain killer. I also find some cases with bleeding which is difficult to manage. After stabilizing, we usually refer these cases and counsel the attendants."*

Two common problems of LARC are missing string of IUD and improper insertion of implant. In both the situations, the clients are usually referred to the higher-level facilities.

While sharing experience of handling a client with missing IUD string, one nurse said that she had to refer the patient to Mohammadpur Fertility Services and Training Centre (MFSTC) in Dhaka to locate and remove the IUD by using a specialized instrument.

Another doctor, while sharing his experience about a client with misplacement of implant, said that it was not possible for them to locate and extract the misplaced implant at local level, and the client had to be referred to the district-level facility.

### 3.8.3. Dealings with public when managing clients having adverse events

According to our respondents, they rarely face adverse events in recent days originated by relatives of the clients or local people related to FP service provision. In case of any such event, the hospital managers and service providers were capable of managing the situation effectively by proper counseling and coordination.

In this connection one doctor of a DH said:

*"In rare cases, if pregnancy occurs after tubectomy or having IUD, the people from the client-side raise a hue and cry at the facility. In such a situation, we motivate them through counseling by explaining the situation from medical ground so that they get convinced."*

## 3.9. Collaboration, coordination, and support

### 3.9.1. Bridging the gap for collaboration between DGFP and DGHS

Most of our respondents acknowledged that a major contribution of Ipas has been: paving the path for collaboration between the DGFP and the DGHS in terms of service delivery, direct logistics supply from the DGFP to the DGHS health facilities, reporting of the DGHS facilities to the DGFP, and handling of incentives from Imprest fund directly by the health facilities of the DGHS.

One key informant from central level said:

*"There is a huge contribution of Ipas in terms of developing collaboration in between the DGFP and the DGHS. For some reasons, we were struggling to ensure FP services in the DGHS-affiliated health facilities through coordinating with them. Ipas played a bigger role in developing that coordination."*

They informed that one steering committee was formed where the Director General of Health Services was the chairman and one director from the DGFP worked as the Member Secretary. The steering committee, with support from Ipas, was formed to make collaboration effective. Line directors/directors from the DGHS, Directorate General of Nursing and Midwifery (DGNM), and DGFP, representatives from FCDO, PNGOs, and OGSB were included as members of the committee. This committee is responsible for coordinating inter-directorate issues, reviewing policy documents for safe MR, PAC and quality FP services, approve the proposed policies, discuss about various implementation issues of the project, like identifying challenges, priority of action plan, etc. From the very beginning of the project, this committee played a significant role as a key player for both the directorates. So, this was one of the successes of the project that it could bring all the health leaders from both the directorates in a table.

Our respondents recognized Ipas's policy advocacy to the DGFP-DGHS alliance for empowering the DGHS-affiliated health facilities to handle Imprest fund as one of the major successes of the Ipas-run project.

One program manager of DGFP said:

*"There are some incentives for clients. When the DGHS health facilities started to deliver these services, question arose where they would get the money to incentivize the clients. So, the medical college hospitals got the authorization to manage the Imprest fund directly. To do so, Ipas has paved the path. They have knocked at the door in several places, held meetings with us, the DGHS, MCHs frequently. They knocked as many times as needed to convey the message that it was possible to provide the incentive from the Imprest fund directly by the health facility."*

However, some program managers also reported lacking in coordination within the DGHS facilities for owning and managing the Imprest fund.

One district-level program manager said:

*"One DGHS facility, after getting the Imprest fund, failed to utilize that due to gaps in coordination to identify the person to be responsible for managing the fund that ultimately resulted in return of the fund."*

Some local-level program managers also commented that Ipas could do better if they could create a platform through policy advocacy where all the relevant stakeholders at supply-side could exchange their thoughts and generate solutions on how to improve and sustain the current FP service delivery through the project. Some of our IDIs also mentioned that they rarely felt involved with the Ipas project and their activities as they hardly maintained the communication.

One district-level program manager said,

*"There is a gap in coordination by Ipas. Sometimes, we cannot feel that Ipas is working with us. It gives us an impression that they are a different organization. If the Ipas coordinator does not properly communicate with us, then it is difficult to understand the gaps in program implementation. Also, no coordination meeting takes place; even in our monthly meeting, the health sector does not represent."*

## 3.9.2. Supervision and monitoring

The key informants and service providers expressed that Ipas played a predominant role in the overall supervision and monitoring of the SDPs of the DGHS-affiliated health facilities for training as well as counseling the service providers, supplying logistics from the DGFP, and incorporating FP-related service statistics in the DHIS2 of the DGHS.

One district-level program manager said:

*"After being informed about any type of problem, Ipas used to act immediately. This support helped these SDPs affiliated with the DGHS for delivering FP-related services smoothly."*

Ipas developed an effective monitoring mechanism both for project implementation and for understanding the year-to-year comparison of impact of the program. For program implementation, Ipas conducted medical monitoring visits with team consisting of international clinical experts to assess FP, MR and PAC services, safety, medical quality, compliance to standards/guidelines, and joint monitoring visits with team consisting of government officials of the DGHS and the DGFP to motivate local management, ensuring consistent logistic supplies, solving Imprest fund-related problems in the program-supported facilities. Ipas deployed six field facilitators who conducted monthly monitoring visits to ensure quality service delivery. To understand the impact of the program, Ipas collected routine data from the facilities and analyzed those on a regular basis to understand the situation. It also conducted clients' exit survey to understand the extent to which the clients were being benefitted by the program intervention [1, 6-8].

However, some of the KIs stated that Ipas could also involve the administrative body (personnel in-charge or the personnel assigned for the overall supervision) of the facilities in their overall monitoring activities to ensure optimum FP, MR and PAC service delivery. However, Ipas mostly communicated with service providers, and their (i.e. Ipas's) effort to connect with the higher administration at the facility-level was minimal. In this regard, our respondents also mentioned that a more effective monitoring and feedback mechanism to ensure improved service delivery will be built if Ipas involve the facility-level administrative body in their monitoring process.

One district-level program manager said:

*"They could involve the facility in-charge. If in each 2/3 days, they want to know from the service providers how they are progressing in FP service delivery, while the service providers are not accountable to Ipas to tell them. But service providers are definitely accountable for reporting to the facility in-charge."*

At the same time, our respondents suggested to increase Ipas's manpower for better monitoring below the district level, as Ipas lack ed manpower to maintain the necessary liaison.

## 3.10. Sustainability

The key informants mentioned that ensuring sustainability of the program intervention depended largely on the inclusion of the interventions as part of activities in the operational plan (OP) of the DGHS.

One program manager from the DGHS mentioned:

*"For any development program, sustainability is not ensured until and unless the program is being included in the governmental mechanism. This is also true for the program of Ipas."*

The same key informant also stated:

*"In the OP, the budget allocation for logistics has been incorporated so that the Government will provide fund to the facility. But out of hundreds of activities, this is just one. So, if I buy the logistics and because the next activities are not being systematically institutionalized, the commodities will stay under-utilized because the other consequent activities are not incorporated in the OP. But if all the activities get included in the OP, it is good. Yes, some of the activities have already been incorporated in the OP."*

To some extent, Ipas succeeded to include some of the program interventions in the revised OP and ensured sustainability for PPFP service provision in the DGHS facilities, these includes direct handling of Imprest fund by the DGHS, logistic supply through SDPs from the DGFP to the DGHS, service reporting using DHIS2 of the DGHS, short- and long-acting FP methods, MR and PAC service provision by trained midwives and nurses through policy advocacy. Ipas also facilitated to issue related official memos by the concern departments under MoH&FW. Ipas is still working to include other interventions in the next year's OP.

Regarding taking account of the formalities to revise a change in policy, a key informant from the DGHS mentioned:

*"A concern and consciousness have grown amongst us (i.e. DGFP, DGHS, and DGNM). Ipas definitely contributed in developing that consciousness within us. Even in the absence of Ipas, their intervention will sustain and continue. But in many cases, there are some limitations in the Government's institutional infrastructure or operational plans. We develop operational plans in every five years and conduct a mid-term evaluation for its revision for necessary changes. So, if Ipas is not there, we have to take help from other organizations to minimize the gap."*

# 4. Quantitative findings:

## 4.1. FP service performance at Ipas QFP project intervention facilities

Of the total 8,78,177 FP services provided from 210 Ipas QFP project intervention facilities during February 2017 and December 2020, the majority (85.4%) were short acting FP methods and the rest 14.6% were LARC and PM. While examining the FP service performance of short acting FP methods by division and by all FP methods, the highest percentage was seen in Rajshahi (90.4%) and the lowest in Dhaka (81.9%) division of all FP methods. Of all FP methods, the service performance for oral contraceptive was highest in each division ranging from 53.3% in Dhaka to 63.9% in Rangpur. The service performance for condoms varied from 6.1% in Chittagong to 21.5 % in Rajshahi of all FP methods. Division wise, the FP service performance of LARC and PM out of all FP methods per division was highest in Dhaka (18.1%) and lowest in Rajshahi (9.6%). Looking at the performance of LARC and PM out of total FP service performance, the provision of implant was the highest (6.9%) followed by IUD (4.0%) and tubectomy (3.7%). (**Table 5**).

**Table 5: Percentage distribution of FP service performance in Ipas QFP project intervention facilities by FP method and by administrative divisions in Bangladesh.**

| Site Type | Barisal n=86664 | Chattagram n=126853 | Dhaka n=224804 | Rajshahi n=130598 | Rangpur n=104475 | Sylhet n=204783 | Total n=878177 |
|---|---|---|---|---|---|---|---|
| | % of services | | | | | | |
| Injectables | 16.6 | 17.0 | 12.5 | 6.5 | 7.2 | 16.3 | 12.9 |
| Oral contraceptives | 59.6 | 61.6 | 53.3 | 62.4 | 63.9 | 61.6 | 59.7 |
| Condom | 13.0 | 6.1 | 16.0 | 21.5 | 13.5 | 7.3 | 12.8 |
| ***Short-acting method*** | ***89.2*** | ***84.7*** | ***81.9*** | ***90.4*** | ***84.6*** | ***85.3*** | ***85.4*** |
| IUD | 2.9 | 6.8 | 4.9 | 2.6 | 2.5 | 3.6 | 4.0 |
| Implant | 5.6 | 4.6 | 8.4 | 4.6 | 9.8 | 7.3 | 6.9 |
| Tubectomy | 2.3 | 3.9 | 4.9 | 2.4 | 3.1 | 3.9 | 3.7 |
| ***LARC and PM*** | ***10.8*** | ***15.3*** | ***18.1*** | ***9.6*** | ***15.4*** | ***14.7*** | ***14.6*** |

Of all the short-acting methods provided from Ipas QFP project intervention facilities over the project period about two-thirds 68.3% were provided from DGHS facilities. While examining by types of short acting FP methods, about three-fourths of each oral contraceptives (74.3%) and condom (72.4%) were provided from facilities under DGHS and for injectables about one-third of the services were provided by DGHS, DGFP and RHSTEP respectively (**Table 6**).

**Table 6: Percentage distribution of service performance of short acting FP methods by facility type under the QFP project.**

| Facility type | % of services | | | |
|---|---|---|---|---|
| | **Injectable n=113578** | **Oral contraceptive pill n=524096** | **Condom n=112160** | **Total n= 749859** |
| Medical College Hospital (MCH) (n=15) | 17.5 | 27.3 | 38.0 | 27.4 |
| District Hospital (n=35) | 10.2 | 23.4 | 18.9 | 20.7 |
| Upazila Health Complex (UHC) - Health Unit (n=85) | 8.4 | 23.6 | 15.5 | 20.1 |
| ***DGHS facilities (n=135)*** | ***36.2*** | ***74.3*** | ***72.4*** | ***68.3*** |
| Upazila Health Complex (UHC) - FP Unit (n=31) | 23.1 | 5.9 | 7.1 | 8.7 |
| Mother and Child Welfare Centre (MCWC) (n=10) | 9.5 | 5.9 | 4.4 | 6.2 |
| ***DGFP facilities (n=41)*** | ***32.6*** | ***11.9*** | ***11.5*** | ***14.9*** |
| ***Private MCHs/hospitals (n=19)*** | ***2.2*** | ***2.6*** | ***1.7*** | ***2.4*** |
| ***RHSTEP clinics (n=15)*** | ***29.0*** | ***11.2*** | ***14.3*** | ***14.4*** |

Of all the LARC and PM services provided from QFP project intervention facilities over the project period, 46.8% were provided from DGHS facilities and another 45.2% from DGFP facilities. While examining by type of LARC and PM services, 61.5% of IUD and 71.7% of tubectomy were provided from DGHS facilities and for implant, DGFP facilities had the highest service performance (69.2%), followed by DGHS facilities (25.1%) (**Table 7**).

**Table 7: Percentage distribution of service performance of LARC and PM FP methods by facility type under the QFP project.**

| Facility type | % of services | | | |
|---|---|---|---|---|
| | IUD n=35400 | Implant n=60667 | Tubectomy n=32251 | Total n=128318 |
| Medical College Hospital (MCH) (n=15) | 23.8 | 15.9 | 50.1 | 26.7 |
| District Hospital (n=35) | 25.8 | 7.3 | 19.7 | 15.5 |
| Upazila Health Complex (UHC) - Health Unit (n=85) | 12.0 | 1.8 | 2.0 | 4.7 |
| ***DGHS facilities (n=135)*** | ***61.5*** | ***25.1*** | ***71.7*** | ***46.8*** |
| Upazila Health Complex (UHC) - FP Unit (n=31) | 12.6 | 49.0 | 13.1 | 30.0 |
| Mother and Child Welfare Centre (MCWC) (n=10) | 13.4 | 20.2 | 8.0 | 15.3 |
| ***DGFP facilities (n=41)*** | ***26.1*** | ***69.2*** | ***21.2*** | ***45.2*** |
| ***Private MCHs/hospitals (n=19)*** | ***1.6*** | ***1.4*** | ***5.7*** | ***2.5*** |
| ***RHSTEP clinics (n=15)*** | ***10.8*** | ***4.3*** | ***1.4*** | ***5.4*** |

The majority of the short acting (61%) and LARC and PM (76%) clients were >=25 years of age. However, among the clients who accepted LARC and PM, only 3% were <= 19 years of age. The corresponding figure among the short acting method was 8% (**Figure 3**).

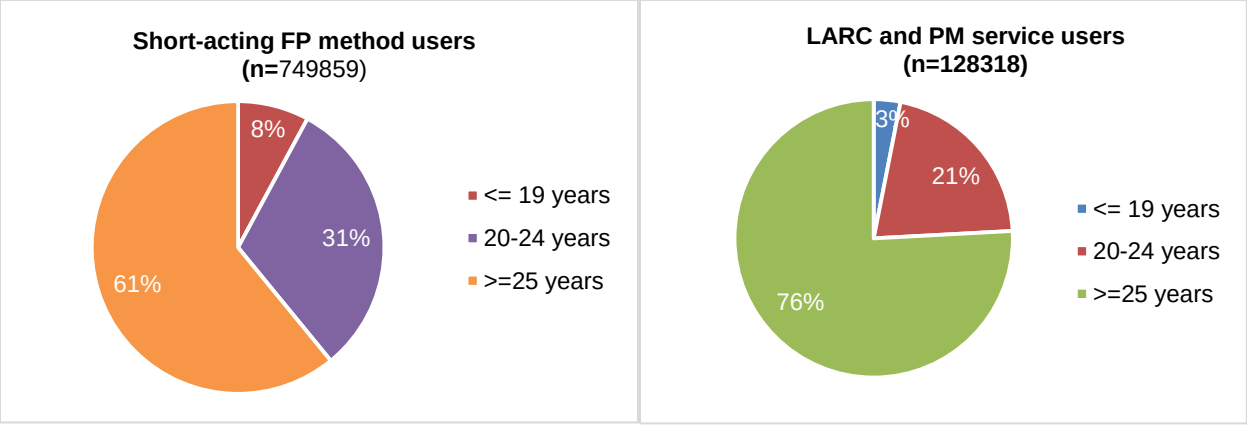



**Figure 3: Age distribution of clients receiving short acting FP methods (left) and LARC and PM FP methods (right) under the QFP project.**

### 4.1.1. Year wise FP service performance at QFP project supported intervention facilities

Out of the total number of FP services provided over the project period, the year wise short acting FP service performance increased from 7.3% in 2017 to 31.5% in 2020. While examining the year wise FP service performance of different short acting FP methods, there has been 5 fold increase in provision of oral contraceptives, from 6.5% of in 2017 to 32.1% in 2020. The corresponding increase for condoms and injectables were 4 and 3 folds respectively. While examining the year wise LARC and PM FP service performance, there has been 12 fold increase in the provision of implant from 2.9% in 2017 to 35.6% in 2020, a 3 fold increase (10.3% - 30.3%) in IUDs and more than 2 fold increase tubectomy (10.9 % to 26.7%) **(Table 8).**

**Table 8: Percentage distribution of different FP methods service performance during the QFP project period (2017 to 2020).**

| FP method | n | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| Injectables | 113578 | 10.1 | 22.3 | 38.6 | 29.0 |
| Oral contraceptives | 524096 | 6.5 | 24.3 | 37.2 | 32.1 |
| Condoms | 112160 | 8.2 | 21.4 | 39.1 | 31.3 |
| ***Short-acting method*** | 749859 | 7.3 | 23.5 | 37.7 | 31.5 |
| IUD | 35400 | 10.3 | 22.7 | 36.7 | 30.3 |
| Implant | 60667 | 2.9 | 13.3 | 48.2 | 35.6 |
| Tubectomy | 32251 | 10.9 | 23.3 | 39.1 | 26.7 |
| ***LARC and PM*** | 128318 | 7.0 | 18.4 | 42.7 | 31.9 |
| **Total** | **878177** | **7.2** | **22.8** | **38.4** | **31.6** |

In DGHS, DGFP and private hospitals/clinics, the year wise FP service provision (quantity of services) contribution for all short acting FP methods increased from 2017 to 2019. For example, in DGHS facilities, there has been 6 fold increase (7% to 45%) in the service provision of injectables. Similarly, for oral contraceptives and condom, there has been 9 times and 7 times increase respectively from 2017 to 2019. In DGHS facilities, there has been a sharp drop in FP service provision of short acting FP methods in 2020 which is likely related to the COVID-19 pandemic. However, this was not the case in DGFP facilities and to some extent in private facilities, in which, FP service provision for short acting FP methods continued increasing in 2020. On the other hand, in RHSTEP clinics, a decreasing trend has been observed (**Figure 4**).

