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USAID ACCELERATING UNIVERSAL ACCESS TO FAMILY PLANNING (AUAFP) PROJECT

Training Needs Assessment

Training Needs Assessment

for the

Accelerating Universal Access to Family Planning (AUAFP) Project

ACKNOWLEDGEMENT

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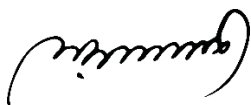Senior Country Director, Pathfinder International, Bangladesh

PREFACE

Bangladesh has made commendable achievements in reducing the total fertility rate (TFR) from 3.4 in 1993-94 to 2.3 in 2017-18. Out of eight divisions, Dhaka, Khulna, Rajshahi and Rangpur have already reached the replacement level of fertility of TFR 2.2. The current contraceptives prevalence rate is 62%. The use of modern contraceptive method has increased over the last more than two decade from 36% in 1993-94 to 52 % in 2017-18. The 4th Health, Population and Nutrition Sector Program (HPNSP) set the targets to increase contraceptive prevalence (modern and traditional) from 62% to 75% by 2022. FP2020 aligned with 7th Five Year Plan and Sector program set targets to increase the share of Long Acting Permanent Method (LAPM) from 8.0% to 20.0%, reduce the unmet need from 12.0% to 10.0% and reduce discontinuation rate of FP method from 30.0% to 20.0% by 2021.

Pathfinder International, in partnership with IntraHealth International and with strategic support from the Obstetrics-Gynecology Society of Bangladesh (OGSB) and University of Dhaka is implementing the USAID funded Accelerating Universal Access to Family Planning (AUAFP)/Shukhi Jibon Project in Bangladesh. The goal of Shukhi Jibon is to contribute for the improvement of health and human capital in Bangladesh through Family Planning services. The five-year project (July 2018-July 2023) is being implemented under the guidance of Ministry of Health and Family Welfare (MOHFW), specifically with Directorate General of Family Planning (DGFP), Directorate General of Health Services (DGHS) and National Institute of Population Research and Training (NIPORT). The project is being implemented in the divisions of Chattogram, Dhaka, Mymensingh, and Sylhet, phase by phase approach. In the meantime, activities have been begun as pilot basis six districts, providing needs-driven technical assistance and systems strengthening, and it will expand to all other districts of the four divisions from the third year of the project onwards.

NIPORT is responsible for developing human resources and generates evidence for improving health, population and nutrition programs and policies in Bangladesh. NIPORT is the only in-service training institute with residential facilities under MOH&FW that is entrusted to develop skilled health and family planning professionals, program managers and field level workers of Bangladesh. A Letter of Collaboration has been signed between NIPORT and Pathfinder International for implementation of the project.

A Training Needs Assessment (TNA) has been conducted under the Shukhi Jibon Project from February to March 2019, for developing a need-based capacity building program towards creating maximum impact with optimum resource utilization. Quantitative and qualitative methods were utilized/used over the sample group of 493 facilities and FP providers, 25 trainers, and 10 heads of training facilities in the six pilot project districts (Dhaka, Faridpur, Mymensingh, Sylhet, Rangamati and Chattogram). NIPORT officials participated in reviewing the questionnaires, performed quality control supervisory visits during the data collection and reviewed the report for finalization.

I would like to thank IntraHealth International for taking the lead in conducting the TNA. I would like to express my special gratitude to our training unit colleagues for their valuable guidance and cooperation. I am happy with the quality and comprehensiveness of the findings. I hope the findings of the Training Needs Assessment will help to develop the capacity building program and designing for the improvement of the performance of family planning service providers in Bangladesh.

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MESSAGE

I am very happy to know that USAID's Shukhi Jibon has conducted a Training Need Assessment (TNA) which would be very helpful to design and develop need-based capacity development programs and to create necessary learning opportunities for the family planning (FP) trainers and the service providers. I firmly believe that the Competency-Based Training methods, which have been introduced by Shukhi Jibon towards building the capacity of FP trainers at NIPORT and DGFP, would effectively contribute to improve the performance of FP providers for providing quality services. The findings of TNA illustrated the remaining gaps and painted the challenges which would help NIPORT to take appropriate actions towards achieving the national vision. Shukhi Jibon has already disseminated the findings of the TNA at national and district level, and all the valuable feedbacks received from the disseminations have been incorporated in the final report for printing.

I would like to thank all those who were part of designing, data collection, data analysis and report writing of the TNA. I also thank NIPORT colleagues who participated in the process and provided valuable input and guidance for the TNA. I would also like to thank USAID for supporting this initiative.

Finally, I hope that the findings of the TNA will serve its purpose for designing need-based capacity building programs for the family planning service providers who will provide quality services.

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ACRONYMS

ADCC	Assistant Director Clinical Contraception
ADFP	Assistant Director- Family Planning
AUAFP	Accelerating Universal Access to Family Planning
AYFS	Adolescent- and Youth-Friendly Services
AUFWO	Assistant Upazila Family Welfare Officer
MBBS	Bachelor of Medicine, Bachelor of Surgery
BHFS	Bangladesh Health Facility Survey
CCSDP	Clinical Contraception Services Delivery Program
CC	Community Clinic
CHCP	Community Health Care Provider
DDFP	Deputy Director Family Planning
DGO	Diploma in Gynecology and Obstetrics
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
ECP	Emergency Contraceptive Pill
FCPS	Fellow of the College of Physicians and Surgeons
FP	Family Planning
FPI	Family Planning Inspector
FPCS QIT	Family Planning Clinical Supervision and Quality Improvement Team
FWA	Family Welfare Assistant
FWO	Family Welfare Officer
FWV	Family Welfare Visitor
FWVTI/RPTI	Family Welfare Visitor Training Institute/Regional Population Training Institute
HA	Health Assistant
HPNSP	Health, Population and Nutrition Sector Program
HQ	Headquarters
GoB	Government of Bangladesh
HSC	Higher Secondary Certificate
IDIs	In-Depth Interviews
IT	Information Technology
IUD	Intrauterine Device
KIIs	Key Informant Interviews
LAM	Lactational Amenorrhea Method
LAPM	Long Acting/Permanent Method
MO	Medical Officer
MCH	Maternal and Child Health
MCH-FP	Maternal and Child Health – Family Planning
mCPR	Modern Contraceptive Prevalence Rate
MCHTI	Maternal and Child Health Training Institute
MCPS	Member of the College of Physicians and Surgeons
MCWC	Maternal and Child Welfare Center
MFSTC	Mohammadpur Fertility Services & Training Centre
MS/MPhil	Master of Surgery/Master of Philosophy

NIPORT	National Institute of Population Research and Training
NSV	Non Scalpel Vasectomy
OGSB	Obstetrical and Gynecological Society of Bangladesh
PAC FP	Post Abortion Care Family Planning
PPFP	Postpartum Family Planning
RTC	Regional Training Center
RCTC	Regional Consultant Training Centre
RPTI	Regional Population Training Institute
RTI	Reproductive Tract Infection
SACMO	Sub-Assistant Community Medical Officer
SSC	Secondary School Certificate
TFI	Training Facility Inventory
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
TNA	Training Needs Assessment
TOT	Training of Trainers
TRD	Training, Research, and Development
UFPO	Upazila Family Planning Officer
UHC	Upazila Health Complex
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

The USAID funded, Accelerating Universal Access to Family Planning (AUAFP) project, also known as Shukhi Jibon conducted a Training Needs Assessment (TNA) to inform program strategies that could strengthen the family planning (FP) workforce and training institutes to overcome the current plateau in modern contraceptive prevalence rates. The TNA was conducted in six districts of Bangladesh: Sylhet, Mymensingh, Dhaka, Faridpur, Rangamati and Chattogram. The core research team, comprised of 17 members, used a mixed methods approach to measure different components of the TNA. Data were collected from 493 FP service providers, 25 trainers, and 10 heads of training institutes. This report led to several key findings on FP in Bangladesh.