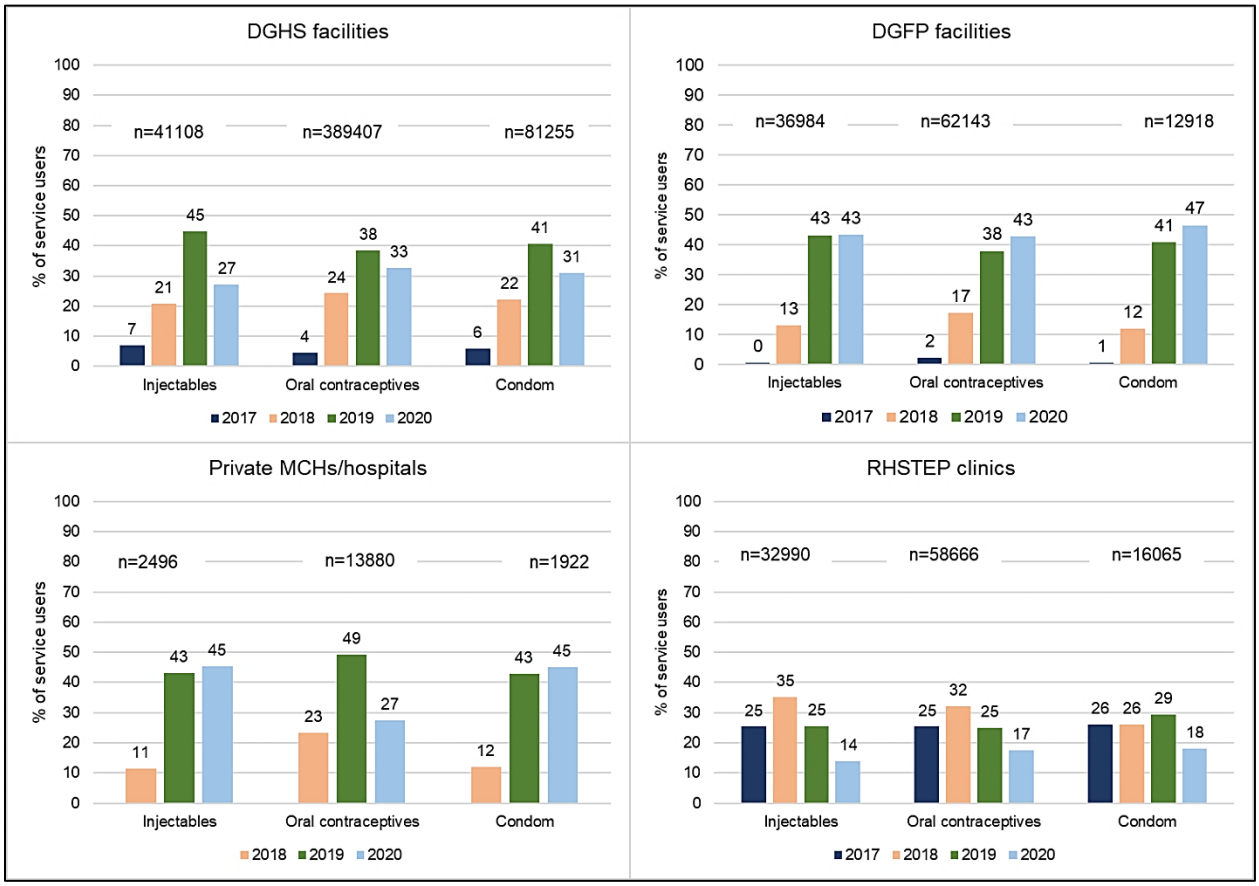



**Figure 4: Trend in service provision of different short acting FP methods during the QFP project period (2017 to 2020) in DGHS, DGFP, private and NGO facilities**

According to secondary data of QFP project of Ipas during 2017 and 2019, there has been a consistent increase in the service provision of IUD, implant and tubectomy in DGHS, DGFP and private sector facilities. For example, in DGHS facilities, there has been more than 3 times (11% to 35%) increment in the service provision of IUD. The corresponding figures for implants and tubectomy were 7 times (6% to 43%) and more than 2 times (14% to 35%) respectively. However, in RHSTEP clinics the service provision of IUD and implant were lower than the other types of facilities and the tubectomy service performance declined from 49% in 2017 to 8% in 2020. In 2020, a drop in service performance of the related services in all the four types of facilities were likely to be related to the COVID-19 pandemic (**Figure 5**).

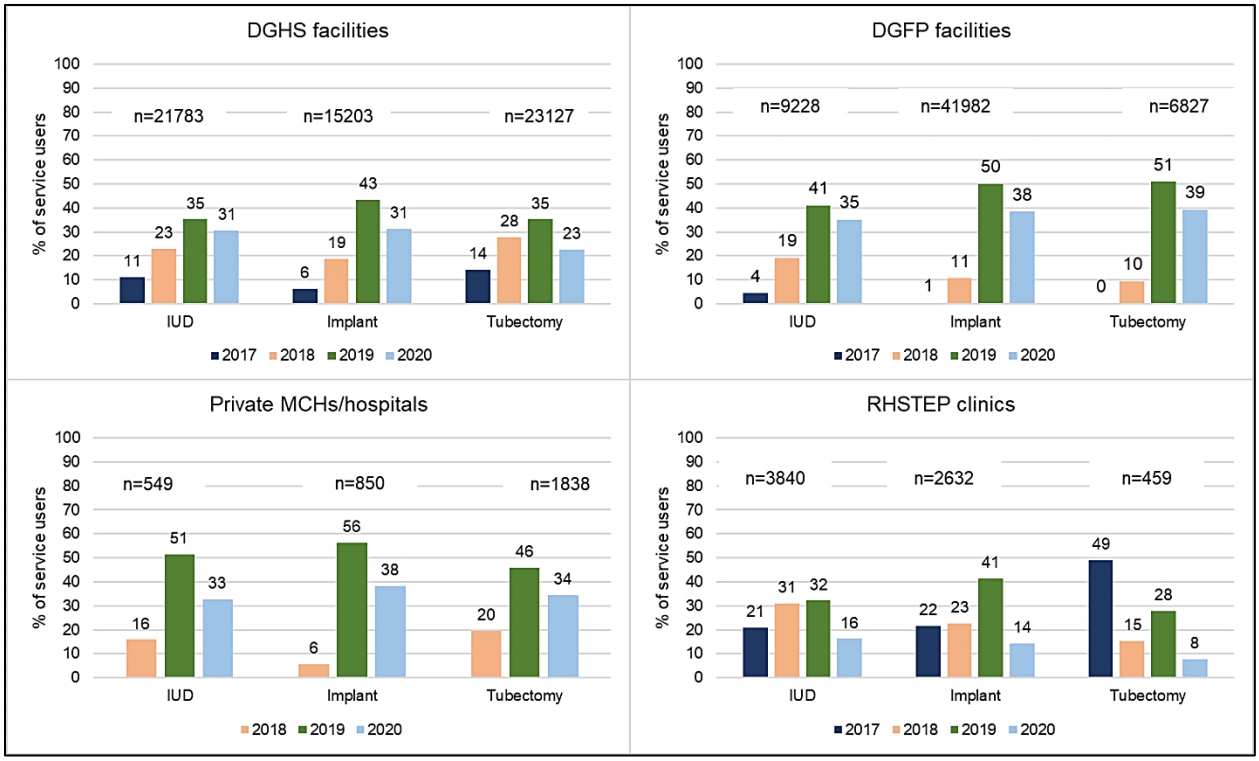



**Figure 5: Trend in service provision of different LARC and PM FP methods during the QFP project period (2017 to 2020) in DGHS, DGFP, private and NGO facilities.**

We also examined the LARC and PM FP service performance in different types of facilities by client type, which is shown in **Figure 6**. In DGHS facilities, the LARC and PM service provision among PPFP clients increased more than three times from 10% in 2017 to 37% in 2019. However, between 2019 and 2020, the LARC and PM service performance among PPFP clients in DGHS facilities declined from 37% to 29%. Similarly, the LARC and PM FP service performance among PAFP clients in DGHS facilities increased from 18% in 2017 to 33%in 2019. A decline can also be seen for PAFP after 2019, from 33% in 2019 to 21% in 2020. The FP service performance for interval clients in DGHS facilities increased from 13% in 2017 to 48% in 2019 and decreased to 27 % in 2020.

In DGFP facilities, the service provision of LARC and PM among PPFP clients increased from 2% in 2017 to 52% in 2019 and decreased to 35% in 2020. Among the PAFP clients the LARC and PM FP service performance increased from the first project year 17% to 37% in the second project year (2018) and then decreased in year three and four, to 17%. The LARC and PM FP service performance among interval clients increased 4 times from 2018 to 2019 (11% to 48%) and declined to 40% in 2020. In private facilities, the LARC and PM FP service performance among the PPFP clients was the highest in 2019 (52%) but went down to 32% in the following year. For PAFP and interval clients the service provision in private facilities was low. In RHSTEP clinics, the LARC and PM FP service performance among PPFP, PAFP and interval clients consistently increased from 2017 to 2019 and then declined in 2020 (**Figure 6**).

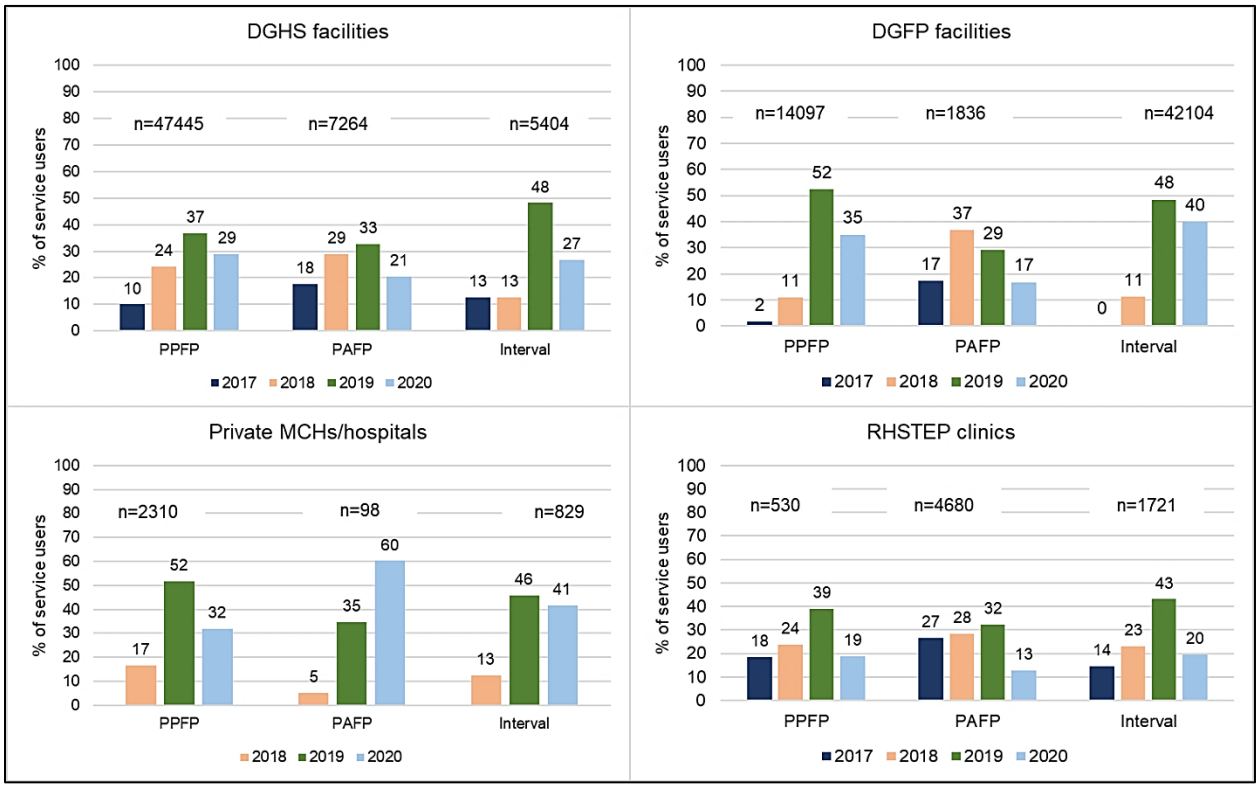



**Figure 6: Trend in service provision of LARC and PM FP methods by different FP client type over the QFP project period (2017 to 2020) in DGHS, DGFP, private and NGO facilities.**

The trend in service provision of the IUD for different client types over the project period separated by DGHS, DGFP, private MCH/hospitals and NGO clinics are shown in **Figure 7**. The IUD FP service performance for PPFP and PAFP clients is highest in DGHS and DGFP facilities. In DGHS and DGFP facilities the provision of IUD services among PPFP clients during the project period increased from 2017 to 2019 and then declined in 2020. Similar pattern is observed for the provision of IUD services among PAFP clients in facilities of DGHS and DGFP. However, the rate of increment in the provision of IUD services among the PPFP clients was greater than that for PAFP clients. For interval clients there is an increase in the provision of IUD services over the project period from 11% in 2017 to 37% in 2020 in DGHS facilities and from 0% in 2017 to 42% in 2020 in DGFP facilities.

In RHSTEP facilities the IUD service performance for PPFP clients is low (n=137 over the project period). However, higher for PAFP clients. The service provision of IUD among PAFP clients during the project period increased from 23% in 2017 to 30% in 2019 but decreased to 14% in 2020. The provision of IUD services, among interval clients in RHSTEP clinics increased more than two times between 2017 and 2019. (**Figure 7**).

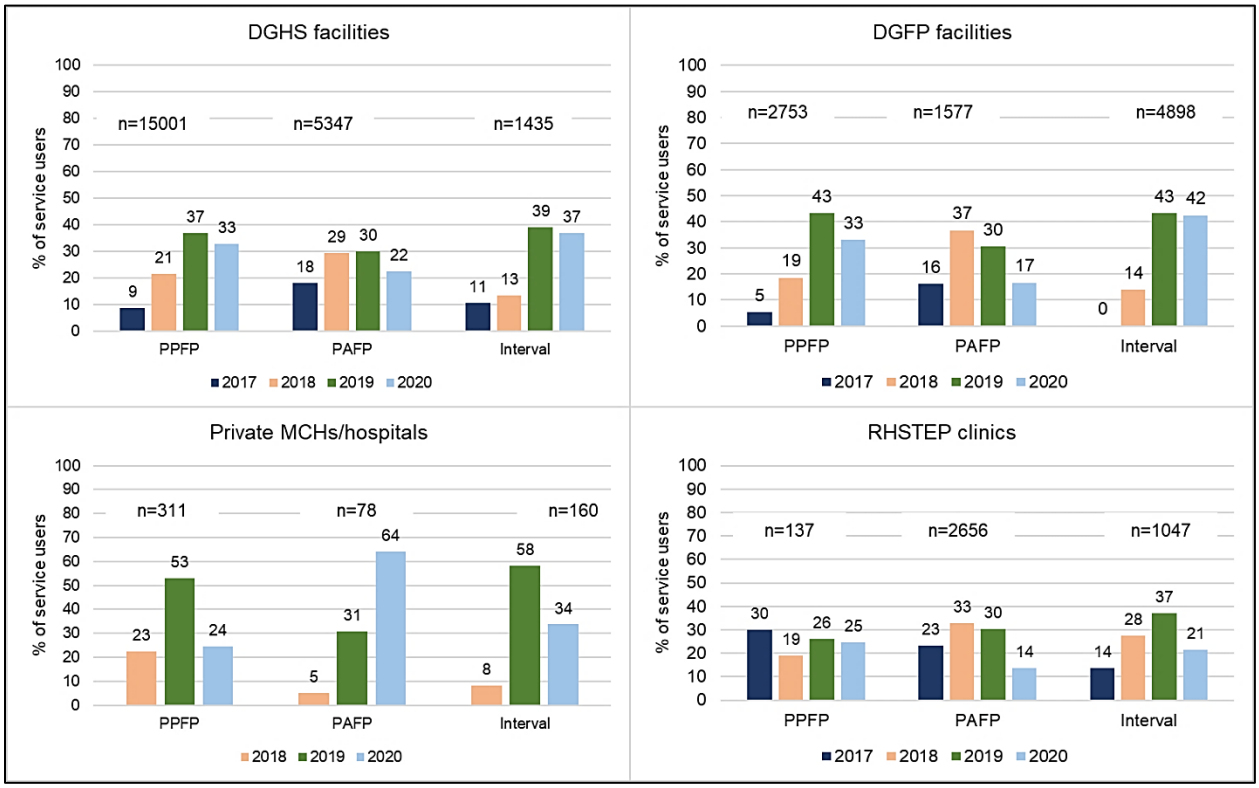



**Figure 7: Trend in service provision of IUD among different FP client types over the QFP project period (2017 to 2020) in DGHS, DGFP, private and NGO facilities.**

The trend in service provision of implant for different client types over the project period separated by DGHS, DGFP, private MCH/hospitals and NGO facilities are shown in **Figure 8**. The implant FP service performance for PPFP clients is highest in DGHS and DGFP facilities. For both DGHS and DGFP facilities the provision of implant services for PPFP clients over the project period was highest in 2019 and the declined in 2020. The implant FP service performance for PAFP clients was highest in DGHS facilities and RHSTEP clinics In DGHS facilities the provision of implant services for PAFP clients increased three times from 13% in 2017 to 42%in 2019, and in RHSTEP clinics the provision of implant services for PAFP increased from 24 % in 2017 to 38% in 2019 (**Figure 8**).

The service provision for interval clients was highest in DGFP and DGHS facilities but decreased from 2019 to 2020 in both DGFP and DGHS facilities. (**Figure 8**).

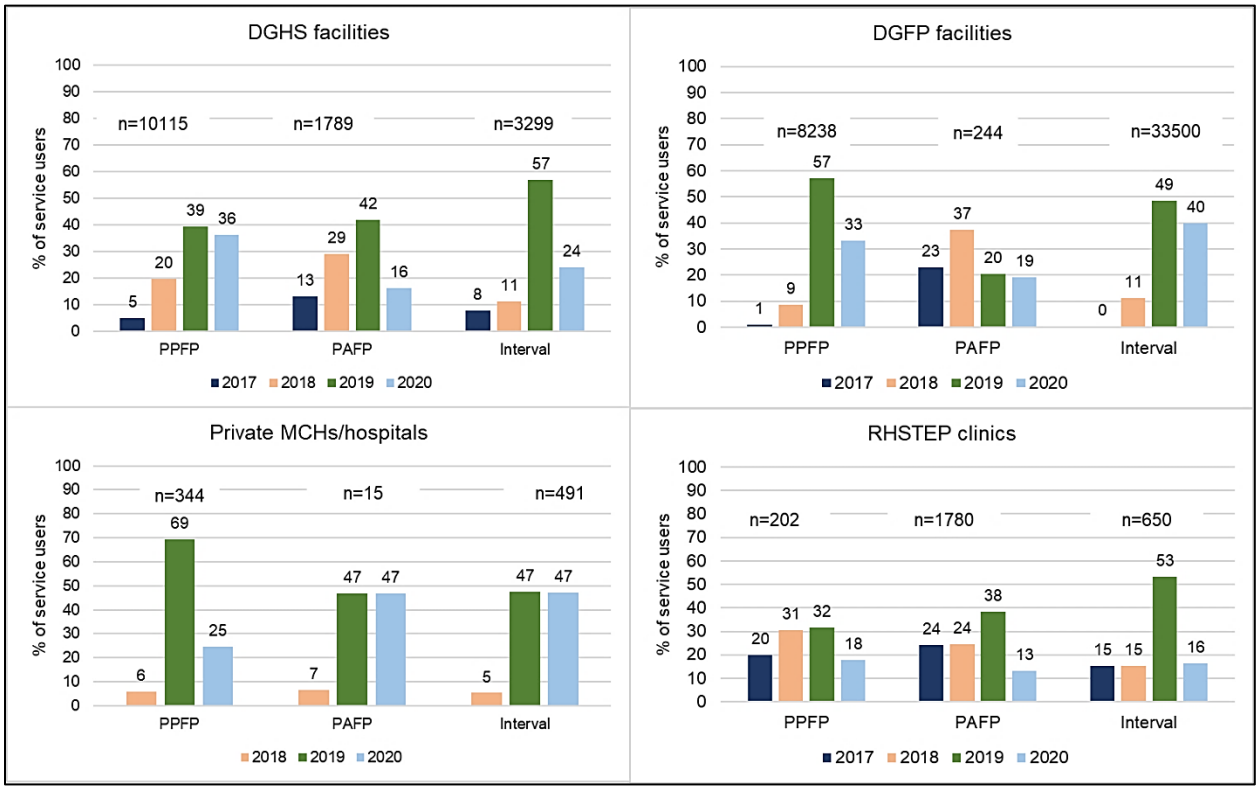



**Figure 8: Trend in service provision of implant among different FP client types over the QFP project period (2017 to 2020) in DGHS, DGFP, private and NGO facilities.**

The trend in service provision of tubectomy for different client types over the project period separated by DGHS, DGFP, private MCH/hospitals and NGO facilities are shown in **Figure 9**. The tubectomy FP service performance for PPFP clients was highest in DGHS facilities. The provision of tubectomy services for PPFP clients increased from 13% in 2017 to 36%in 2019 and then dropped to 23% in 2020. In DGHS facilities a relatively small number the tubectomy services was provided for PAFP (n=128) and interval (n=670) clients (**Figure 9**). In DGFP facilities the tubectomy FP service performance for PPFP was also highest in 2019 and dropped in 2020. The tubectomy FP service performance for interval clients was highest in DGFP facilities. In private hospitals the provision of tubectomy services for PPFP clients increased more than two fold from 2018 to 2019. (**Figure 9**).

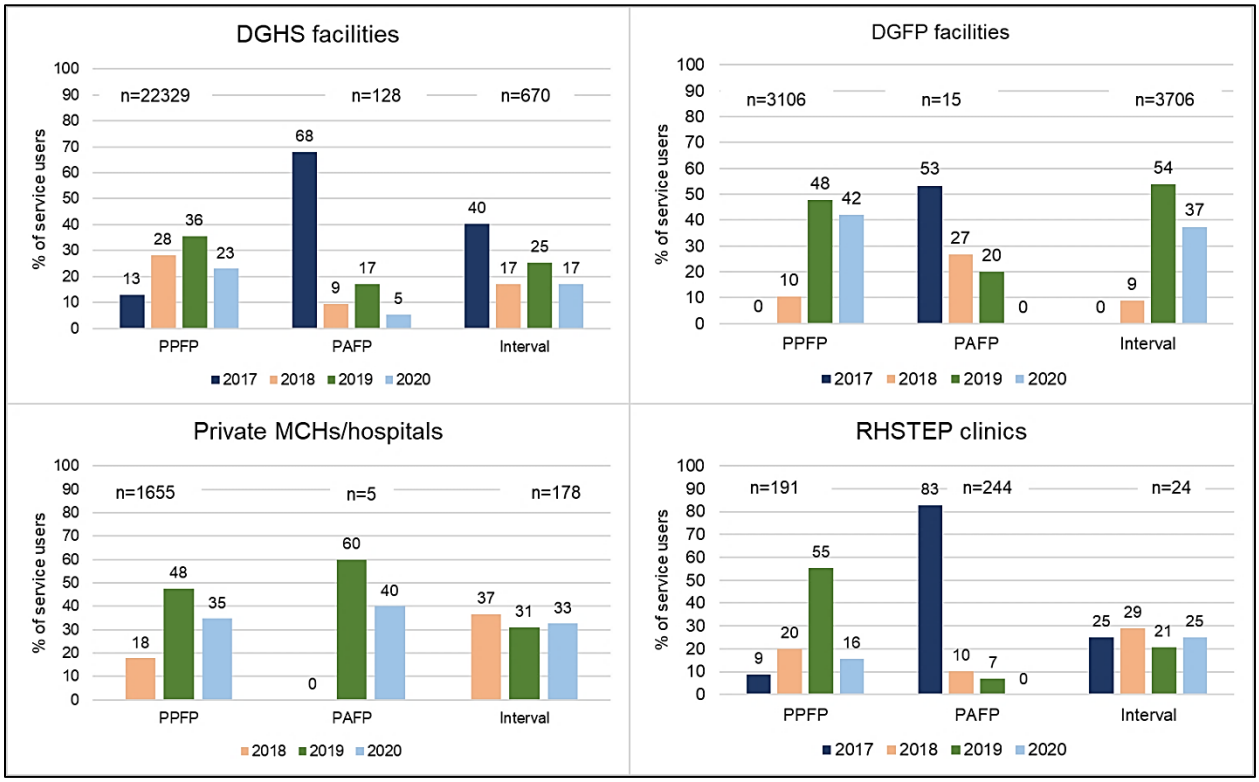



**Figure 9: Trend in service provision of tubectomy among different FP client types over the QFP project period (2017 to 2020) in DGHS, DGFP, private and NGO facilities.**

## 4.1. Acceptance rate of FP services at Ipas QFP intervention facilities during 2017 to 2020

Our findings on changes in acceptance rate of all FP methods (proportion of method acceptors among all FP clients) during 2017 and 2020 is shown in **Table 9.** Looking at the short acting FP methods, the acceptance of oral contraceptives increased by 7.4% points. Meanwhile, there has been an overall decline in acceptance of each condoms and injectables, which has declined by 1.8% and 6.2% points respectively. Looking at the LARC and PM FP methods, the acceptance of implant increased by 5.0% points while the acceptance of IUD and tubectomy declined by 1.9% and 2.4% points respectively between 2017 and 2020.

**Table 9: Trend in acceptance rate of different types of short acting and LARC and PM services in Ipas QFP project intervention facilities over time (2017- 2020).**

| FP method | 2017 n=63449 | 2018 n=200197 | 2019 n=337326 | 2020 n=277205 |
|---|---|---|---|---|
| Injectables | 18.1 | 12.6 | 13.0 | 11.9 |
| Oral contraceptives | 53.3 | 63.6 | 57.7 | 60.7 |
| Condoms | 14.5 | 12.0 | 13.0 | 12.7 |
| ***Short-acting method*** | 85.9 | 88.2 | 83.7 | 85.2 |
| IUD | 5.8 | 4.0 | 3.9 | 3.9 |
| Implant | 2.8 | 4.0 | 8.7 | 7.8 |
| Tubectomy | 5.5 | 3.8 | 3.7 | 3.1 |
| ***LARC and PM*** | 14.1 | 11.8 | 16.3 | 14.8 |

While examining the trend in acceptance rate for different FP methods over the project period we see that in DGHS facilities there has been an increasing trend in the acceptance of oral contraceptives (55% to 71%) and decreasing trend for injectables (9% to 6%), IUD (8% to 4%) and tubectomy (10% to 3%) from 2017 to 2020. For condom and implant, there has been no change in over time (**Figure 10**).

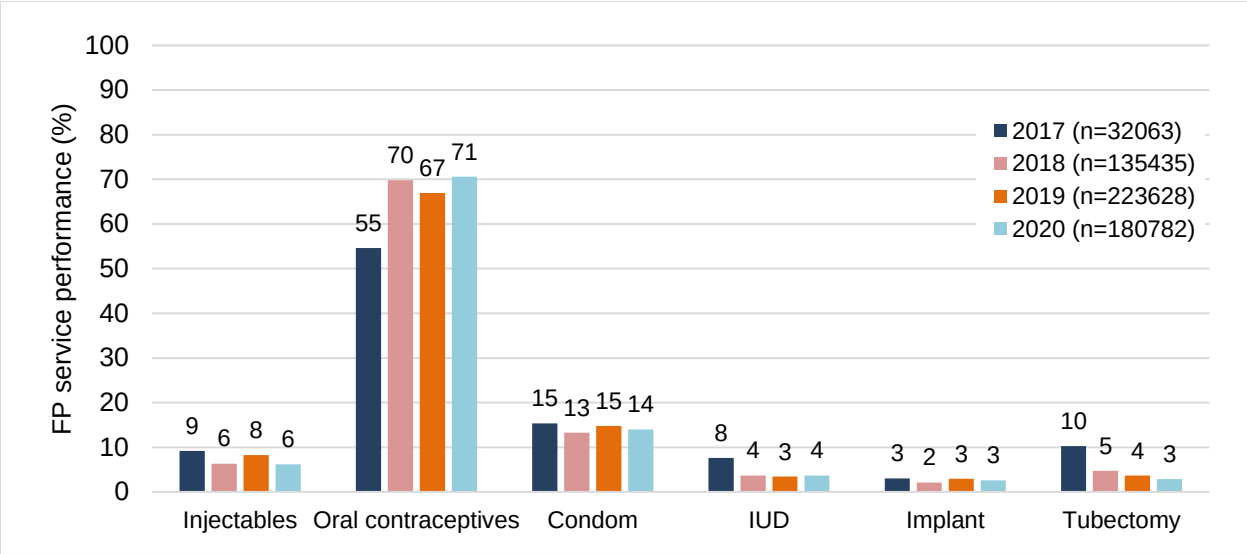



**Figure 10: Acceptance rate of FP services in DGHS supported intervention facilities over the QFP project period time (2017- 2020).**

Our analysis on the trend in acceptance for different FP methods in DGFP facilities, revealed that among the short acting methods there has been an increasing trend in acceptance of injectables (8% to 23%), and condoms (3% to 9%) during the project period (2017 to 2020). There has also been an increasing trend in acceptance of implant from 2017 to 2019 (9% to 29%) and tubectomy from 2017 to 2019 (0% to 5%). However, we observe a decreasing trend in acceptance of IUD 18% in 2017 to 5% in 2020 (**Figure 11**).

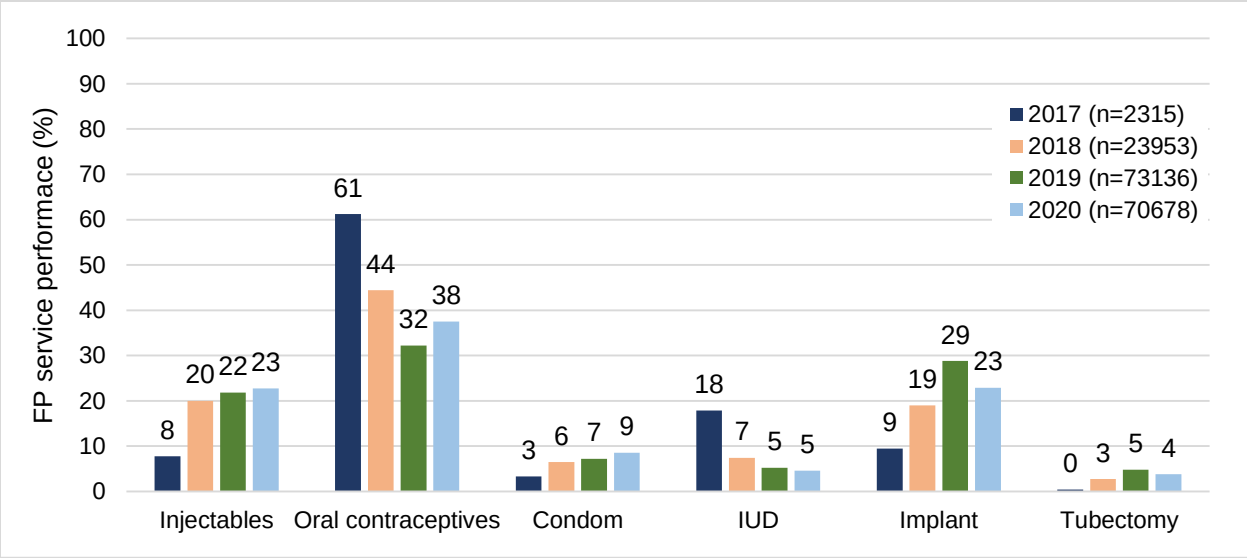



**Figure 11: Acceptance rate of FP services in DGFP supported intervention facilities over the QFP project period time (2017- 2020).**

As shown in **Figure 12**, in private facilities there has been an increasing trend in acceptance of injectables (7% to 16%) and condoms (5% to 12%), whereas that for oral contraceptives decreased from 76% to 55% over the project period (2018 to 2020). For LARC and PM methods there has been an increasing trend, IUD (2% to 3%), implant (1% to 5%) and tubectomy (8% to 9%).