Key Findings

The TNA found that the average number of years of work experience among FP service providers was 16–23 years for Medical Officers (MOs), Sub-assistant Community Medical Officers (SACMOs), Family Welfare Visitors (FWVs), and Family Welfare Assistants (FWAs). In contrast, Community Health Care Providers (CHCPs) and midwives were relatively new to their positions: their average number of years of work experience was only seven. This difference could be attributed to CHCPs and Midwives being fairly new cadres in Bangladesh compared with the others. The TNA also examined providers' perceptions of the services mandated by their job descriptions versus the services they were actually providing. Counseling emerged as the most critical task in FP service delivery. Although this task was perceived as the most critical, only ~17.8% of CHCPs, for example, were providing counseling services. In addition, nearly 40% of all cadres reported that they felt uncomfortable providing this service. The TNA revealed that MOs and SACMOs reported the highest levels of comfort in providing FP services, while the lowest level was reported by midwives, with just 18% feeling comfortable with their skills. The service providers' comfort level might also stem from their actual knowledge of FP methods. For example, only 49.3% of FWVs knew when to start a client on a contraceptive method. FP providers also faced challenges to delivering services. The TNA found that overcoming myths was the most commonly cited challenge faced by FP service providers, followed by clients' fears of long-acting reversible and permanent FP methods. There were also factors that demotivate FP service providers, affecting their desire to continue providing services. The two major factors that were found were the lack of career development opportunities and high workloads. With regard to career development, FWAs, Family Planning Inspectors (FPIs), and SACMOs join and retire in the same position, which can be demotivating, whereas promotions were available for Upazila Family Planning Officers (UFPOs), FWVs, and MOs. The TNA also found that a majority of the providers received basic training in FP, but practicums and refresher trainings were few. Although the trainings might be relevant, providers still reported that they felt they did not have adequate knowledge and skills for the services they provide.

The TNA revealed pertinent information regarding adolescent- and youth-friendly services (AYFS). Out of the cadres surveyed, the most extensive FP services provided to adolescents were related to menstrual issues. Additionally, close to one-third of the MOs, FWVs, FWAs, and CHCPs discussed issues such as delaying a first pregnancy and the adverse effects of adolescent pregnancy. However, the types and distribution of services were mostly related to reproductive health and not to FP. The

low provision of AYFS came from a lack of training, confidence, and comfort. Social barriers were also present, as parents have influence in their communities.

The TNA also examined trainers and training facilities on their current status. Trainers were given a questionnaire on their knowledge and perceptions of skills. The TNA revealed that 58% of trainers had good knowledge and application of adult learning principles; however, 21.7% of trainers did not have adequate e-learning skills, and 25% found their skills in conducting refresher trainings to be inadequate. For the training institutes, the TNA found that on average, all ten institutes surveyed typically provide training on FP methods, but in last year, only four FP trainings were given. The training institutes also rely heavily on external trainers. Approximately one-third of the training institutes were fully dependent on outsourced trainers. The TNA also revealed that although the training institutes had moderate to good physical infrastructure, they lacked clinical practice facilities and related mannequins and models for practicums.

For on the job training, about half (49.5%) of the FWVs have received on-the-job training sometime in their careers, while more than over 60% of the MOs, Midwives, SACMOs, and FWAs have not received on-the-job training. The rate of not receiving on-the-job training was highest among CHCPs (93.6%). On the job training has been mostly on counseling, LAPM, PPFP and PACFP. On supervision, 67% MOs, 43 % FWVs, 63% Midwives, 56% SACMOs, 28% FWAs and 21% CHCPs mentioned that they do not recall their supervisor using a checklist during the supervision. While providers depend on their supervisors to respond to work related questions and general performance support, few of them get responses and direct feedback from their supervisors.

More than 70% of midwives and CHCPs possess a smartphone, 87% of MOs have smartphones, 63% of SACMOs, and approximately 40% FWVs and FWAs possess a smartphone. Eight out of ten FP service providers communicate with their supervisors by mobile phone for work purposes. The same situation exists for their communication with their colleagues and their FP services clients. Using the mobile phone for learning is limited with approximately 47% of providers mentioning they have ever heard or read work related information using their mobile phones. Willingness to use the mobile phone for learning is high however with approximately 30% of FWV, Midwives, SACMOs and FWAs expressed willingness to use the phone for learning – the level of willingness could be an age related -most of the older providers and not as technological savvy as their younger colleagues.

Recommendations

1. The recent cohort of frontline FP service providers have entered their jobs with more education than was required for their position. This education should be utilized as an opportunity for redesigning FP service-related training programs.

2. Approximately 60% of frontline FP service providers have more than 25 years of work experience. This statistic means that a significant number of service providers will retire soon. Thus, continuity of recruitment should be in place so that no service gap is created, as 40% of frontline FP service provider positions are vacant.

3. The FP service providers' job responsibilities are not specifically written in their job descriptions and FP service providers (particularly frontline workers) have incomplete knowledge of their job responsibilities. Job descriptions need to be written clearly and specifically, there should be a systematic and specific dissemination system for informing the FP service providers about their job responsibilities.

4. A significant number of providers face challenges like FP myths in society and fear among clients regarding long-acting reversible and permanent methods. Thus, initiatives should be taken to dispel these myths and fears at the community level. Initiatives should also be taken to optimize the providers' capacity/performance to improve services.

5. The lack of career development opportunities is one of the most significant demotivating factors for providing FP services. Thus, the providers' current career development pathways should be reviewed and aligned to create opportunities and increase motivation.

6. FP service providers face challenges in terms of providing AYFS due to their lack of capacity and confidence in dealing with adolescent issues. Thus to improve AYFS, initiatives should be taken to increase providers' capacity and confidence.

7. The providers received their last FP refresher training at least five to ten years ago, depending on the FP method or service. At the same time, the providers expressed a high degree of perceived need for training. Thus, context-specific refresher trainings for the current providers should be provided.

8. The trainings that FP service providers receive on counseling were mostly inadequate for all service providers. Thus, counseling training for all the providers should be strengthened

9. The practicum trainings received by the FP service providers were very inadequate. Thus, competency- and skill- based trainings should be given high priority.

10. Initiatives should be taken to strengthen the supportive supervision system. Specifically, training should be provided to supervisors to improve their skills in using checklists, giving feedback to supervisees, and providing necessary training to supervisees during supervisory visits

11. There is need for a continuing medical education system. Thus, such a system should be developed for the FP service providers—one that incorporates updated training curricula, practical laboratory sessions, and teaching methods.

12. The training institutes currently depend heavily on outsourced trainers due to in-house trainer vacancies. Thus, initiatives should be taken to fill the vacant in-house trainer positions at the training institutes.

13. The capacity of the training institutes needs to be strengthened. The capacities of both in-house and outsourced trainers working at the training institutes should be improved through Competency-Based Training Methods and Adult Learning Methodology

14. The outsourced trainers' engagement requires strengthening. Thus, a pool of qualified outsourced trainers should be created, but only after providing ToTs to them.

15. On-the-job training as currently practiced is inadequate. Thus, the on-the-job training system should be strengthened.

Background

Accelerating Universal Access to Family Planning (AUAFP) is a United States Agency for International Development (USAID)-funded project in Bangladesh, implemented by Pathfinder International in partnership with IntraHealth International, with strategic support from the Obstetrical and Gynecological Society of Bangladesh, the World Health Organization, and the University of Dhaka. The main objectives of this project are to increase the qualified family planning (FP) workforce and to expand access to quality FP services through a collaborative health system capacity-building partnership with the Government of Bangladesh. Through a phased approach, this project is being implemented in four divisions (Dhaka, Mymensingh, Sylhet, and Chattogram) of Bangladesh and currently being piloted in 6 districts (Dhaka, Faridpur, Mymensingh, Sylhet, Rangamati and Chattogram).

Despite significant improvements in achieving some FP services targets, challenges remain. These challenges include barriers to reducing of the total fertility rate, responding to unmet FP needs and the discontinuation of FP methods, increasing the modern contraceptive prevalence rate (mCPR), and broadening the FP method mix to include long-acting reversible and permanent methods. Challenges also persist in human resources issues, such as inadequate training for health providers, inappropriate placement of service providers, and inadequate supervision. The infrastructure of the health, nutrition and population sector also presents challenges. The government is seeking to address these challenges to improve health and FP services in Bangladesh.

The AUAFP project focuses on four geographic divisions (Dhaka, Mymensingh, Sylhet, and Chattogram), where key challenges, including inequalities, are overwhelming. According to the Bangladesh Health Facility Survey 2014, these divisions are lagging in achieving the national targets for mCPR and having facilities with inadequately trained FP service providers. The public sector is the main provider of FP methods, and it faces many structural challenges related to its health workforce and facilities. AUAFP conducted this training needs assessment (TNA) to better understand the barriers to these supply side factors and to inform program strategies for strengthening the FP workforce and training institutes to overcome the current plateau in mCPR. The objectives of this comprehensive TNA were to:

- Determine FP service providers' knowledge, perception of their skills to provide FP servcies and practices;
- Identify gaps and strengths in the desired performance quality, with special attention to adolescent- and youth-friendly services (AYFS) and gender;
- Analyze providers' tasks (i.e., job descriptions) as part of the gap analysis;
- Determine the root causes of the identified gaps and the training requirements for filling them;
- Assess the organizational and managerial capacity of training institutes and the trainers' perception of their competencies in developing and delivering competency-based FP training and current FP knowledge levels ;
- Assess the inventory of training institutes in six pilot districts
- Assess the needs and perceptions of in-service competency-based training, e-learning, on-the-

job mentorship training, relevant continuing medical education, and mobile communication-based learning for FP service providers;

- Assess FP supervision and mentoring at multiple levels of the Directorate General of Family Planning (DGFP) and the Directorate General of Health Services (DGHS), including the training and performance of supervisors, to understand their training needs and gaps;
- Map how supportive supervision and mentoring is currently working at the field level;
- Examine and map career pathways for FP service providers as a tool for motivation and retention;
- Document the reasons for high attrition or turnover; and
- Identify key challenges, bottlenecks, and strengths, as well as identify priority areas for the training institutes

Methodology

This study adopted a mixed methods approach for measuring the different components of the TNA, as this assessment required exploring issues both qualitatively and quantitatively. Components of the methodology are described below. The methodology comprised a survey among FP service providers and trainers and a facility inventory to gather quantitative data, as well as key informant interviews (KIIs) and In-depth Interviews (IDIs) to gather qualitative data.

Study Area

The study area of this TNA was the AUAFP project piloting area. The TNA was conducted in the six districts of Bangladesh which are shown in the map.
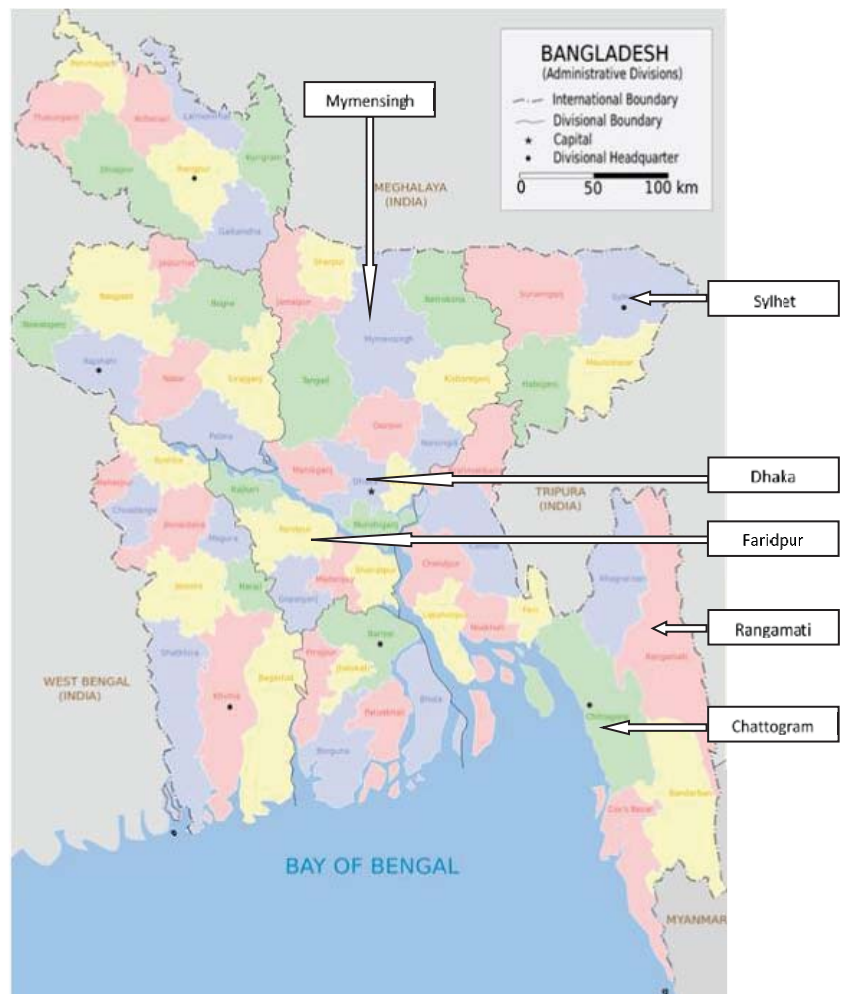
Figure 1: Locations of the Study

Data Collection Methods and Sampling

This TNA collected both primary and secondary data. A desk review was conducted to extract secondary data from different documents, while KIIs, IDIs, a survey, and a training institute inventory were conducted to collect primary data. The AUAFP project team drafted the necessary questionnaires, and the consultant team finalized the instruments in consultation with the AUAFP team. NIPORT officials and officials from MEASURE Evaluation's Bangladesh Office reviewed and provided feedback about the data collection instruments.