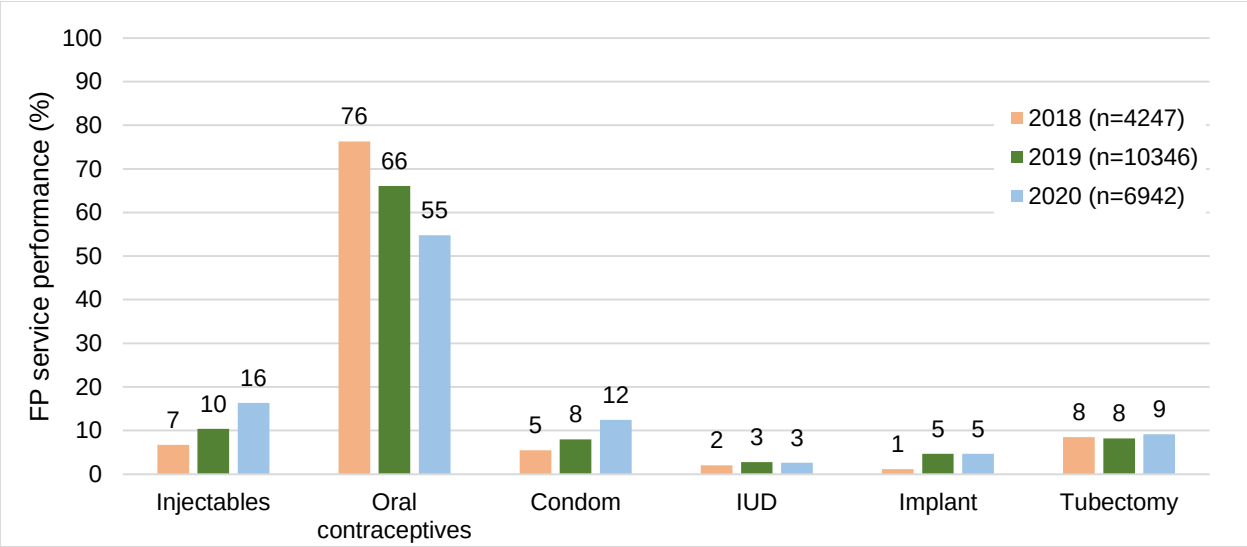



**Figure 12: Acceptance rate of FP services in private MCHs/hospitals supported intervention facilities over the QFP project period time (2017- 2020).**

In RHSTEP clinics, there has been a decreasing trend in acceptance of injectables, from 29% in 2017 to 25% in 2020. For pills and condoms there has been a slight increasing trend during the project period (2017 to 2020) (**Figure 13**).

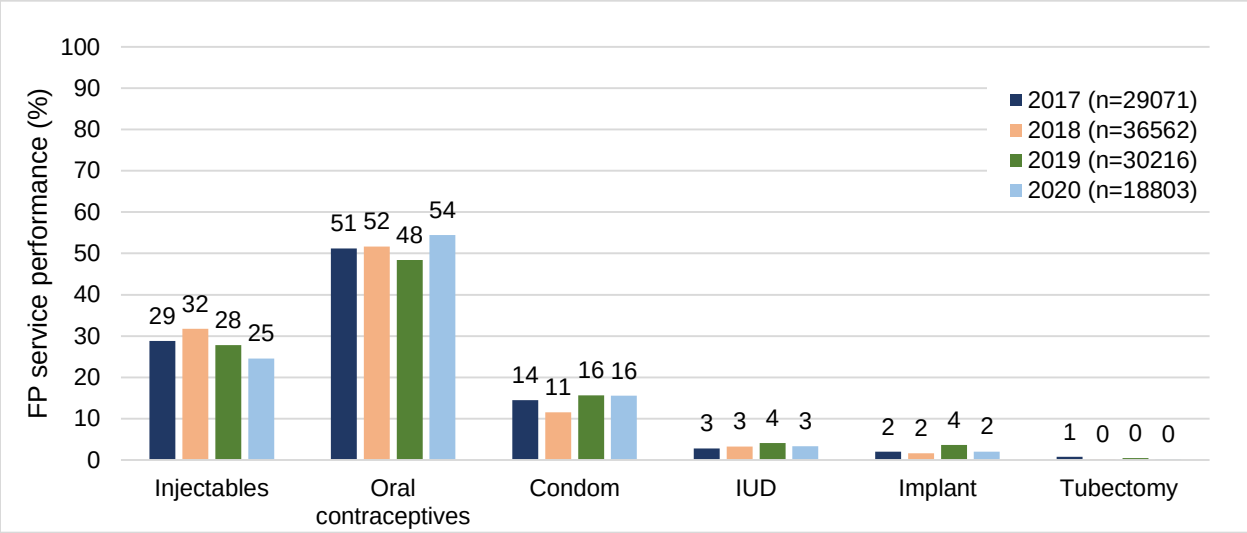



**Figure 13: Acceptance rate of FP services in RHSTEP supported intervention facilities over the QFP project period time (2017- 2020).**

We also analyzed the change in rate of acceptance of LARC and PM during 2017 and 2020 in PPFP, PAFP and interval clients by type of facilities (**Figure 14)**. In both DGHS and DGFP facilities, there has been a decline in rate of acceptance in LARC and PM in each PPFP, PAFP and interval clients. However, in private facilities and RHSTEP clinics some increment in acceptance of LARC and PM in PPFP clients is observed, though in 2020 there is a drop (10%) in LARC and PM than the previous year.

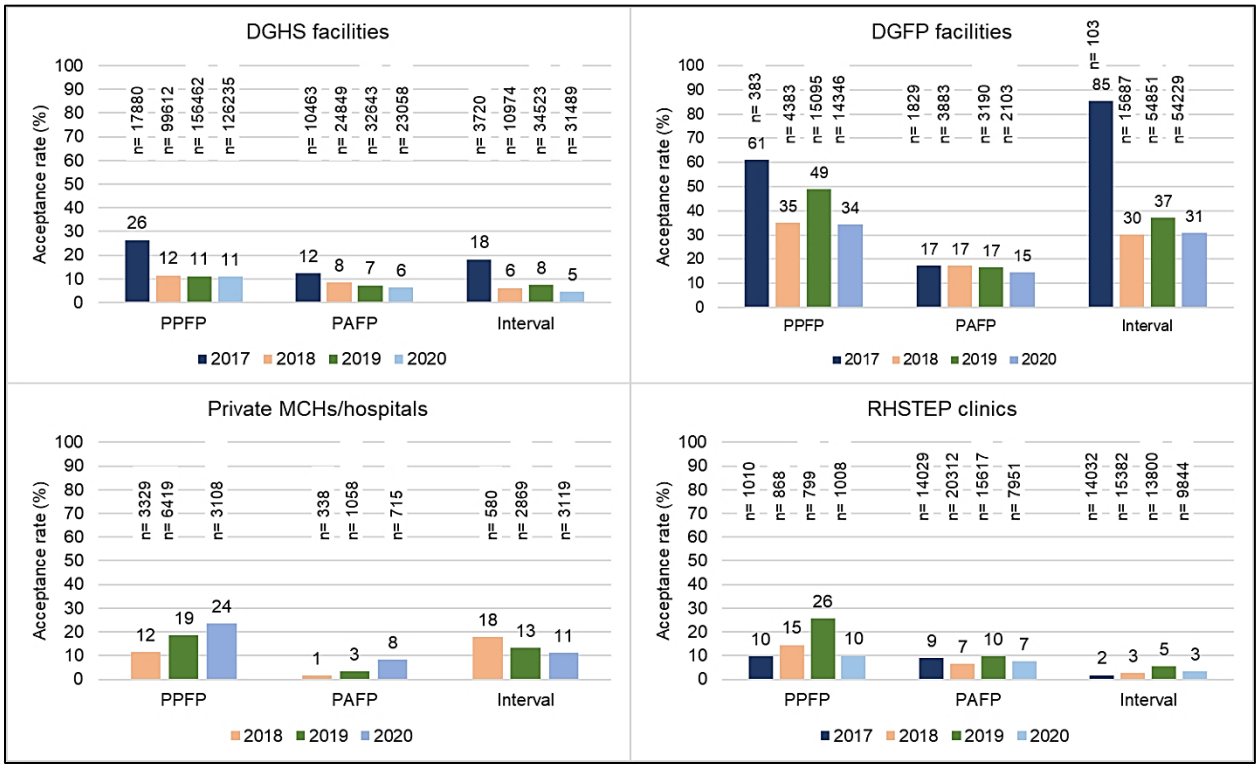



**Figure 14: Acceptance rate of LARC and PM FP methods services among different client types during 2017 and 2020 in Ipas intervention facilities by facility type.**

We also examined component wise change in acceptance of LARC and PM in PPFP, PAFP and interval clients by facility type over time. For IUD, a decline in rate of acceptance over time is observed for each PPFP, PAFP and interval clients, in both DGHS and DGFP facilities. However, the rate in acceptance of IUD in each of the three types of clients in DGFP facilities is higher than the corresponding figures in DGHS facilities. In RHSTEP and private clinics, no noticeable change in rate of acceptance is observed in different client types over time (**Figure 15**).

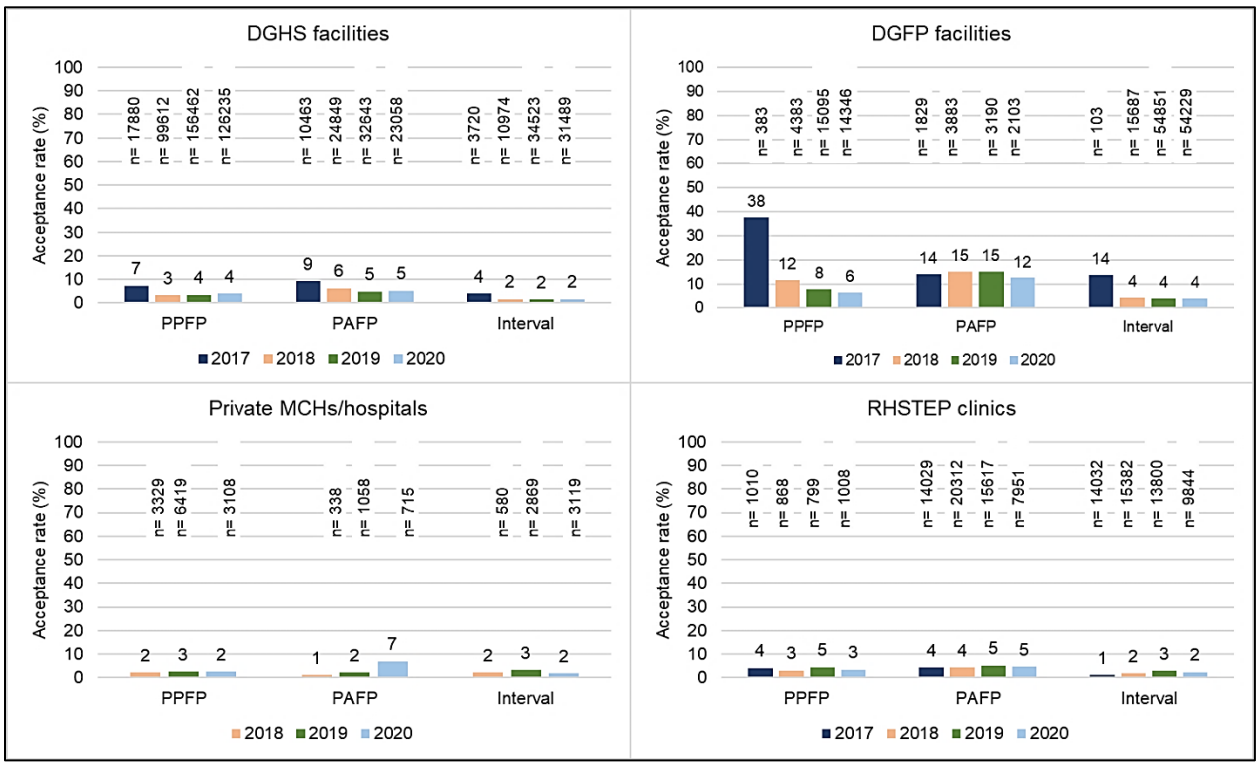



**Figure 15: Acceptance rate of IUD services among different client types during 2017 and 2020 in Ipas intervention facilities by facility type.**

For implants, no noticeable change in acceptance rate of FP services overtime in any of the three client types in DGHS facilities is observed. In DGFP facilities though there is no sign in increased acceptance rate of implant overtime, however, that in each PPFP and interval clients is much greater than the corresponding figure in the DGHS facilities. Though acceptance rate in RHSTEP clinics increased from 4.0% to 8.0% in PPFP clients, again dropped to 4% in 2020. In private MCHs and hospitals, implant as interval method increased from 4% to 7% between 2018 and 2020 (**Figure 16**).

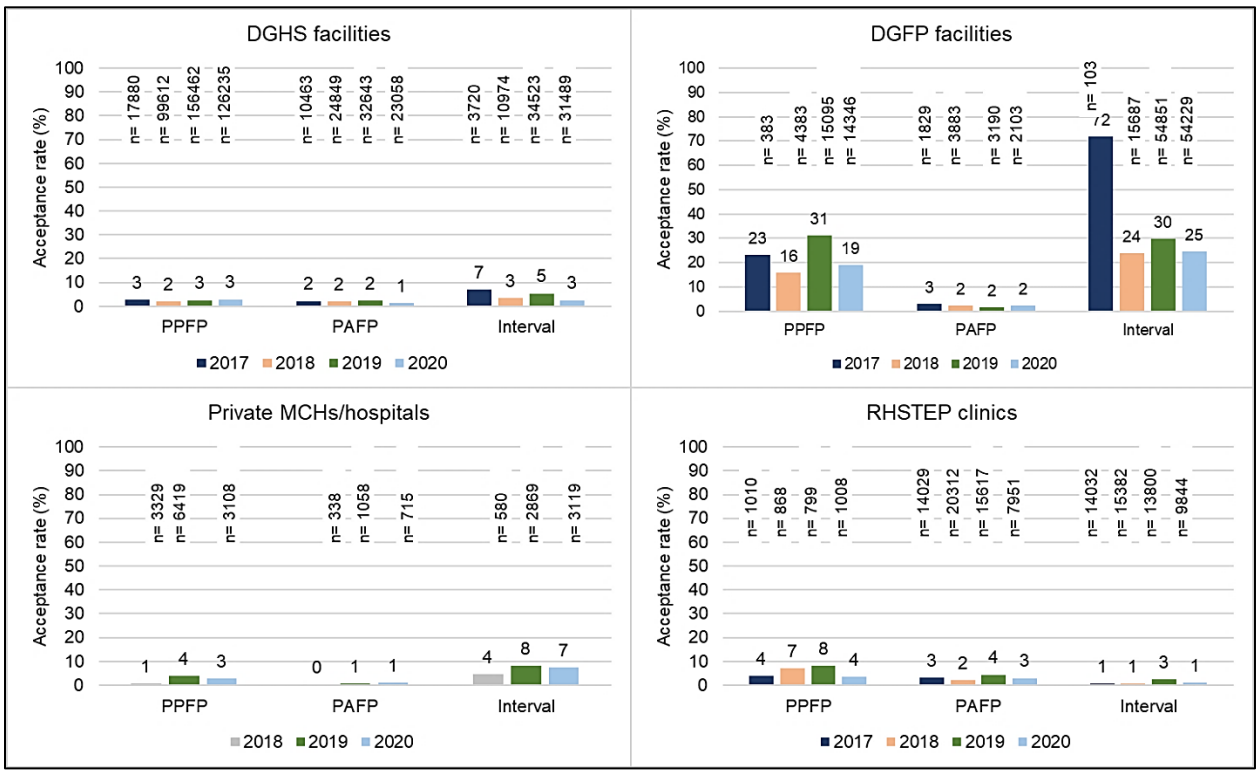



**Figure 16: Acceptance rate of implant services among different client types during 2017 and 2020 in Ipas intervention facilities by facility type.**

The acceptance rate of tubectomy in DGHS facilities in PPFP clients decreased from 16% to 2017 to 4% in 2020. However, in facilities of DGFP, private and RHSTEP, the acceptance rate of tubectomy in PPFP clients has increased over time, though in RHSTEP clinics there has been a drop in 2020 (**Figure 17**).