The quantitative survey was conducted in the six districts of the AUAFP project area. The locations (District, Upazila, and Union) from where the data were collected can be found in *Appendix A*. The quantitative survey was conducted in all district hospitals and the Maternal and Child Welfare Centers (MCWCs) of the six districts. Two upazilas were randomly selected from each District, and then four Unions were randomly selected from each Upazila. In total, the TNA thus planned to collect data from six Districts, 12 upazilas, and 48 Unions. The target was to interview all the FP service providers working at the selected District, Upazila, and Union levels to understand their knowledge, perceptions of skills, and practices in providing quality services. As a result, no sampling was used when interviewing the respondents of this TNA at the selected service delivery points. However, due to shortages and vacancies in the service provider workforce at each level, the TNA had to increase the number of service delivery points from the number originally planned. The TNA was therefore conducted in 16 upazilas rather than the planned 12. Moreover, data for this TNA were collected from 83 Unions instead of the planned 48. While conducting the data collection, it was found that approximately 35% to 40% of the FP service provider positions were vacant at the Union level. It is important to note that despite expanding the geographic area, this TNA could not reach the planned sample size during the fieldwork due to the unavailability of service providers. The planned and actual sample sizes for the quantitative survey of FP service providers are shown in Table 1.

Table 1: Distribution of Planned and Actual Sample Sizes

Aspects of sample size	Planned	Actual
Geographic coverage		
Districts	6	6
Upazilas	12	16
Unions	48	83
Survey of FP service providers		
MOs	42	39
FWVs	102	101
Midwives	24	22
SACMOs	48	46
FWAs	240	238
Community Health Care Providers (CHCPs)	48	47
Total Sample for FP service providers survey	504	493
Survey of trainers on training management	34	25
IDIs of FP service providers		
FWVs	6	5
SACMOs	6	6
FPIs	6	5
FWAs	6	5
Total sample for IDIs of FP service providers	24	21
KIIs of supervisors and trainers	63	47
Training facility inventory assessments	13	10

Survey of FP Service Providers

The TNA included a survey of service providers at different levels to understand their FP methods- and services-related knowledge, perception of their skills, and practices in providing quality services. The research team also assessed their needs and perceptions regarding in-service competency-based

training, e-learning, on-the-job mentorship training, relevant continuing medical education, and mobile communication-based learning. The survey was conducted to provide information to assess FP supervision and mentoring at multiple levels of DGFP and DGHS services, including the training and performance of supervisors, to understand their training needs and gaps, as well as to determine how supportive supervision and mentoring is currently working at the field level.

Survey of the FP Trainers

A survey was also conducted among the trainers of the FP service providers. This survey was conducted to assess the trainers' perception of their competencies in delivering training, training management, use of competency-based skills, and any improvements made to their collaborative competencies. The survey was conducted using a structured questionnaire that the trainers completed themselves. The planned and actual sample sizes for this survey are shown in Table 1.

In-Depth Interviews (IDIs) of the FP Service Providers

IDIs were conducted for FP service providers to assess their FP knowledge and perception of their skills and to determine their needs for in-service competency-based training, e-learning, on-the-job mentorship training, and mobile communication-based learning. FP supervision and mentoring were also assessed at multiple levels of the DGFP and DGHS, including assessing supervisors' training and performance to understand their training needs and gaps, as well as how supportive supervision and mentoring is currently working in the field. IDIs were conducted with four types of FP service providers; family welfare visitors (FWVs), sub-assistant community medical officers (SACMOs), family planning inspectors (FPIs), and family welfare assistants (FWAs). The planned and actual sample sizes for the FP service provider IDIs are shown in Table 1.

Key Informant Interviews

The TNA conducted key informant interviews (KIIs) with the trainers and supervisors of the FP service providers, as well as relevant senior government officials at NIPORT, the DGFP, and the DGHS at the national, district, and Upazila levels. The purpose of the KIIs was to identify FP service providers' perceptions of their skills in terms of their level of comfort in providing FP services, practices, the gaps and strengths of the desired job performance, with special attention paid to AYFS and gender. The KII respondents included FP trainers, facilitators, managers, and administrators at the training institutes and health facilities at the national, district, and Upazila levels. The planned and actual sample sizes for the KIIs are presented in Table 1.

Training Institute Inventory

The TNA also conducted a capacity assessment and an inventory of the training institutes, including an assessment of their organizational and management capacity, as well as the trainers' perception of their ability to develop and deliver competency-based FP training. A training facility inventory (TFI) was conducted at the training institutes/facilities of NIPORT and the DGFP at the national, district, and Upazila levels. Three types of training institutes were available in the six pilot districts of AUAFP project: (1) NIPORT-led training cente rs, including regional training centers (RTCs); (2) family welfare visitor training institutes (FWVTIs); and (3) Clinical Contraception Services Delivery Programme (CCSDP)-led RCTCs. It was originally proposed that this TNA would not cover the NIPORT-led RTCs, as Save the Children International had recently conducted a TFI in the RTCs. However, during the fieldwork, it was found that the CCSDP-led regional consultant training centers (RCTCs) were nearly nonexistent (except the Mohammadpur Fertility Services & Training Centre [MFSTC] and the Maternal and Child Health

Training Institute [MCHTI]). Thus, the CCSDP-led RCTCs were removed from the data collection list, and the NIPORT-led RTCs were included. In summary, this TNA collected data from the following training facilities: the Rangamati, Dhaka, Faridpur, and Sylhet FWVTIs; the MFSTC; the MCHTI; and the Faridpur, Iswarganj (Mymensingh), Kaptai (Rangamati), Sitakunda (Chattogram), and Dhamrai (Dhaka) RTCs of NIPORT. The planned and actual sample sizes for the TFI are shown in Table 1.

Research Team

The core research team comprised a team leader, two research fellows, 12 field assessors for the quantitative survey, and two research assistants for the qualitative data collection. Twelve university graduates (six male and six female) were recruited as field assessors for data collection. Six teams were formed to collect survey data from six districts. Each team of two field assessors, one female and one male, were led by a district training officer provided by IntraHealth International. The core research team and two research assistants collected qualitative data. The interviews with high-profile key informants based in Dhaka were conducted by the team leader, while National Divisional-, District-, and Upazila- level KIIs were conducted by the two research fellows and two research assistants. A nine-day long training (which included one day of pre-testing) was provided to the entire data collection team by the team leader of this TNA and IntraHealth officials. The team leader coordinated all field teams, and the teams administered informed consent forms before collecting any data. The research team maintained the confidentiality of the collected data to ensure research ethics.

Implementation Plan

NIPORT, the DGFP, and the DGHS approved the TNA and sent letters to the respective district officials to garner support for the data collection team. Ethical approval was not needed, as the TNA did not collect data from clients or conduct observations. The IntraHealth district training officers communicated with the respective departments and officials of NIPORT, the DGFP, and the DGHS to schedule the interview dates and time with FP service providers. The data collection team then made visits to collect data.

Quality Control Mechanisms

The following mechanisms were put into practice to ensure quality data collection:
- The entire data collection team was trained on the Shukhi Jibon project's background, the TNA's objectives, data collection techniques and tools, data management, and research ethics in collecting data;
- The data assessors' level of understanding was assessed during the training session;
- Out of 15 potential data collectors, 12 were finally selected based on their performance during the training;
- The district training officers of the Shukhi Jibon project checked all the completed questionnaires for quality of the data at the end of the daily data collection;
- The district training officers reported on the data quality to the team leader and clinical training manager of Shukhi Jibon;
- The clinical training manager discussed data collection quality issues with the team leader;
- The team leader shared the feedback received from the district training officers and the clinical training manager among all other data collection teams on the same day to standardize the methods of data collection of all teams;
- The core research team randomly visited the data collection teams at field sites and checked

the quality of the data;

- Senior officials from NIPORT and Shukhi Jibon observed the data collection at randomly selected field sites and checked the quality of the data; and
- The Research Team Lead regularly debriefed the Shukhi Jibon team to review the data collection process, answer any questions, and provide feedback;

Analysis and Reporting

To address each of the objectives of the TNA, both quantitative and qualitative data were analyzed. The data analysis of this TNA was performed by using NVivo and SPSS for the qualitative and quantitative data, respectively. The quantitative data were first entered in the CSPro program. The data were analyzed by SPSS, and the findings were disaggregated by the types of service providers. Frequency distributions and the mean were calculated as part of the quantitative analysis of the data. The qualitative data were first transcribed, for entering in the NVivo software. The qualitative data were analyzed using thematic analysis of qualitative data techniques. The different components of this TNA guided and directed the qualitative data analysis.

Organization and Structure of the TNA

This TNA report has been organized into nine chapters. The current chapter (Chapter One) deals with the background and methodology of the TNA. Chapter Two briefly presents the background characteristics of the respondents, followed by the FP service providers' knowledge and perceptions of their skills and practices (Chapter Three). Chapter Four presents the findings on the AYFS delivered by the FP service providers. Chapter Five explores the trainings received by the FP service providers and their perceived training needs. Chapter Six presents the findings of the capacity assessment of the training institutes in providing training to FP service providers. Chapters Seven and Eight examine on-the-job trainings, supervisory visits, e-learning, and mapping of supportive supervision and mentoring. Finally, Chapter Nine presents recommendations based on the findings of the TNA.

CHAPTER TWO: BACKGROUND CHARACTERISTICS OF THE RESPONDENTS

This chapter presents the background characteristics of the respondents who were interviewed as part of this TNA.

Types of FP Service Providers

This TNA collected data from 493 FP service providers, and their distribution by sex is presented in Table 2. FP services in Bangladesh are predominantly delivered by female providers. Nearly two-thirds of the midwives were basically nurse-midwives (data not shown in the table). Among the doctors, 17.9% were working as senior consultants (gynecologists), 25.6% were working as junior consultants (gynecologists), 30.8% were working as medical officers (MOs) in maternal and child health – family planning (MCH-FP), 17.9% were working as MOs in clinics, 5.1% were working as MOs in family welfare, and only 2.6% were working as MOs – anesthesiologists (data not shown in the table).

Table 2: Percentage Distribution of the FP Service Providers by Sex

Sex of the Respondents	MOs (n=39)	FWVs (n=101)	Midwives (n=22)	SACMOs (n=46)	FWAs (n=238)	CHCPs (n=47)
Female	64.1	100.0	100.0	23.9	100.0	100.0
Male	35.9			76.1		

Educational Status of the FP Service Providers

Table 3 shows the educational status of the different FP service providers. It should be noted here that the different cadres of FP service providers had different educational level entry requirements for their respective jobs. The data show that over 45% of MOs had higher qualifications.

On the other hand, the entry requirement for the FWV position was a secondary school certificate (SSC) with 18 months of completed training from the FWVTI. The table shows that only one-third (31.7%) of the FWVs were working with only the entry requirement, while 60% of FWVs had higher qualifications (38.6% had a higher secondary certificate (HSC), 12.9% had a bachelor's degree, and 8.9% had a master's degree).

Two types of midwives are working now in Bangladesh: those who have completed a diploma in midwifery and those who have completed a six-month training on midwifery in addition to their nursing qualification. The entry requirement for both nurses and midwives were having an HSC. The midwifery program is very new, and the nursing program is older. Table 3 shows that 36.4% of midwives had a midwifery degree, while 22.7% had a nursing degree.

At present, the entry requirement for FWAs is an SSC, though previously people with a qualification below the SSC could join as an FWA. Table 3 shows that only 37.4% of FWAs were working with the minimum entry requirement, while the rest were working with a higher qualification. The entry requirement for CHCPs is an HSC-level educational qualification. The table shows that only 19.1% of CHCPs had this entry-level requirement (an HSC), while approximately 75% of CHCPs had a higher qualification (42.6% of CHCPs have a master's degree and 34% have a bachelor's degree).

Table 3: Percentage Distribution of the Educational Statuses of the FP Service Providers

Highest Educational Level of the Respondents	MO (n=39)	FWV (n=101)	Midwife (n=22)	SACMO (n=46)	FWA (n=238)	CHCP (n=47)
HSC		38.6	3.6	8.7	28.2	19.1
SSC		31.7	13.6	13.0	37.4	
Bachelor's Degree		12.9		8.7	13.4	34
Below SSC		4.0	4.5		10.1	
Master's Degree/Postgraduate Degree		8.9			7.1	42.6
Bachelor's Degree (Hons)		1.0	4.5	2.2	3.4	2.1
Diploma in Midwifery		1.0	36.4			
Nursing Graduate Degree		1.0	4.5			
Diploma in Medical Assistant/ Diploma in Medical Faculty		1.0		67.4		
Diploma in Nursing			22.7		0.4	
MBBS	46.2					
Fellow of the College of Physicians and Surgeons (FCPS)	25.6					
Diploma in Obstetrics & Gynecology	10.3					
Master of Surgery/Master of Philosophy (MS/MPhil)	12.8					
Member of the College of Physicians and Surgeons (MCPS)	5.1					

Duration of Work Experience of the FP Service Providers

Table 4 shows the years of work experience among the different cadres of FP service providers. All of the FP service providers had worked for quite a long time in the same position and in the same locality, except for the CHCP position, as it was relatively new compared to the other types of providers. The table shows that MOs had on average 16.7 years of work experience, with 51.3% of MOs had between 15 and 24 years of experience and 12.8% had 25 years or more of experience. The average number of years of work experience among the FWV cadre was 21.95 years, with 59.4% of FWVs having worked 25 years or more. Midwives comprise a newly created cadre in Bangladesh and thus they had on average only seven years of work experience. The average years of work experience among the SACMOs was more than 23 years, with 63% of SACMOs having 25 years or more of work experience. FWAs had more than 19 years of work experience on average, with more than 50% (52.5%) of them working 25 years or more as an FWA. CHCPs form another cadre that was created a few years back, and thus they had an average of less than seven years of work experience. FWVs, SACMOs, FWAs, and CHCPs were recruited from their own locality, and thus they had been working in their current location for quite a long period. More than 50% of FWVs, SACMOs, and FWAs had been working 25 years or more, and thus they are likely to retire soon.