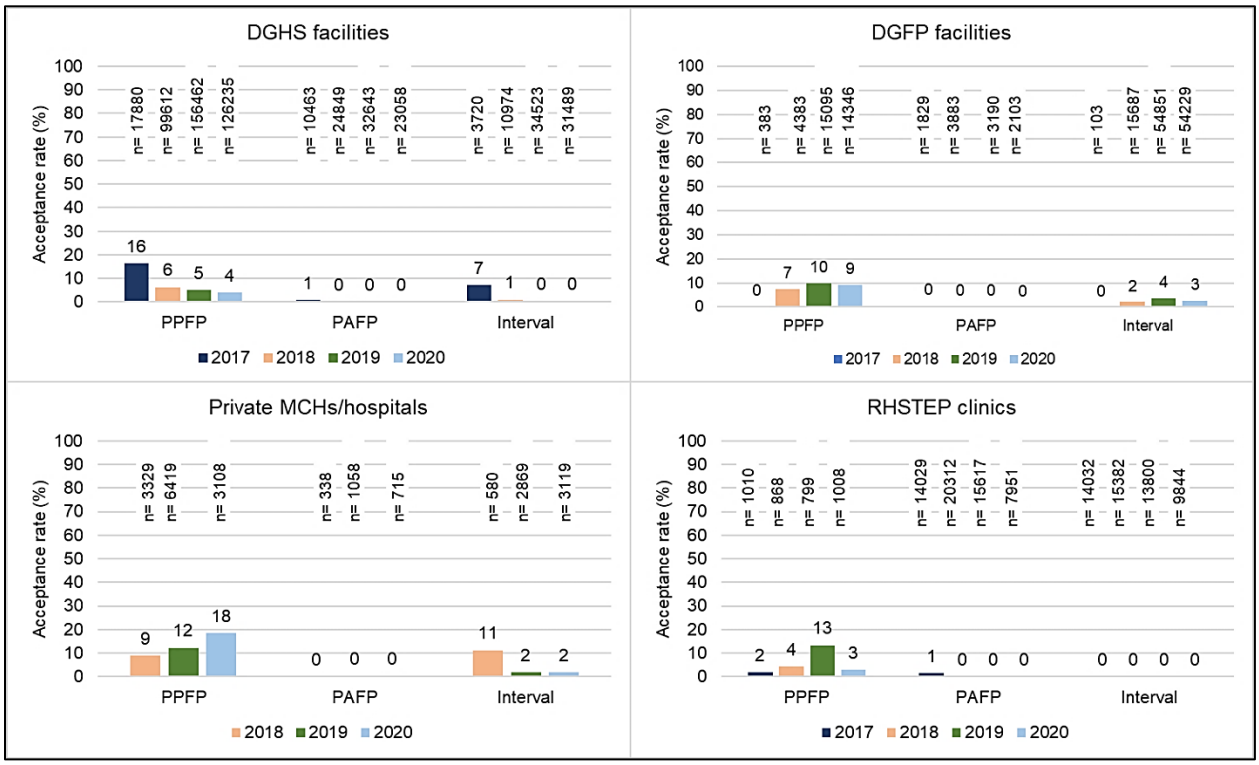



**Figure 17: Acceptance rate of tubectomy services among different client types during 2017 and 2020 in Ipas intervention facilities by facility type.**

## 4.2. Determinant analysis for LARC and PM in QFP project intervention facilities

The results from our determinant analysis to identify the potential factors for acceptance of LARC and PM in all Ipas intervention facilities are shown below**.**

**Table 10: Factors associated with acceptance of LARC and PM in QFP intervention facilities.**

| Potential Factors | n | LARC and PM % | Unadjusted OR (95% CI) | Adjusted OR (95% CI) |
|---|---|---|---|---|
| **Age (in years)** | | | | |
| <= 19 years | 62992 | 6.3 | Ref | Ref |
| 20-24 years | 261034 | 10.3 | 1.71 (1.65-1.77) | 1.60 (1.52-1.68) |
| >=25 years | 554151 | 17.6 | 3.15 (3.05-3.26) | 2.84 (2.71-2.97) |
| **Project year** | | | | |
| Year 1 | 63449 | 14.1 | Ref | Ref |
| Year 2 | 200197 | 11.8 | 0.82 (0.79-0.84) | 0.95 (0.91-0.98) |
| Year 3 | 337326 | 16.3 | 1.18 (1.16-1.21) | 1.24 (1.19-1.28) |
| Year 4 | 277205 | 14.8 | 1.06 (1.03-1.08) | 1.48 (1.43 – 1.55) |
| **Facility type** | | | | |
| RHSTEP clinics | 114652 | 6.0 | Ref | Ref |
| DGHS facilities | 571908 | 10.5 | 1.83 (1.78-1.87) | 4.16 (3.98-4.35) |
| DGFP facilities | 170082 | 34.1 | 8.05 (7.84-8.26) | 29.55 (28.10-31.07) |
| Private MCHs/ hospitals | 21535 | 15.0 | 2.75 (2.63-2.87) | 2.89 (2.69-3.10) |
| **Site category** | | | | |
| Primary | 375097 | 13.7 | Ref | Ref |
| Secondary | 233180 | 16.9 | 1.28 (1.26-1.30) | 1.17 (1.14-1.20) |
| Tertiary | 269900 | 13.9 | 1.02 (1.00-1.03) | 0.57 (0.56-0.59) |
| **Provider type** | | | | |
| Nurse/midwife | 480147 | 2.7 | Ref | Ref |
| FWV/SACMO/Paramedics | 238340 | 4.3 | 1.64 (1.60- 1.69) | 0.52 (0.50 – 0.54) |
| Doctor | 159690 | 65.9 | 70.23 (68.82-71.68) | 122.0 (118.5 – 125.7) |
| **Ipas trained provider** | | | | |
| No | 599670 | 18.2 | Ref | Ref |
| Yes | 278507 | 6.9 | 0.33 (0.32-0.34) | 1.10 (1.07-1.13) |
| **Patient type** | | | | |
| Interval | 265202 | 18.9 | Ref | Ref |
| Postpartum | 450937 | 14.3 | 0.72 (0.71-0.73) | 1.65 (1.60 – 1.70) |
| Post-abortion | 162038 | 8.6 | 0.40 (0.39-0.41) | 0.31 (0.30 - 0.33) |
| **Client type** | | | | |
| Adopters | 768815 | 15.9 | Ref | Ref |
| Changers | 9542 | 44.3 | 4.21 (4.04-4.38) | 3.63 (3.33-3.95) |
| Continuers | 99820 | 1.9 | 0.10 (0.09-0.11) | 0.18 (0.17-0.19) |

After adjusting for other covariates from our determinant analysis, in the Ipas intervention facilities, as compared to year 1, the odds of acceptance of LARC and PM in year 3 was 1.24 times and in year 4, 1.48 times higher **(Table 10).**

**Table 11: Change in accaptance of LARC and PM by type of method adjusted for other covariates in QFP intervention facilities.**

| Potential Factors | n | Acceptance rate % | Unadjusted OR (95% CI) | Adjusted OR (95% CI) |
|---|---|---|---|---|
| **For IUD** | | | | |
| Year 1 | 63449 | 5.8 | Ref | Ref |
| Year 2 | 200197 | 4.0 | 0.68 (0.66 - 0.71) | 0.73 (0.70 - 0.77) |
| Year 3 | 337326 | 3.9 | 0.66 (0.63 - 0.68) | 0.70 (0.67 - 0.73) |
| Year 4 | 277205 | 3.9 | 0.66 (0.63 - 0.69) | 0.78 (0.74 - 0.81) |
| **For implant** | | | | |
| Year 1 | 63449 | 2.8 | Ref | Ref |
| Year 2 | 200197 | 4.0 | 1.47 (1.39 - 1.54) | 0.91 (0.87 – 0.97) |
| Year 3 | 337326 | 8.7 | 3.31 (3.16 - 3.48) | 1.36 (1.29 - 1.44) |
| Year 4 | 277205 | 7.8 | 2.95 (2.81 - 3.10) | 0.72 (0.68 - 0.75) |
| **For tubectomy** | | | | |
| Year 1 | 63449 | 5.5 | Ref | Ref |
| Year 2 | 200197 | 3.8 | 0.67 (0.64 - 0.69) | 0.39 (0.37 - 0.41) |
| Year 3 | 337326 | 3.7 | 0.66 (0.64 - 0.69) | 0.34 (0.32 - 0.35) |
| Year 4 | 277205 | 3.1 | 0.55 (0.52 - 0.57) | 0.20 (0.19 - 0.21) |

After stratification by type of LARC and PM adjusted for other covariates[4], revealed that in QFP intervention facilities as compared to year 1, the odds of acceptance of implant was 1.36 times higher in year 3, though in year 4 the odds was 0.72 times lower. On the other hand, for each IUD and tubectomy as compared to the base year, the likelihood of acceptance of the corresponding odds were 0.78 times and 0.20 times lower in year 4, which were statistically significant **(Table 11)**.

[4] Other covariates: Age, facility type, site category, provider type, Ipas trained provider, patient type, client type

**Table 12: Factors associated with acceptance of LARC and PM in QFP intervention facilities under DGHS.**

| Potential Factors | n | LARC and PM % | Unadjusted OR (95% CI) | Adjusted OR (95% CI) |
|---|---|---|---|---|
| **Age (in years)** | | | | |
| <= 19 years | 53346 | 4.3 | Ref | Ref |
| 20-24 years | 194694 | 6.3 | 1.49 (1.42-1.56) | 1.60 (1.51-1.70) |
| >=25 years | 323868 | 14.0 | 3.59 (3.44-3.75) | 3.32 (3.14-3.51) |
| **Project year** | | | | |
| Year 1 | 32063 | 20.9 | Ref | Ref |
| Year 2 | 135435 | 10.6 | 0.45 (0.43-0.46) | 0.85 (0.81-0.89) |
| Year 3 | 223628 | 10.0 | 0.42 (0.41-0.44) | 0.86 (0.82-0.90) |
| Year 4 | 180782 | 9.2 | 0.38 (0.37-0.40) | 1.39 (1.32-1.46) |
| **Site category** | | | | |
| Primary | 156687 | 3.8 | Ref | Ref |
| Secondary | 165613 | 11.9 | 3.39 (3.29-3.49) | 1.53 (1.48-1.60) |
| Tertiary | 249608 | 13.8 | 4.04 (3.93-4.16) | 0.66 (0.63-0.69) |
| **Provider type** | | | | |
| Nurse/Midwife | 427455 | 2.6 | Ref | Ref |
| FWV/SACMO/Paramedics | 69192 | 2.1 | 0.82 (0.78-0.87) | 1.15 (1.09-1.22) |
| Doctor | 75261 | 63.2 | 64.54 (63.01-66.11) | 167.49 (161.81-173.37) |
| **Ipas trained provider** | | | | |
| No | 362170 | 12.7 | Ref | Ref |
| Yes | 209738 | 6.7 | 0.49 (0.48-0.50) | 1.16 (1.12-1.20) |
| **Patient Type** | | | | |
| Interval | 80706 | 6.7 | Ref | Ref |
| Postpartum | 400189 | 11.9 | 1.87 (1.82-1.93) | 1.28 (1.22-1.35) |
| Post-abortion | 91013 | 8.0 | 1.21 (1.17-1.25) | 0.14 (0.13-0.15) |
| **Client type** | | | | |
| Adopters | 535995 | 11.1 | Ref | Ref |
| Changers | 4654 | 11.4 | 1.03 (0.94-1.13) | 1.02 (0.88-1.17) |
| Continuers | 31259 | 1.1 | 0.09 (0.08-0.10) | 0.16 (0.14-0.18) |

After adjusting for other covariates, in DGHS facilities, the odds of acceptance of LARC and PM was 1.39 times higher in year 4, compared to year 1, which was statistically significant **(Table 12)**.

**Table 13: Change in accaptance of LARC and PM by type of method adjusted for other covariates in QFP intervention facilities under DGHS.**

| Project year | n | Acceptance rate % | Unadjusted OR (95% CI) | Adjusted OR (95% CI) |
|---|---|---|---|---|
| **For IUD** | | | | |
| Year 1 | 32063 | 7.6 | Ref | Ref |
| Year 2 | 135435 | 3.7 | 0.46 (0.44 - 0.49) | 0.64 (0.61-0.68) |
| Year 3 | 223628 | 3.4 | 0.43 (0.41 - 0.45) | 0.62 (0.59-0.65) |
| Year 4 | 180782 | 3.7 | 0.47 (0.44 - 0.49) | 0.73 (0.69-0.77) |
| **For implant** | | | | |
| Year 1 | 32063 | 3.0 | Ref | Ref |
| Year 2 | 135435 | 2.1 | 0.69 (0.64 - 0.74) | 0.86 (0.80-0.93) |
| Year 3 | 223628 | 3.0 | 0.97 (0.90 - 1.04) | 1.19 (1.11-1.28) |
| Year 4 | 180782 | 2.6 | 0.86 (0.80 - 0.92) | 0.84 (0.78-0.90) |
| **For tubectomy** | | | | |
| Year 1 | 32063 | 10.2 | Ref | Ref |
| Year 2 | 135435 | 4.8 | 0.44 (0.42 - 0.46) | 0.40 (0.39-0.42) |
| Year 3 | 223628 | 3.6 | 0.33 (0.32 - 0.35) | 0.31 (0.29-0.32) |
| Year 4 | 180782 | 2.9 | 0.26 (0.25 - 0.27) | 0.18 (0.17-0.19) |

After stratification by type of LARC and PM, adjusted for other covariates[5] revealed that in QFP intervention facilities under DGHS, as compared to year 1, the odds of acceptance of implant was 1.19 times higher in year 3, though in year 4 the odds was 0.84 times lower. On the other hand, for each IUD and tubectomy as compared to the base year, the likelihood of acceptance of the corresponding odds were 0.73 times and 0.18 times lower in year 4, which were statistically significant **(Table 13)**.

[5] Other covariates: Age, site category, provider type, Ipas trained provider, patient type, client type

**Table 14: Factors associated with acceptance of LARC and PM in QFP intervention facilities under DGFP.**

| Potential Factors | n | LARC and PM (%) | Unadjusted OR (95% CI) | Adjusted OR (95% CI) |
|---|---|---|---|---|
| **Age (in years)** | | | | |
| <= 19 years | 4367 | 31.5 | Ref | Ref |
| 20-24 years | 38561 | 33.7 | 1.11 (1.04 – 1.19) | 1.27 (1.18 - 1.37) |
| >=25 years | 127154 | 34.3 | 1.14 (1.07 - 1.22) | 1.50 (1.39 - 1.61) |
| **Project year** | | | | |
| Year 1 | 2315 | 27.7 | Ref | Ref |
| Year 2 | 23953 | 29.1 | 1.07 (0.98 - 1.18) | 0.71 (0.63 - 0.79) |
| Year 3 | 73136 | 38.7 | 1.65 (1.50 - 1.81) | 0.85 (0.77 - 0.95) |
| Year 4 | 70678 | 31.3 | 1.19 (1.08 - 1.30) | 0.37 (0.33 - 0.41) |
| **Provider type** | | | | |
| Nurse/Midwife | 3718 | 12.9 | Ref | Ref |
| Doctor/FWV/SACMO/ Paramedics | 166364 | 34.6 | 3.59 (3.26 - 3.95) | 1.42 (1.27 - 1.58) |
| **Ipas trained provider** | | | | |
| No | 148498 | 37.1 | Ref | Ref |
| Yes | 21584 | 14.0 | 0.28 (0.27 - 0.29) | 0.19 (0.18 - 0.20) |
| **Patient Type** | | | | |
| Interval | 124870 | 33.7 | Ref | Ref |
| Postpartum | 34207 | 41.2 | 1.38 (1.34 - 1.41) | 1.10 (1.07 - 1.13) |
| Post-abortion | 11005 | 16.7 | 0.39 (0.37 - 0.41) | 0.31 (0.29 - 0.33) |
| **Client type** | | | | |
| Adopters | 129000 | 41.4 | Ref | Ref |
| Changers | 3778 | 92.4 | 17.07 (15.13 - 19.25) | 16.39 (14.50 - 18.53) |
| Continuers | 37304 | 2.9 | 0.04 (0.04 - 0.05) | 0.03 (0.03 - 0.03) |

After adjusting for other covariates, in DGFP facilities, as compared to base year, the odds of acceptance of LARC and PM was significantly lower in each of the implantation year of the QFP Project **(Table 14**)**.**

**Table 15: Change in accaptance of LARC and PM by type of method adjusted for other covariates in QFP intervention facilities under DGFP**

| Project year | n | Acceptance rate % | Unadjusted OR (95% CI) | Adjusted OR (95% CI) |
|---|---|---|---|---|
| **For IUD** | | | | |
| Year 1 | 2315 | 17.8 | Ref | Ref |
| Year 2 | 23953 | 7.4 | 0.37 (0.33 - 0.41) | 0.73 (0.64 - 0.82) |
| Year 3 | 73136 | 5.2 | 0.25 (0.23 - 0.28) | 0.55 (0.49 - 0.62) |
| Year 4 | 70678 | 4.6 | 0.22 (0.20 - 0.25) | 0.60 (0.53 - 0.69) |
| **For implant** | | | | |
| Year 1 | 2315 | 9.5 | Ref | Ref |
| Year 2 | 23953 | 19.0 | 2.25 (1.95 - 2.59) | 0.40 (0.33 - 0.49) |
| Year 3 | 73136 | 28.8 | 3.87 (3.36 - 4.45) | 0.51 (0.42 - 0.63) |
| Year 4 | 70678 | 22.9 | 2.84 (2.47 - 3.26) | 0.21 (0.17 - 0.26) |
| **For tubectomy** | | | | |
| Year 1 | 2315 | 0.4 | Ref | Ref |
| Year 2 | 23953 | 2.7 | 7.15 (3.70 - 13.82) | 2.76 (1.39 - 5.48) |
| Year 3 | 73136 | 4.8 | 12.80 (6.65 - 24.66) | 3.19 (1.61 - 6.31) |
| Year 4 | 70678 | 3.8 | 10.13 (5.26 - 19.52) | 2.77 (1.40 - 5.48) |

After stratification by type of LARC and PM, adjusted for other covariates[6], revealed that in QFP intervention facilities under DGFP, as compared to year 1, the odds of acceptance of tubectomy was about 3 times higher in each of the implentation years of QFP Project, which were statistically significant **(Table 15)**.

[6] Other covariates: Age, facility type, provider type, Ipas trained provider, patient type, client type

**Table 16: Factors associated with acceptance of LARC and PM in QFP intervention facilities under private sector.**

| Potential Factors | n | LARC and PM (%) | Unadjusted OR (95% CI) | Adjusted OR (95% CI) |
|---|---|---|---|---|
| **Age (in years)** | | | | |
| <= 19 years | 1148 | 4.9 | Ref | Ref |
| 20-24 years | 6399 | 7.8 | 1.65 (1.24-2.19) | 2.63 (1.84-3.77) |
| >=25 years | 13988 | 19.2 | 4.62 (3.52-6.07) | 8.06 (5.71-11.37) |
| **Project year** | | | | |
| Year 2 | 4247 | 11.6 | Ref | Ref |
| Year 3 | 10346 | 15.5 | 1.40 (1.26-1.56) | 3.72 (3.13-4.41) |
| Year 4 | 6942 | 16.4 | 1.49 (1.33-1.67) | 2.57 (2.15-3.07) |
| **Provider type** | | | | |
| Nurse/Midwife | 11210 | 0.7 | Ref | Ref |
| FWV/SACMO/Paramedics | 5040 | 2.4 | 3.59 (2.69-4.78) | 1.97 (1.44-2.70) |
| Doctor | 5285 | 57.5 | 195.48 (155.21-246.20) | 349.15 (274.42-444.22) |
| **Ipas trained provider** | | | | |
| No | 17733 | 15.9 | Ref | Ref |
| Yes | 3802 | 11.2 | 0.67 (0.60-0.74) | 0.46 (0.38-0.55) |
| **Patient Type** | | | | |
| Interval | 6568 | 12.6 | Ref | Ref |
| Postpartum | 12856 | 18.0 | 1.52 (1.39-1.65) | 0.50 (0.42-0.60) |
| Post-abortion | 2111 | 4.6 | 0.34 (0.27-0.42) | 0.02 (0.01-0.02) |
| **Client type** | | | | |
| Adopters | 19122 | 16.4 | Ref | Ref |
| Changers | 136 | 49.3 | 4.96 (3.54-6.96) | 5.66 (2.92-10.95) |
| Continuers | 2277 | 1.8 | 0.10 (0.07-0.13) | 0.23 (0.16-0.35) |

After adjusting for other covariates, in private facilities under the QFP Project, as compared to base year, the odds of acceptance of LARC and PM was about 3.7 and 2.6 times higher in year 3 and year 4 respectively, which were statistically significant **(Table 16).**

**Table 17: Change in accaptance of LARC and PM by type of method adjusted for other covariates in QFP intervention facilities under private sector.**

| Project year | n | Acceptance rate % | Unadjusted OR (95% CI) | Adjusted OR (95% CI) |
|---|---|---|---|---|
| **For IUD** | | | | |
| Year 2 | 4247 | 2.0 | Ref | Ref |
| Year 3 | 10346 | 2.7 | 1.34 (1.05 - 1.71) | 1.33 (1.04-1.72) |
| Year 4 | 6942 | 2.6 | 1.27 (0.98 - 1.65) | 1.43 (1.09-1.88) |
| **For implant** | | | | |
| Year 2 | 4247 | 1.1 | Ref | Ref |
| Year 3 | 10346 | 4.6 | 4.34 (3.21 - 5.87) | 2.94 (2.14-4.04) |
| Year 4 | 6942 | 4.7 | 4.37 (3.21 - 5.96) | 3.61 (2.61-4.99) |
| **For tubectomy** | | | | |
| Year 2 | 4247 | 8.5 | Ref | Ref |
| Year 3 | 10346 | 8.2 | 0.96 (0.85 - 1.10) | 1.72 (1.50-1.98) |
| Year 4 | 6942 | 9.1 | 1.09 (0.95 - 1.25) | 1.68 (1.45-1.94) |

After stratification by type of LARC and PM adjusted for other covariates[7], revealed that in QFP intervention facilities under private sector, the odds of acceptance of each IUD, implant and tubectomy were significantly higher in both year 3 and year 4 than the corresponding base year (year 2) **(Table 17)**.

[7] Other covariates: Age, facility type, provider type, Ipas trained provider, patient type, client type

**Table 18: Factors associated with acceptance of LARC and PM in RHSTEP clinics under QFP project.**

| Potential Factors | n | LARC and PM (%) | Unadjusted OR (95% CI) | Adjusted OR (95% CI) |
|---|---|---|---|---|
| **Age (in years)** | | | | |
| <= 19 years | 4131 | 5.6 | Ref | Ref |
| 20-24 years | 21380 | 5.4 | 0.95 (0.82 - 1.10) | 1.12 (0.97 - 1.31) |
| >=25 years | 89141 | 6.2 | 1.12 (0.98 - 1.28) | 1.31 (1.14 - 1.51) |
| **Project year** | | | | |
| Year 1 | 29071 | 5.5 | Ref | Ref |
| Year 2 | 36562 | 5.1 | 0.92 (0.86 - 0.98) | 0.88 (0.82 - 0.94) |
| Year 3 | 30216 | 8.1 | 1.52 (1.43 - 1.62) | 2.54 (2.37 - 2.73) |
| Year 4 | 18803 | 5.5 | 1.00 (0.92 - 1.09) | 2.95 (2.67 - 3.26) |
| **Provider type** | | | | |
| Nurse/Midwife | 37764 | 3.2 | Ref | Ref |
| FWV/SACMO/Paramedics | 47800 | 2.1 | 0.64 (0.59 - 0.70) | 0.89 (0.81 - 0.98) |
| Doctor | 29088 | 16.2 | 5.84 (5.48 - 6.24) | 8.32 (7.68 - 9.02) |
| **Ipas trained provider** | | | | |
| No | 71269 | 7.1 | Ref | Ref |
| Yes | 43383 | 4.2 | 0.58 (0.54 - 0.61) | 0.82 (0.77 - 0.87) |
| **Patient Type** | | | | |
| Interval | 53058 | 3.2 | Ref | Ref |
| Postpartum | 3685 | 14.4 | 5.01 (4.52 - 5.56) | 2.70 (2.40 - 3.03) |
| Post-abortion | 57909 | 8.1 | 2.62 (2.48 - 2.78) | 1.25 (1.17 - 1.34) |
| **Client type** | | | | |
| Adopters | 84698 | 7.6 | Ref | Ref |
| Changers | 974 | 14.9 | 2.13 (1.78 - 2.55) | 3.96 (3.23 - 4.86) |
| Continuers | 28980 | 1.3 | 0.16 (0.14 - 0.17) | 0.39 (0.34 - 0.44) |

After adjusting for other covariates, in RHSTEP clinics, the likelihood of accepting LARC and PM were 2 and 3 times higher in year 3 and year 4 respectively, as compared to year 1, which were statistically significant **(Table 18).**

**Table 19: Change in accaptance of LARC and PM by type of method adjusted for other covariates in RHSTEP clinics under QFP project.**

| Project year | n | Acceptance rate % | Unadjusted OR (95% CI) | Adjusted OR (95% CI) |
|---|---|---|---|---|
| **For IUD** | | | | |
| Year 1 | 29071 | 2.8 | Ref | Ref |
| Year 2 | 36562 | 3.2 | 1.18 (1.08 - 1.29) | 1.08 (0.98 - 1.18) |
| Year 3 | 30216 | 4.1 | 1.51 (1.38 - 1.65) | 1.64 (1.50 - 1.80) |
| Year 4 | 18803 | 3.3 | 1.21 (1.09 - 1.34) | 1.35 (1.20 - 1.52) |
| **For implant** | | | | |
| Year 1 | 29071 | 2.0 | Ref | Ref |
| Year 2 | 36562 | 1.6 | 0.83 (0.74 - 0.93) | 0.78 (0.69 - 0.87) |
| Year 3 | 30216 | 3.6 | 1.87 (1.69 - 2.07) | 1.82 (1.64 - 2.02) |
| Year 4 | 18803 | 2.0 | 1.02 (0.89 - 1.16) | 0.90 (0.78 - 1.03) |
| **For tubectomy** | | | | |
| Year 1 | 29071 | 0.8 | Ref | Ref |
| Year 2 | 36562 | 0.2 | 0.25 (0.19 - 0.32) | 0.26 (0.20 - 0.34) |
| Year 3 | 30216 | 0.4 | 0.55 (0.44 - 0.68) | 0.50 (0.40 - 0.63) |
| Year 4 | 18803 | 0.2 | 0.25 (0.17 - 0.35) | 0.14 (0.10 - 0.21) |

After stratification by type of LARC and PM, adjusted for other covariates[8], revealed that in RHSTEP clinics, as compared to year 1, the likelihood of acceptance of IUD increased by 1.6 and 1.4 times in year 3 and year 4 respectively. For implant, the likelihood of its accaptence was 1.8 times higher in year 3 and 0.9 times lower in year 4. For tubectomy, as compared to year 1, the likelihood of acceptance was significantly lower in each of the successive year of the QFP Project intervention **(Table 19)**.

[8] Other covariates: Age, facility type, provider type, Ipas trained provider, patient type, client type

## 4.3. MR and PAC service performance at QFP intervention facilities

During the QFP project period (2017-2020), about one-third (32.7%) of all MR services provided under the project were provided in Dhaka division, followed by Chattagram (18.0%) and Sylhet (17.5%). Of the total PAC services provided under the project, Dhaka division also had the largest share (30.3%) followed by Rajshahi (17.5%) and Sylhet (17.4%) (**Table 20**).

**Table 20: Percentage distribution of MR and PAC services provided in QFP intervention facilities by administrative divisions in Bangladesh**

| Services | n | Barisal | Chattagram | Dhaka | Rajshahi | Rangpur | Sylhet |
|---|---|---|---|---|---|---|---|
| MR | 75139 | 7.1 | 18.0 | 32.7 | 15.3 | 9.4 | 17.5 |
| PAC | 97945 | 9.8 | 15.8 | 30.3 | 17.8 | 8.9 | 17.4 |
| Total | 173084 | 8.6 | 16.8 | 31.3 | 16.7 | 9.1 | 17.5 |

According to secondary data of QFP project, of all the MR services provided under the project, the majority (64.8%) were provided by RHSTEP clinics. The facilities under DGHS were the second largest (25%) service provider for MR, followed by the facilities under DGFP (10%). The health unit of UHC contributed to the majority (19%) of the MR services under the DGHS facilities, followed by DHs (4.4%). Of the total number of PAC services provided under the project, 81% were provided by DGHS facilities. RHSTEP clinics and facilities under DGFP contributed to 11.5% and 4.2% of the PAC services respectively. In DGHS facilities, the MCHs were the largest (31.1%) provider of PAC services, followed by DHs (27.1%) and health unit of UHCs (22.8%) (**Table 21**).

**Table 21: Percentage distribution of MR and PAC services provided in QFP intervention facilities by facility type**

| Site type | % of services | | |
|---|---|---|---|
| | MR n=75139 | PAC n=97945 | Total n=173084 |
| Medical College Hospital (MCH) (n=15) | 1.6 | 31.1 | 18.3 |
| District Hospital (n=35) | 4.4 | 27.1 | 17.2 |
| Upazila Health Complex (UHC) - Health Unit (n=85) | 19.0 | 22.8 | 21.2 |
| ***DGHS facilities (n=135)*** | 25.0 | 81.0 | 56.7 |
| Upazila Health Complex (UHC) - FP Unit (n=31) | 5.9 | 1.7 | 3.5 |
| Mother and Child Welfare Centre (MCWC) (n=10) | 4.1 | 2.5 | 3.2 |
| ***DGFP facilities (n=41)*** | 10.0 | 4.2 | 6.7 |
| ***Private MCHs/hospitals (n=19)*** | 0.2 | 3.2 | 1.9 |
| ***RHSTEP clinics (n=15)*** | 64.8 | 11.5 | 34.7 |

The provision of MR and PAC services provided over the project period separated by DGHS, DGFP, private and NGO facilities are shown in **Figure 18**. In DGHS facilities, the provision of MR service increased from 12% in 2017 to 33% in 2019 and the provision of PAC services increased from 13% in 2017 to 35% in 2019. The service provision declined in 2020 for MR and PAC respectively. In DGFP facilities and RHSTEP clinics the service provision of MR and PAC only increased from 2017 to 2018 and then declined after 2018. (**Figure 18**).

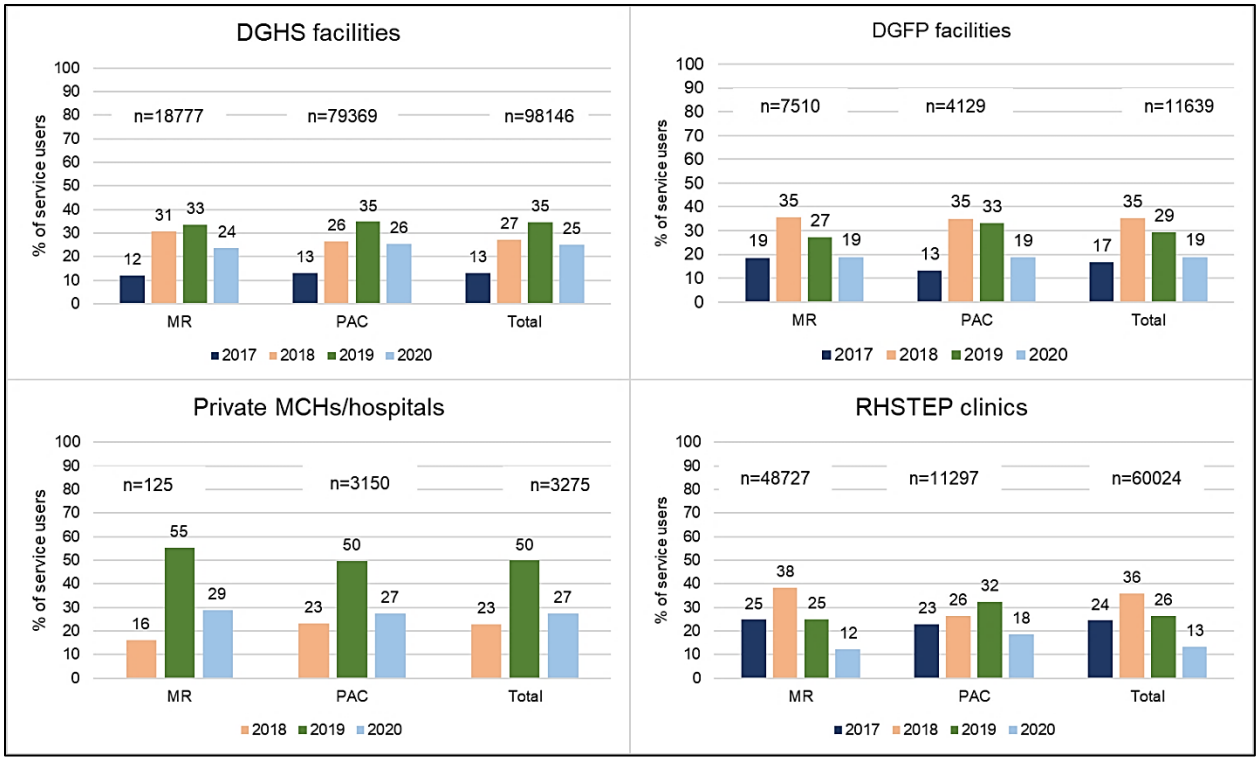



**Figure 18: Trend in service provision of MR and PAC over the project period (2017 to 2020) in DGHS, DGFP, private and NGO facilities.**

While examining the service statistics of MR and PAC of QFP project of Ipas over time, we found an increasing trend in PAC service performance in QFP intervention facilities during 2017 and 2020 (48.0% to 64.8%), whereas there has been a decreasing trend in MR service performance (52.0% to 35.2%) during the same period. From January 2020 to June 2020, there has been a sharp drop in the MR service performance (34.6% to 26.6%) that may be due to COVID-19 pandemic crisis resulting in less accessibility to facilities for MR services. During the same period there has been an increase in the PAC service performance (65.4% to 73.4%), which might also be due to the COVID-19 crisis and may relate to self-use of MRM requiring emergency PAC services (**Figure 19**).

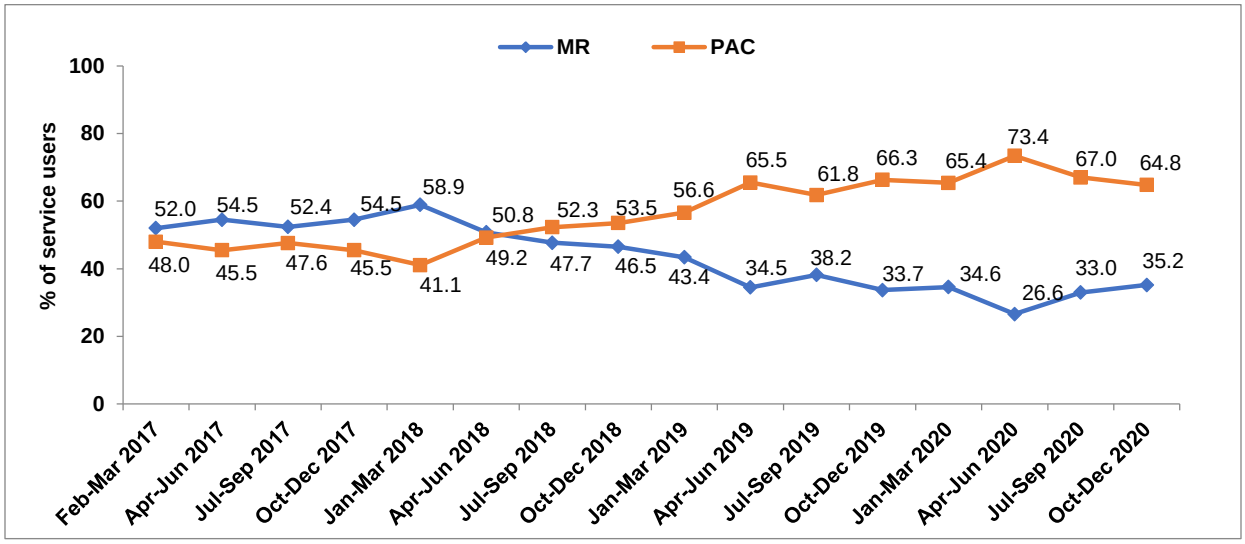



**Figure 19: Trend in MR and PAC service performance by quarter over the project period (2017 to 2020).**

Of all clients receiving MR services over the project period from all QFP intervention facilities, three-fourths (78%) were >=25 years of age and among the PAC clients two-thirds were within the same age group. The proportion of women receiving PAC services in the <=19 years age group (8%) is two times higher than that of MR clients in same age group (4%) (**Figure 20**).