Table 4: Percentages and Mean Distribution of Years of Work Experience of FP Service Providers

Variables	MO (n=39)	FWV (n=101)	Midwife (n=22)	SACMO (n=46)	FWA (n=238)	CHCP (n=47)
Years of Work Experience in Providing FP Services (%)						
Less than five years	20.5	9.9	54.5	6.5	9.2	12.8
5–14 years	15.4	17.8	22.7	23.9	33.2	87.2
15–24 years	51.3	12.9	18.2	6.5	5.0	
25 years or more	12.8	59.4	4.5	63.0	52.5	
Average Number of Years of Work Experience in Providing FP Services	16.7	21.95	7.05	23.04	19.2	6.87
Years of Work Experience in Providing FP Services at Their Current Location						
Less than five years	46.2	40.6	68.2	28.3	10.9	31.9
5–14 years	43.6	26.7	22.7	28.3	35.7	68.1
15–24 years	7.7	13.9	4.5	19.6	7.1	
25 years or more	2.6	18.8	4.5	23.9	46.2	
Average Number of Years of Providing FP Services at Their Current Location	6.7	10.83	4.82	13.77	17.8	5.89

CHAPTER THREE: FP SERVICE PROVIDERS' JOB RESPONSIBILITIES, PRACTICES, AND PERCEPTIONS OF SKILLS

This chapter provides findings on the job responsibilities, practices, perceptions of skills, and challenges faced by the FP service providers, including gaps in knowledge regarding different methods of FP.

Job Responsibilities and Job Performance: What is the Reality?

FP service providers' Job Responsibilities

This TNA conducted a review of the official job descriptions of the FP service providers. The summary job descriptions are provided in Table 5. The table shows that the job descriptions were rather broadly written. In many cases, the job responsibilities of the service provider cadre were not explicitly stated. For example, the job descriptions mentioned that the midwives would provide FP services, but the actual tasks were not specified. The FWAs working at the Ward level had their job responsibilities and descriptions clearly outlined in the FWA registrar, yet those who were working in the MCHTI or MFSTC did not. The detailed job descriptions of these FP service providers can be found in *Appendix B*.

Table 5: FP Job Description Responsibilities of Different FP Service Providers

CHCP	FWA
• Supply and distribution of short-term family planning methods such as condom, pill, ECP (emergency contraceptive) etc. • Provide primary health care and ensure timely referral to higher facilities in case of any complications of the health and family planning clients. • Arrange group and provide suggestions on the importance of family planning and different methods for the behavioral change of the clients of the clinic. • Motivate eligible couples to adopt permanent and long-acting methods (NSV[1], tubectomy, IUD[2], Implant) and send them to union/upazila health complex to receive the service.	• Visit door to door to determine the number of all the eligible couples in the assigned unit (union/ward level) and incorporate in the register. • Develop the list of regular users of family planning methods, discontinuers of the methods and all the eligible couples who never adopted any methods and prepare the service plan accordingly. • Motivate the eligible couples (as applicable to the client) to adopt family planning methods. • Supply and distribution of short-term family planning methods such as condom, pill, ECP (emergency contraceptive) etc. • Provide a second and following dose of injectable contraception upon receiving training. • Prepare the requistion list for contraceptive supplies of the unit, receive the supplies accordingly and ensure proper distribution.

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[1] NSV = No Scalpel Vasectomy
[2] IUD = Intrauterine Device

FWV	SACMO
• Identify, motivate, counsel and providing services of all the family planning methods along with risk management and referral. • IUD insertion in the patients. • Provide assistance to the doctors in providing permanent and long-acting family planning methods. • Follow-up of the IUD and Implant patients. • Assist in the diagnosis of bleeding and other problems of the recipients of the family planning methods and collection of necessary samples to send to the laboratory. • Visit the community clinic in a regular interval for IUD insertion and injection services. • Provide family planning services from the satellite clinic two days a week.	• Motivate and provide suggestions to the visiting eligible couples to adopt family planning methods as per their demand and suitability for the method. • Provide training to the FWA on clients motivation and counseling to grow interest in family planning methods. • Identification of the right method for the right woman and follow the manual/instruction circular or guidance of the senior authority in providing services. • Record the complications of the family planning clients in the register and refer to Medical Officer (FWO) /Medical Officer (MCH-FP)/Medical Officer (Clinic) if necessary and conduct regular follow up. • Provide assistance in organizing a family planning campaign in the center. • Provide necessary counseling and reproductive health services to adolescents. • Provide treatment of RTI and STD based on the symptoms and counseling on HIV/AIDS. • Provide necessary counseling on permanent family planning methods in case HIV/AIDS and STI. • Provide condom to prevent sexually transmitted disease. • Refer clients visiting services for infertility to the respective hospital.
Midwife	**Medical Officer***
• Provide family planning services and counseling to the clients. • Provide health education on family planning, post-abortion care, gender discrimination and violence against women.	• Overall management of family planning services in MCWC. • Provide support and counseling to the client in choosing a family planning method, take necessary initiative and ensure follow up. • Ensure registration of the clients of the clinical family planning methods, conduct a clinical investigation, provide support and counseling to the client in choosing a clinical method. • Provide services on permanent methods, other methods and other clinical methods. • Ensure quality of the permanent and associated methods following the direction of the district technical committee and the service manual. • Prepare an appropriate plan to increase the

			clinical services of family planning in the district.

- clinical services of family planning in the district.
- Prepare the visit plan for the remote areas to provide permanent methods of the family planning services.
- Organize and conduct campaigns in remote areas to provide permanent methods of the family planning services.
- Conduct timely follow up of the clients of permanent family planning services.
- Collect reports from the mobile campaign teams providing permanent methods and compile the report.

Different types of MOs working in different locations had slightly different job descriptions. For example, an MO (Clinical Contraception – CC) works at the district level, an MO (Clinic) works at the MCWC level, an MO (MCH-FP) works at the Upazila level, and an MO (Family Welfare) works at the Union level.

This TNA also asked all the FP service providers about whether they knew their job descriptions, to which almost all reported that they did. However, a significant proportion of the FP service providers had only partial knowledge of their job responsibilities. More than 60% of CHCPs, 42.7% of FWAs, 37% of SACMOs, 57.1% of Midwives, 30.7% of FWVs, and 16.7% of MOs knew their job responsibilities partially (Table 5). The major sources of information for knowing their job descriptions were basic training, their supervisor, and their appointment letter (though we checked their appointment letters and did not find any job descriptions there).