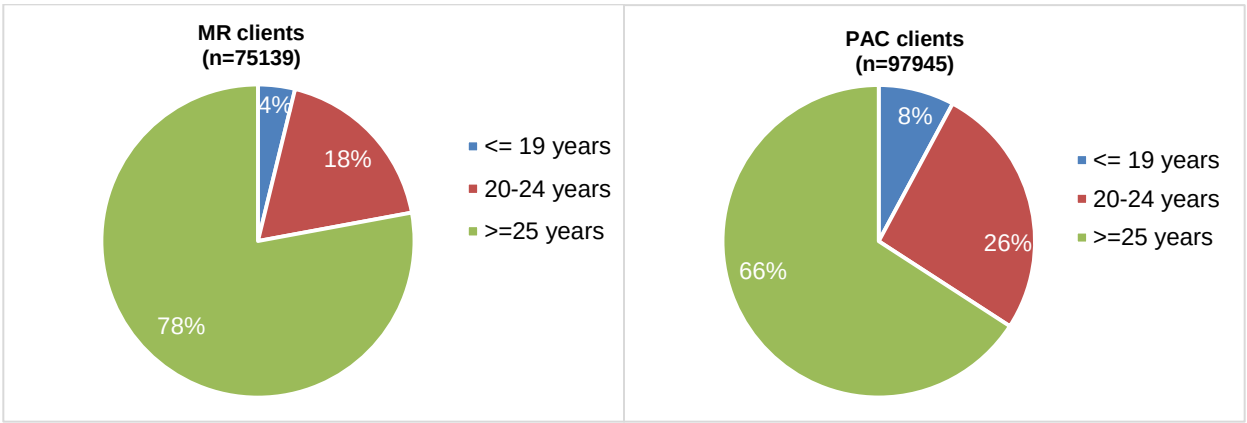



**Figure 20: Age distribution of women recieving MR services (left) and PAC services (right) from QFP intervention facilities over the project period (2017 to 2020).**

The service provision of PAC was found to be higher than MR in DGHS and private facilities except FP unit of UHCs, MCWCs and RHSTEP clinics (**Figure 21**).

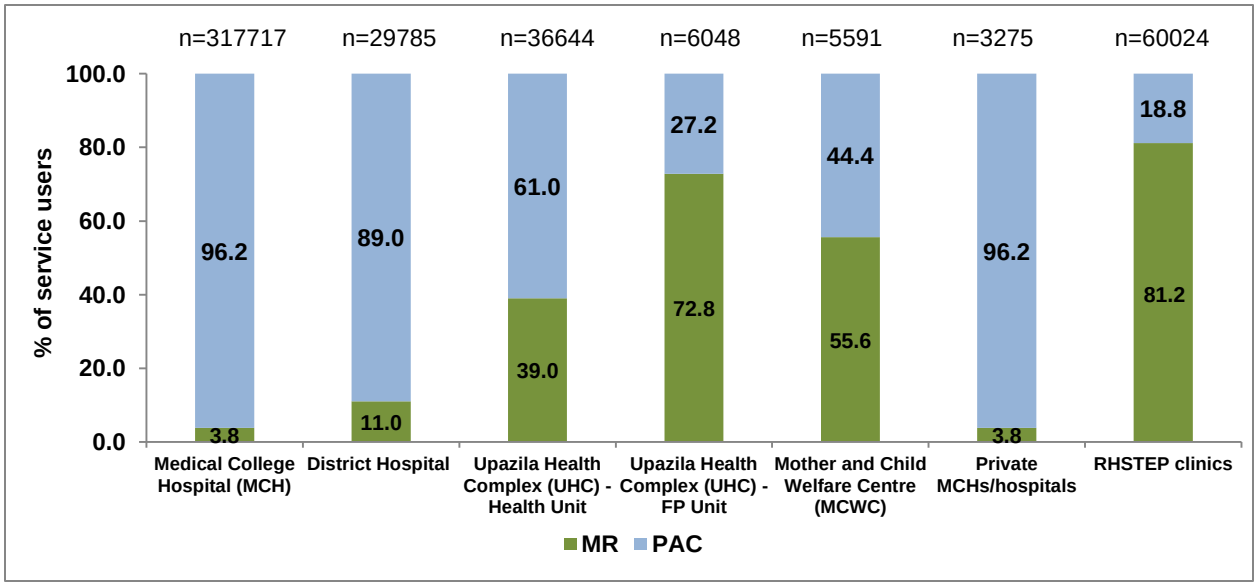



**Figure 21: Percentage distribution of MR and PAC service performance by facility type.**

In DGHS facilities, most of the MR and PAC services were provided by nurses/midwifes. In DGFP facilities and RHSTEP clinics these services are mostly provided by FWVs/SACMOs/Paramedics. However, in private MCHs/hospitals, doctors provided most of the MR and PAC services (**Figure 22**).

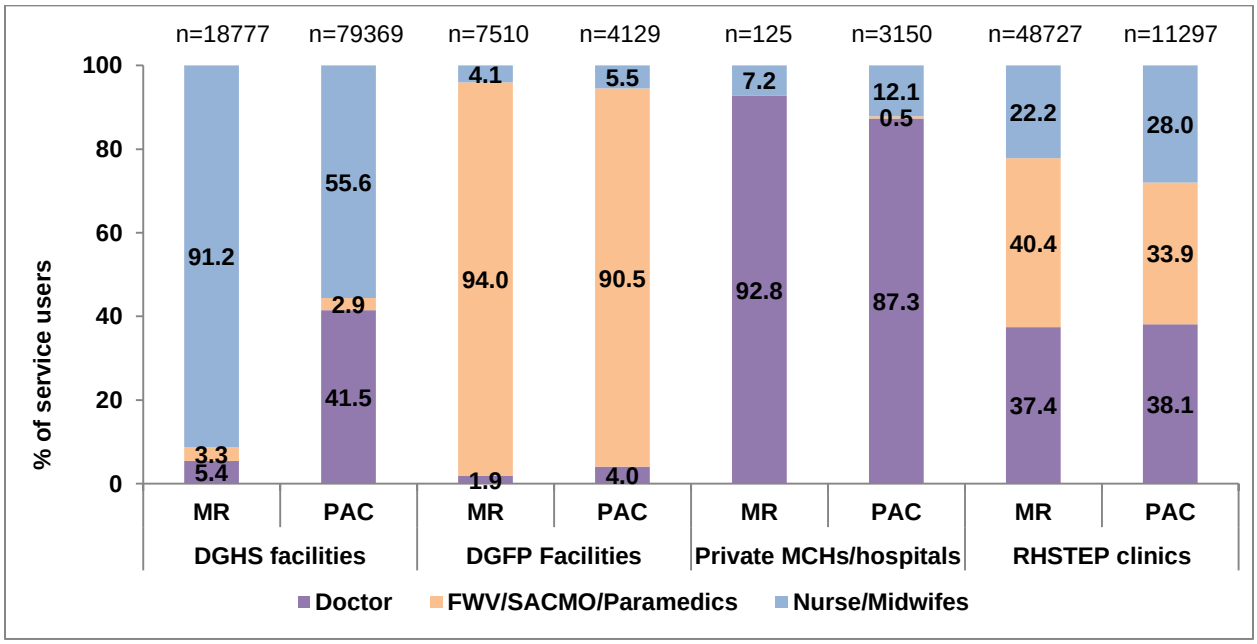



**Figure 22: Percentage distribution of MR and PAC service performance by provider type in DGHS, DGFP, private and NGO facilities.**

While examining the MR and PAC service performance by procedure type we found that most services were performed by using MVA (only a small proportion were performed by EVA, this was from Mitford hospital only). Of the total MR services provided under the QFP project, 9.5% were performed using Mifepristone & Misoprostol. Of the total number of PAC services provided under the QFP project 10.0% were performed by using D&C/'Sharp Curettage' and 3.7% using misoprostol. (**Figure 23**).

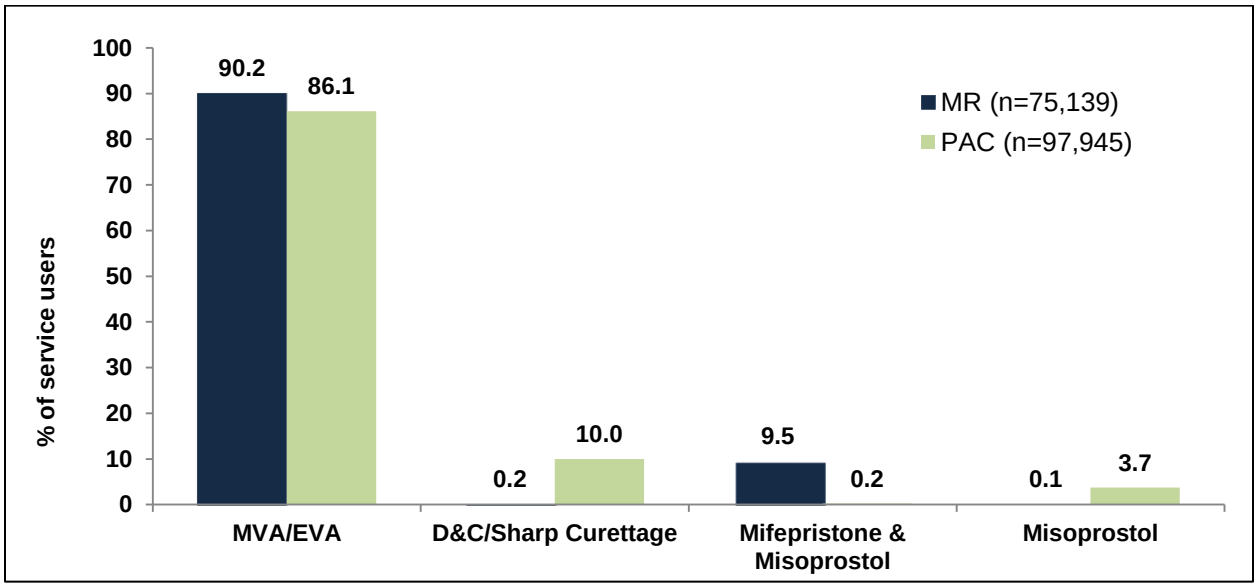



**Figure 23: Percentage distribution of MR and PAC service performance by different primary procedure**

Among the clients who received MR and PAC services, in each category, three-fifths adopted oral contraceptives. This was followed by adoption of injectables (16.4% for MR clients and 14.2% for PAC clients) and condoms (10.2% for MR clients and 11.0% for PAC clients). For LARC methods the PAFP acceptance rate was the highest for IUD, above 5% followed by implant, above 2%. The acceptance rate for tubectomy for PAFP clients was less than 1%. Of all MR and PAC clients 4.6% and 7.6% respectively chose not to adopt any FP method **(Figure 24)**.

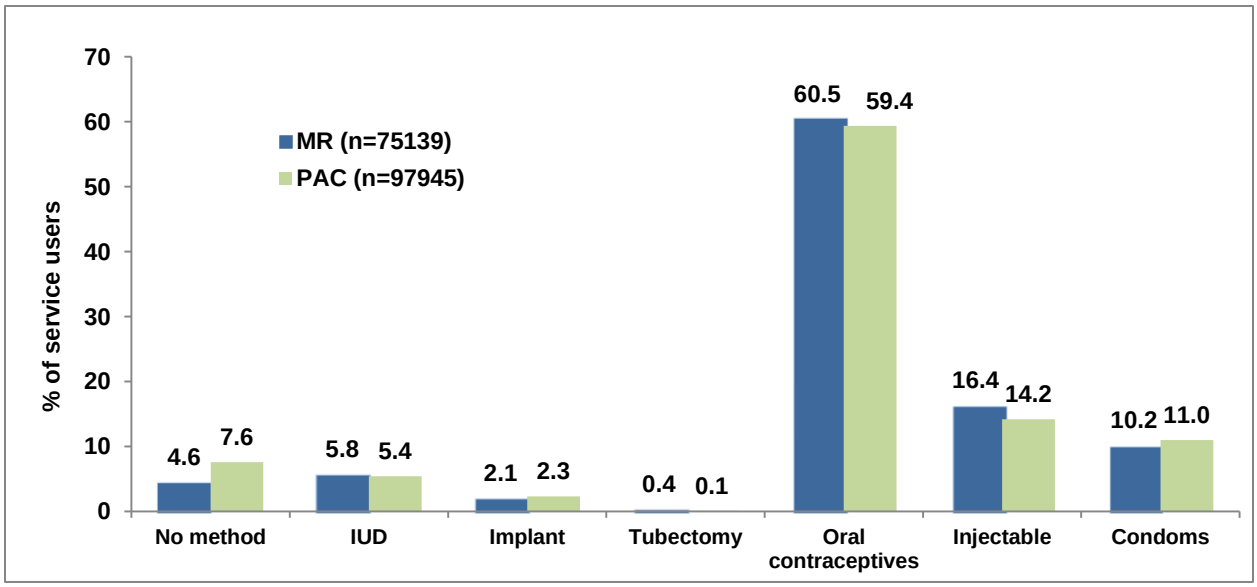



**Figure 24: Percentage distribution of different FP methods after MR or PAC services in QFP intervention facilities over the project period (2017 to 2020).**

Almost all (about 99%) of the of the MR and PAC service users were given pain management intervention for the related services **(Figure 25)**.

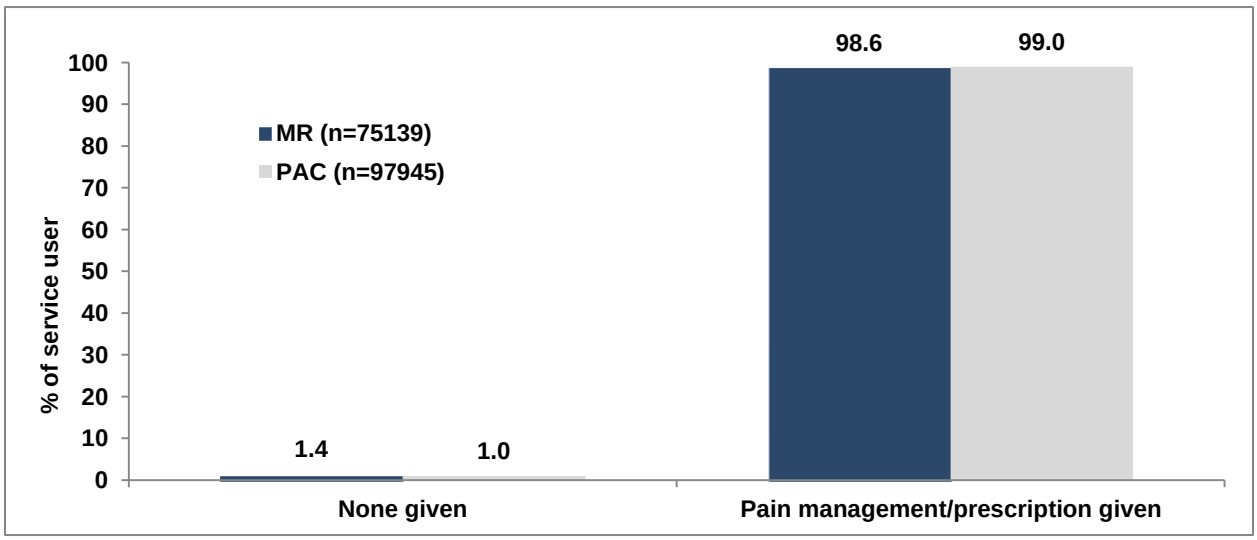



**Figure 25: Percentage distribution of pain management/prescription given for MR and PAC services in QFP intervention facilities over the project period (2017 to 2020).**

From our secondary data analysis, we found that the majority (94%) of the clients adopted a FP method after having MR or PAC services from QFP intervention facilities (**Figure 26).**

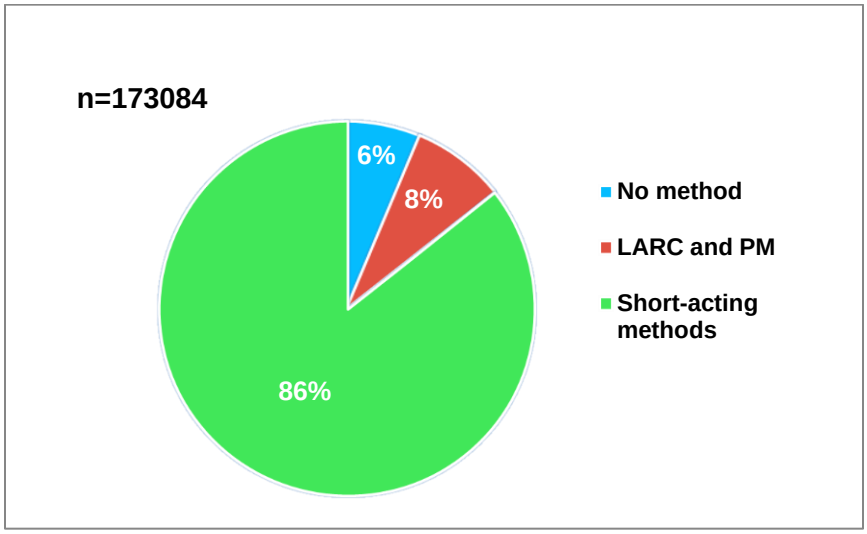



**Figure 26: Percentage distribution of acceptance of PAFP method over the project period (2017 to 2020).**

Almost all (99.3%) of the MR service users reported of having amenorrhea. However, among the PAC service users, almost all (99.2%) complained of bleeding **(Table 22)**.