Table 6: Percentage Distribution* of Sources of Knowledge Regarding Job Descriptions Among Different Service Providers

Variables	MO (n=39)	FWV (n=101)	Midwife (n=22)	SACMO (n=46)	FWA (n=238)	CHCP (n=47)
Status of Knowledge Regarding Job Description						
Complete	83.3	69.3	42.9	63.0	57.3	39.0
Partial	16.7	30.7	57.1	37.0	42.7	61.0
Sources of Knowing Job Description*						
Through my appointment letter	54.3	12.9	19.0	21.7	11.5	2.2
From my supervisor	17.1	23.8	28.6	17.4	27.0	19.6
During basic training	40.0	85.1	42.9	50.0	80.3	82.6
Through circular	25.7	6.9	14.3	8.7	3.0	10.9
From registrar of FWA				2.2	21.8	13.0
Upazila Health and Family Welfare Center manual	8.6	18.8	4.8	23.9	6.0	2.2

Variables	MO (n=39)	FWV (n=101)	Midwife (n=22)	SACMO (n=46)	FWA (n=238)	CHCP (n=47)
From job orientation meeting	5.7	5.9	9.5	10.9	3.0	13.0
Others	11.4	1.0	19.0	2.2	8.1	4.3

* multiple responses

Providers' Perceptions of Their Job Responsibilities vs. Actual Services Provided

Table 6 shows the FP service providers' perceptions of the different FP services they were supposed to provide as per their job description and the services they were actually providing. The table shows that counseling has emerged as the most critical task in FP service delivery among all service providers. It shows that 74.4% of MOs perceived that they were supposed to provide counseling services, while almost same percentage of MOs were actually providing those services. Among FWVs, 79.2% of respondents perceived that they were supposed to provide counseling services, while 75% of them were doing so. In contrast, there were discrepancies between the perceptions and delivery of counseling services among Midwives (with 68.2% perceiving that they were supposed to provide counseling services, but only 50% of them actually doing so), as well as SACMOs (76% vs. 64%), and CHCPs (78.7% vs. 17.8%). Thus, it can be said that there was a gap in terms of perception and actually providing counseling services across the service providers, but the largest gaps were observed among the midwives, SACMOs, and CHCPs.

Although, fewer MOs perceived that they were supposed to provide short-acting FP methods (which varied between 30% to 45%, depending on the method), they were not actually providing any short acting FP methods other than discussing the lactational amenorrhea method (LAM). However, one of the elements of the MO job description is to *provide services on permanent methods, other methods and other clinical methods* (Table 5), and the "other methods" can certainly include short-acting methods. On the other hand, more FWVs, FWAs, and CHCPs perceived that they were supposed to provide short-acting FP methods, and more FWVs and FWAs were also actually providing these methods. However, less than one-fourth of the CHCPs were providing short-acting FP methods. One of the Midwife's job description components was to *provide FP services and counseling to the clients* (Table 5). However, a relatively lower percentage of Midwives perceived that they should provide short-acting FP methods and thus, a lower percentage of them were actually providing those methods.

A high number of MOs perceived that they were supposed to provide intrauterine devices (IUDs), implant removal services, tubectomies, and no scalpel vasectomies (NSVs) according to their job descriptions. As such, a high number of MOs were actually providing these long-acting reversible and permanent methods. A high number of FWVs perceived that they were supposed to provide IUD insertion and removal services, and they are also actually providing these services. Around one-quarter of the FWVs perceived that they were supposed to provide implant insertions and removals, tubectomies, and NSVs. One of the job description components of the FWV position was to "*identify, motivate, counsel and providing services of all the FP methods along with risk management and referral*" (Table 5). This description might lead the FWVs to perceive that they were supposed to provide long-acting reversible and permanent methods. However, only 4% of FWVs reported that they had actually inserted an implant, and 1% reported that they had removed them. Less than one-fourth

of Midwives and SACMOs perceived that they were supposed to provide long-acting reversible and permanent methods.

Approximately one-quarter of the FWAs and less than 10% of CHCPs perceived that they were supposed to provide long-acting reversible and permanent methods. The job descriptions of the FWA and CHCP in Table 5 show that these FP service providers were supposed to "*motivate eligible couples to adopt permanent and long-acting methods (NSV, tubectomy, IUD, Implant) and send them to Union/Upazila health complex to receive the service.*" This job description might influence the FWA and CHCP to perceive that they were supposed to provide long-acting reversible and permanent methods. As they were only supposed to provide motivation and not the actual method, none of them reported that they were actually providing long-acting reversible and permanent methods.

Table 7: Percentage Distribution* of FP Service Providers' Perceptions of FP Tasks They Were Supposed to Provide as Per Their Job Descriptions and the FP Tasks They Were Actually Providing

Types of FP Services	MO (n=39)		FWV (n=101)		Midwife (n=22)		SACMO (n=46)		FWA (n=238)		CHCP (n=47)	
	Supposed to Provide	Actually Providing	Supposed to Provide	Actually Providing	Supposed to Provide	Actually Providing	Supposed to Provide	Actually Providing	Supposed to Provide	Actually Providing	Supposed to Provide	Actually Providing
Counseling												
Counseling	74.4	73.7	79.2	75.0	68.2	50.0	76.1	64.4	79.0	78.5	78.7	17.8
Short-Acting Methods												
Oral contraceptive pill	41.0		99.0	98.0	63.6	59.1	58.7	53.3	100.0	100.0	89.4	23.3
Condom	35.9		99.0	98.0	45.5	36.4	54.3	51.1	100.0	100.0	83.0	21.1
Injectables	43.6		94.1	97.0	27.3	18.2	56.5	51.1	92.4	94.9	53.2	12.8
LAM	33.3	33.3	32.7	26.0	45.5	31.0	17.4	11.1	26.5	24.5	29.8	5.0
Long-Acting Reversible and Permanent Methods												
IUD insertion	59.0	50.0	96.0	90.0	31.8	27.3	23.9	13.3	28.2		4.3	
IUD removal	46.2	44.7	72.3	71.0	27.3	22.7	10.9	11.1	12.6			
Implant insertion	79.5	71.1	34.7	4.0	22.7	31.8	15.2	4.4	26.5		2.1	
Tubectomy	76.9	73.7	25.7				10.9		24.8		2.1	
NSV	64.1	55.3	26.7		4.5		13.0		23.9			
Implant removal	59.0	68.4	17.8	1.0	22.7	22.7	4.3	2.2	8.8		6.4	
Other FP Services												
AYFP	53.8	53.8	67.3	75.0	36.4	22.7	56.5	57.8	73.1	69.2	53.2	13.3
Postpartum Family Planning (PPFP)	61.5	60.5	56.4	60.0	63.6	54.5	37.0	33.0	49.2	43.9	34	4.4
Post abortion Care Family Planning (PAC FP)	43.6	26.3	26.7	26.0	31.8	27.3	17.4	20.0			12.8	
Gender-Responsive FP Services	17.9	28.9	20.8	23.0	4.5		10.9	13.3	15.1	19.4	10.6	1.7
Other	7.7	2.6	4.0	1.0	4.5	9.1	8.7	6.7	2.1	1.7	4.3	0.6

* multiple responses

Client Load of the FP Service Providers

Table 7 shows the client load of the different service providers for different FP services. These data were mostly collected from the registrars maintained by the providers. However, MOs didn't keep any records of the services they provided: their records were mainly kept by the FWVs and midwives. Thus, the average number of clients served by the MOs might also be included in the average number of clients served by the FWVs and midwives. This situation means there was a chance of data duplication where applicable.