**Table 22: Percentage distribution of complaints reported by MR and PAC clients in QFP intervention facilities over the project period (2017 to 2020).**

| Reported complaints | MR n=75139 | PAC n=97945 |
|---|---|---|
| **Bleeding** | 0.0 | 99.2 |
| **Amenorrhea** | 99.3 | 0.2 |
| **Others** | 0.7 | 0.6 |

# 5. Discussion

One of the major contributions of the QFP project of Ipas has been the work towards institutionalizing FP services in DGHS facilities and in strengthening the PPFP and PAFP service provision at inpatient department of 135 DGHS facilities (15 MCHs, 35 DHs, and 85 health units of UHCs). As a result of the QFP project the FP service provision (quantity of services) for PPFP and PAFP clients in DGHS facilities increased. Further, there has been 3 fold increase in IUD service provision in the DGHS facilities across all client types from 2017 to 2019. The corresponding increases for implant and tubectomy services were 7 and 2.5 times respectively.

Ipas intervention also covered 19 private MCHs/hospitals, 15 RHSTEP clinics, and 41 DGFP facilities (31 FP units of UHCs and 10 MCWCs). In the DGFP facilities, there has been 10 times increase in IUD service provision and about 5 times increase in both implant and tubectomy services, across all client types between 2017 to 2019. With the support of Ipas the government organized different FP camps, some focusing on implant service provision which most probably contributed to the increase in the service provision of implant in DGFP facilities. Private facilities were gradually added to the QFP project and although private facilities had a small share of the total number of LARC and PM service provision during the project period (2.5% of the total), there has been 2 to 9 times increase in quantity of different LARC and PM services. In the RHSTEP clinics, increase in quantity IUD and implant services was 1.5 to 2 times during 2017 to 2019 and that for tubectomy services decreased over time. However, doctors who provide implant and tubectomy are not available in all RHSTEP facilities and tubectomy is usually provided after a C-section, where this is not available, the provision of tubectomy is low or even absent. Most of the increments in FP service provision across different QFP intervention facilities took place during the first 3 years of the project (2017 to 2019) while a decrease in the performance is observed for most FP methods across facilities in the 4$^{th}$ year (2020). This decrease is likely related to the COVID-19 pandemic crisis which lead to decrease in client flow and clients opting for short-acting FP methods rather than LARC and PM. The study also shows a steady increase in overall FP service performance during the first three years (2017-2019) and a decrease in 2020 which respondents expressed was due to the pandemic.

The QFP project also had a target to strengthen the provision of short-acting FP methods in the intervention facilities. The DGHS facilities contributing three-fourths of oral contraceptive and condom each and one-third of the injectables demonstrated 7 to 9 times increment in the service provision of different short-acting methods during the first three years of the project. The corresponding changes in the DGFP and private facilities were 2 to 3 times and 2 to 4 times respectively. However, for the RHSTEP clinics, the increment in the service provision of short-acting method was not noteworthy.

The above changes are results of the QFP project, under which the key interventions were; training of service providers on FP, MR and PAC; policy advocacy; FP commodities and supplies through SDPs to DGHS facilities from DGFP; Imprest fund allocation and management at the DGHS facilities; and

coordination among high-level stakeholders for enhancing collaboration among the DGFP, the DGHS, and other relevant stakeholders.

When it comes to MR and PAC services, there has been an increase in the service provision of MR and PAC across different intervention facilities from 2017 to 2019. Among the QFP intervention sites, 81% of all PAC services and 25% of all MR services were performed in DGHS facilities. In DGHS facilities the service provision of MR and PAC increased 3 times from 2017 to 2019. The corresponding changes in the DGFP and private facilities were 2 times and 3 times respectively during the first 3 years of the project. Although about two-thirds (65%) of the total number of MR services provided under the project were from RHSTEP clinics, the provision of MR services in these clinics declined over the project period and one-tenth of the total PAC services provided from RHSTEP clinics, showed less increment in uptake over the lifetime of the project.

During the lifetime of the project, Ipas trained a total of 1,219 service providers on FP, MR and PAC service provision. The quality of Ipas training was highly appreciated by the service providers. The training had allocated substantial time on practical sessions with the provision of practicing on models/dummies as well as real patients. The service providers acknowledged that the training helped enhance their knowledge, skills, and confidence in performing FP, MR and PAC services, including management of complications. The training also helped develop positive attitudes among the service providers toward the clients. Despite training and orientation on VCAT, providers and facility staff have negative attitude towards MR services. According to our study findings, their negative attitudes influenced MR service providers negatively and became a barrier to service provision. To address the problem, there has been a suggestion to enhance the scope of training for the service providers on VCAT, along with incorporating this in refresher training.

Despite improvement in FP service provision (i.e. increment in quantity of services), the QFP project of Ipas could not demonstrate improvement in acceptance (proportion of FP clients accepting a method) of LARC and PM except implant in DGHS facilities. According to our crude analysis, during the lifetime of the QFP project, the acceptance of IUD and tubectomy has declined by about 2 and 3 times respectively. These have been compensated by high acceptance of oral contraceptives over time (56% in 2017 to 71% in 2020) in these facilities, which requires relatively less time and effort of the providers.

However, the private facilities could demonstrate increased acceptance of each IUD, implant and tubectomy. Similarly, RHSTEP clinics also could demonstrate in increasing the acceptance of IUD and implant. The performance in private facilities and RHSTEP clinics in increasing the acceptance of LARC and PM could be related to their commitment and availability of trained providers.

The reason for lack of improvement in acceptance of IUD and tubectomy in DGHS and DGFP facilities are likely to be related to the frequent transfer of trained providers and lack of adequate number of providers resulting in heavy workload for the existing providers which lead to a compromise in the quality of counseling. Due to heavy workload and lack of service providers, it was challenging to deliver the

related services and to maintain quality. Although Ipas has trained a significant number of service providers of different cadres, the optimum utilization of the training became a challenge in intervention facilities under the DGHS, due to frequent transfer of doctors and inter-departmental shifting duty of the nurses. According to the current modality, the service providers themselves are counseling clients for FP, MR and PAC services. However, quality counseling for LARC and PM demand substantial amount of time of the service providers. In the public facilities, particularly in the DGHS facilities, the respondents expressed that it was challenging to ensure quality counseling due to heavy workload and shortage of trained providers.

To address these problems, there is a need of training an adequate number of service providers in the obs/gyne departments so that the required skills are available to provide quality services. Moreover, there is a great demand for introduction of refresher training for the service providers to update their knowledge and skills periodically. In addition, as the government has already deployed midwives at the UHCs and has a plan to provide midwives at the DHs, this new cadre of service providers also should be trained for FP, MR and PAC services. As the midwives are also the key providers of maternal care, they can play a major role in counseling patients starting from ANC for PPFP and also can provide the LARC methods to PPFP and PAFP clients.

Reasons behind low acceptance of IUD in most of the facilities are likely related to demand side factors like social and religious stigma, misconception and lack of support from husband and family members. According to the service providers, deeply rooted social stigma work as barriers to motivating women to accept IUD. Major reasons for low uptake of implant were fear of cessation of menstruation, misconception about not being able to conceive after removal of the method, dependency on doctors for service provision, and management of complications. The uptake of LARC and PM may be improved through effective behavior change communication addressing the related misconceptions. There should be a plan to counsel pregnant women on FP methods during the antenatal check-up as counseling at the time of delivery is neither appropriate nor allows adequate time. Moreover, there is also a need to establish collaboration with the community-based program to counsel the targeted clients from the community level and refer them to designated facilities for the related services. Further, community-based interventions should include engagement of influential community people, such as religious leaders, to motivate husbands and mitigate misconceptions about LARC and PM. The counseling program also needs to be strengthened to eliminate the misconceptions regarding LARC and PM by involving husbands.

Our respondents acknowledged that it has now been possible to get direct supply of the FP commodities and logistics for PPFP and PAFP clients in inpatient department of MCHs and DHs due to inclusion of the DGHS facilities under the SDP (service delivery point of DGFP). This is evident from the increased performance of FP services in terms of both short- and long-acting methods from these facilities. However, the health units of the UHCs, still not well functioning under the SDP system of DGFP, and

consequently continues depending on FP units for supply of the FP commodities. This often causes interruption in service provision, particularly in the evening and night shifts. This might be one of the reasons for low service provision of LARC and PM (only 4.7% of total services) from health units of the UHCs. Therefore, the reason for non-functioning of health units of the UHCs under the SDP system should be further explored to fix the problem. In addition, a mechanism could be developed for maintaining a stock of the FP commodities and logistics at the inpatient department of the health units of the UHCs. It is also important to ensure that the service providers have the correct knowledge about supply mechanism of the commodities and are capacitated so that they can indent necessary logistics directly from the SDP under DGFP.

The QFP project successfully advocated for procurement of manual vacuum aspirators (MVAs) directly by DGHS. Although the DGHS facilities were previously mandated to provide PAC services, they did not have the procurement policy for buying the required commodities, like MVA for MR and PAC. Along with other major policy changes such as permission of Family Welfare Visitors (FWVs) to provide PAC services using MVA, introduction of MVA in DGHS facilities has resulted in reducing unsafe abortion. It has been validated by our respondents that introduction of MVA, along with related training, contributed to the increase in utilization of MR and PAC services in both public and private facilities under the Ipas intervention. Ipas also introduced MRM for both MR and PAC, although the proportion of MR and PAC services by this procedure was low, 9.5% for MR and 0.2% for PAC, compared to other procedure methods. However, self- and unregulated use of MRM is likely to be high as per our respondents. A closer look into the MR and PAC-related secondary data of Ipas show that the use of MR services decreased by about 8% during the lockdown period for COVID-19 that had been compensated for, by a similar proportion of increase in the PAC services. It is likely that a substantial proportion of clients seeking PAC services had used MRM, resulting-in incomplete abortion. However, for further confirmation, we suggest undertaking new studies to assess closely the effect of MRM, including its level of use and knowledge of the users and drug-sellers about the proper use of MRM.

For sustainability, Ipas advocated for procurement of MVA through the OP of the Health, Population and Nutrition Sector Development Program (HPNSDP) and succeeded in procurement in 2021. In addition, Ipas also advocated for local procurement of MRM using facility budget. Both the policy actions have been validated by relevant program personnel as important step forward towards sustainability. However, a mechanism is needed for continued support from Ipas is needed for full operationalization of procurement and supply of logistics for MR and PAC to DGHS facilities.

Another major change in policy initiated through the Ipas QFP project was DGFP allocating Imprest fund directly to MCHs and DHs and thus enabling distribution of the incentives among the clients and the service providers for LARC and PM in DGHS facilities. Our respondents acknowledged that this fund transfer mechanism to some extent helped eliminate barriers in disbursement of funds to clients and designated service providers at the MCHs and DHs. However, some challenges in mobilizing Imprest

fund still exist. One such challenges is the lack of capacity of the managers and service providers at the health facilities in managing the Imprest fund effectively. This not only causes delay in the disbursement of incentives but also creates mistrust among the managers, service providers, and clients. To address this problem, there is a need for orientation of the managers and the service providers on effective management of the Imprest fund. Moreover, the upazila-level facilities of the DGHS and the private facilities are still not included within the scope of the new system of Imprest fund management. Still these facilities need to collect the incentives through the traditional system of the DGFP facilities, which is problematic and time-consuming causing dissatisfaction among the service providers at these facilities. A separate mechanism should be developed for effective management of the Imprest fund for health units of the UHCs and private hospitals. For example, a centralized ICT-based online system under authority of the DGHS can be piloted to assess feasibility before scale-up.

The QFP project of Ipas helped develop reporting system for FP service information using the MIS3 format and entering FP service statistics into DHIS-2. This helped address the problem of under-reporting of FP, MR and PAC services and also enabled periodic review of performance of the intervention facilities. These enabled the managers to provide necessary guidelines for improving scope of services. However, there was a demand for training of the relevant personnel engaged in reporting and management of information.

The QFP project of Ipas invested in developing and disseminating BCC materials for promotion of the FP service provision; providing amenities (furniture, utilities, equipment, instruments, etc.) for setting up FP, MR and PAC procedure rooms/corners; developing and distributing guidelines and protocols for maintaining quality services and providing registers for maintaining records, etc. As per observation of the team during field visit in selected facilities, the BCC materials could be more innovative considering the fact that the most abortion cases come with incomplete abortion. No BCC material was found for raising awareness on not taking non-prescribed MRM or raising awareness among husbands and other family members for methods. In addition, the providers also should be sensitized to maintain all the relevant BCC materials and guidelines including the one on crisis management and develop a culture of time to time review and consult the contents for knowledge update for quality service provision.

Most respondents acknowledged that the initiatives undertaken by Ipas in strengthening collaboration between the DGHS and the DGFP empowered the DGHS-affiliated health facilities for providing effective FP, MR and PAC services. This collaboration worked very well among the high-level stakeholders through establishment of a steering committee. However, some gaps were noted at the local level as some of the program personnel rarely felt involved with the Ipas program and its activities due to lack of effective communication. They also commented that Ipas could do better if they could create a platform through policy advocacy where all the relevant stakeholders at the supply-side could exchange their thoughts and generate solutions on how to improve and sustain the current FP service delivery. The facility-level managers also felt excluded from the Ipas program personnel while monitoring the project

activities. They suggested to involve the administrative body at the health facilities in overall monitoring activities of the project to ensure optimum FP, MR and PAC service delivery.

The key interventions of Ipas for strengthening FP, MR and PAC services were: training of service providers, supply of logistics, and creation of provision for mobilizing Imprest fund. However, for sustainability of training under the leadership of the DGFP, a platform should be developed with the participation of the partner NGOs along with OGSB. For supply of the FP commodities and logistics, Ipas connected the DGHS facilities to the DGFP supply system and linked the DGHS facilities with DGFP MIS reporting through MIS3 and developed a mechanism for reporting service statistics to DHIS2 of HMIS of DGHS. In addition, Ipas advocated the relevant line directors to place the requirements through the related line item of the OP. Ipas also helped creating provision for the procurement of MRM-kit, allocating and using facility budget. However, for adaptation of the above activities in the national health system, support should be continued from Ipas for time being. Side by side a transition plan also should be developed by Ipas for smooth transfer of the learnings from this QFP project to the DGHS by identifying a person with the position of a deputy program manager under the MNC&AH program in DGHS. This deputy program manager should collaborate with the relevant stakeholders and play leadership role in adaptation of the QFP project learnings in the national health system. He/she should also be reportable to the steering committee through the line director of MNC&AH for future roll-on of the project learnings in a sustainable way.

# 6. Conclusions and Recommendations

The initiatives undertaken by Ipas strengthened the DGHS health facilities in providing FP, MR and PAC services effectively and also contributed to increasing the utilization of related services in facilities under DGHS, DGFP, private MCHs/hospitals and RHSTEP clinics. The QFP project of Ipas also could demonstrate some effect in increased acceptance of LARC and PM, though the effect was not exhibited uniformly for IUD, Implant and tubectomy across all facility types. However, our study respondents acknowledged the contribution of training and policy advocacy, like direct collection of FP commodities from DGFP by DGHS facilities through SDP system, procurement of MVA by DGHS and introduction of Imprest fund direct allocation to selected DGHS facilities, in strengthening FP, MR and PAC services in DGHS facilities. Enhanced coordination between the DGHS and the DGFP, along with other stakeholders, contributed to the overall achievements of the QFP project, although some implementation-related challenges have been identified. For adaptation of the learnings in the national health systems, the study makes specific recommendations as follows:

(i) Developing new policy for in-service training of doctors, nurses, and midwives on FP, MR and PAC services as a long-term solution.
(ii) Training an adequate number of service providers, along with the introduction of refresher training, so that the required skills are available to provide quality services.
(iii) Planning to train the new cadre of midwives for PPFP and PAFP.
(iv) Incorporating VCAT of training for the service providers for changing negative attitude towards MR.
(v) Developing a platform under the leadership of DGFP along with the support of other relevant stakeholders for sustainability of training of the providers on FP, MR and PAC services.
(vi) Appointing a counselor at each Ipas intervention facility to improve quality of counseling.
(vii) Establishing collaboration with the community-based program to counsel the targeted clients at the community level.
(viii) Identifying the reasons for non-functionality of SDP system at the health units of the UHCs and orienting the providers on procurements and maintenance of the stock of the FP commodities under SDP system.
(ix) Undertaking new studies to assess closely the effect of MRM, including its level of use and knowledge of the users and drug sellers about MRM.
(x) Organizing orientation program for managers and service providers on efficient management of Imprest fund.
(xi) Bringing the upazila-level facilities of the DGHS and the private facilities within the scope of the new system of independent management of Imprest fund.
(xii) Developing BCC materials considering the fact that most abortion cases come with incomplete abortion.

(xiii) Creating a platform where all the relevant stakeholders at the supply-side could exchange their thoughts and generate solutions on how to improve and sustain the current FP service delivery.

(xiv) Scaling up the interventions under the QFP project to remaining DGHS facilities.

Finally, for realizing the above recommendations in the national health system, continuation of Ipas's support is needed for another 2-3 years to enable transfer of learnings to the DGHS and to support DGHS to further improve their capacity to deliver quality FP, MR and PAC services and for ownership and accountability.

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