The average client load was in line with the perceived services the providers were supposed to deliver as per their job descriptions. The findings show that MOs had a low client load with regard to providing short-acting methods. However, they had a relatively high client load in terms of long-acting reversible and permanent methods. FWVs, FWAs, and CHCPs mostly provided injectables, oral contraceptive pills, and condoms. The providers had a very low load of adolescent clients. It was not possible to ascertain whether these adolescent clients were married or unmarried because the registrars were not disaggregated by marital status.

Overall, the FP daily and monthly client load was not high for any provider. However, it should be mentioned that the providers offer other services besides the FP services shown in the table, and thus their FP client load did not reflect their full client load. Moreover, the opening hours of the service delivery points also affected client load.

Table 8: Distribution of Average Number of FP Clients Served in December 2018

Types of FP Services	Average Number of FP Clients Served by Each Cadre:					
	MO	FWV	Midwife	SACMO	FWA	CHCP
Counseling						
Counseling	18.5	25.4	9.9	21.1	19.6	22.5
Short-Acting Methods						
Injectables		29.5	4.7	6.0	24.6	5.6
Oral contraceptive pill		28.3	14.7	16.0	57.0	20.4
Condom		10.8	5.3	4.7	19.6	7.9
LAM	3.8	2.4	7.4	0.4	3.3	2.8
Long-Acting Reversible and Permanent Methods						
Implant insertion	9.8	3.9		0.4		
IUD insertion	3.4	3.3	0.9	0.5		
IUD removal	0.9	1.1	0.1	0.6		
Implant removal	1.6	0.7		0.5		
Tubectomy	3.5					
NSV	0.6					
Other FP Services						
AYFS	4.1	17.1	1.0	7.6	8.0	15.7
PPFP	5.4	5.6	3.9	3.3		
PAC FP	0.4	1.3	0.3	0.1		
Gender-responsive FP services	0.7	0.9		0.2	1.6	3.8
Other Services		0.1			0.7	3.7

FWAs and CHCPs were supposed to provide short-acting methods only and counseling and referral for other long-acting reversible and permanent methods. It should be noted that CHCPs and FWAs were allowed to provide second and subsequent doses of injectables to the clients after they received training, while the first dose was given by the FWVs. Table 9 shows the places to which FWAs and CHCPs referred their clients for long-acting reversible and permanent methods. It shows that more than 60% of FWAs referred their clients to the Upazila Health Complex (63.4%) and Union Health and Family Welfare Center (62.2%), while 76.6% of CHCPs referred their clients to the Upazila Health Complex. Table 10 shows that FWAs and CHCPs were mainly referring clients for injectables and implant services, followed by IUDs. The data show that referral volumes were relatively low among FWAs and CHCPs for long-acting reversible and permanent methods. Each FWA on average referred only two clients for injectables and 2.3% clients for implants in the preceding month (December 2018). On average, each FWA referred fewer than one client in the preceding month for tubectomy and NSV. The table shows that CHCPs were serving even fewer clients than FWAs.

Table 9: Percentage Distribution* of Places to Which FWAs and CHCPs Refer Clients

Referral Places/FP Service Centers	FWA (n=238)	CHCP (n=47)
District Hospital	0.8	2.1
Maternal and Child Welfare Center	2.9	2.1
Upazila Health Complex	63.4	76.6
Union Health and Family Welfare Center	62.2	38.3
Others	1.3	4.3

*multiple responses

Table 10: Distribution of Average Number of Clients Referred by Each FWA and CHCP in December 2018 for Long-Acting Reversible and Permanent Methods

FP Methods	Average Number of FP Clients Referred by Each	
	FWA	CHCP
Injectables	2.0	1.1
IUD	1.2	0.3
Implant	2.3	0.1
Tubectomy	0.5	0.2
NSV	0.3	0.1

Comfort with Current Level of Skills for Providing FP Services

As it was not possible to measure the skills of the FP service providers directly, this TNA asked the providers about whether they felt comfortable providing FP services with their current level of skills. This question was used as a proxy indicator for measuring the skills of the FP service providers. The findings presented in Table 11 show that the highest level of comfort existed among the MOs (69%), followed by SACMOs (59%). Around 40% of FWVs and 34% of CHCPs felt comfortable with their skills. Finally, only 18% of midwives reported that they felt comfortable with their skills.

While counseling was one of the most critical tasks in FP service delivery for voluntary informed choice, acceptance, client safety, and continuity, over 40% of all cadres, except FWVs, expressed discomfort

in performing this task. Furthermore, it was very surprising that although MOs were supposed to provide tubectomies and NSVs, 50% of them did not feel comfortable providing tubectomies and 66.7% were not comfortable providing NSVs. Similarly, though FWVs were supposed to provide IUD services, 58.9% of them reported that they did not feel comfortable inserting IUDs, and 41.1% did not feel comfortable removing them. Likewise, higher percentages of midwives (73.3%) and SACMOs (66.7%) did not feel comfortable inserting IUDs. Finally, FWAs and CHCPs were supposed to provide the second dose of injectables but 40% of FWAs and 45.2% of CHCPs reported that they did not feel comfortable providing this service.

Table 11: Percentage Distribution of Service Providers Who Feel Comfortable Providing FP Services and the Distribution* of FP Methods with Which FP Service Providers Do Not Feel Comfortable

Variables	MO (n=39)	FWV (n=101)	Midwife (n=22)	SACMO (n=46)	FWA (n=238)	CHCP (n=47)
Percent of FP Service Providers Who Feel Comfortable Providing FP Services	69.0	39.0	18.0	59.0	46.0	34.0
FP Methods for which FP service providers Do Not Feel Comfortable**	MO (n=12)	FWV (n=62)	Midwife (n=18)	SACMO (n=19)	FWA (n=129)	CHCP (n=31)
Counseling						
Counseling on FP methods	41.7	19.6	46.7	40.0	41.0	45.2
Short-Acting Methods						
Oral contraceptive pill		8.8	20.0	6.7	20.0	29.0
Condom		7.1	20.0	6.7	20.0	22.6
Injectables		7.1	26.7	40.0	40.0	45.2
LAM	16.7	5.4	13.3	26.7	7.6	16.1
Long-Acting Reversible and Permanent Method Services						
IUD insertion	16.7	58.9	73.3	66.7		
IUD removal	16.7	41.1	53.3	46.7		
Implant insertion	33.3					
Implant removal	33.3					
Tubectomy	50.0					
NSV	66.7					
Infection prevention	8.3	5.4	20.0	26.7	5.7	9.7
Other FP Services						
PPFP	8.3	23.2	20.0	33.3	23.8	16.1
AYFP	8.3	14.3	26.7	26.7	31.4	13
PAC FP	16.7	8.9	13.3	26.7	2.7	9.7
Gender-responsive FP services		7.1	20.0	26.7	10.5	22.6
Other		7.1	6.7	13.3	8.6	2.0

*multiple responses

**Percentage has been calculated based on the providers who said that they do not feel comfortable

FP service providers' comfort in providing FP services might be associated with their knowledge of the different FP methods. Table 3.8 shows that FP service providers had relatively low knowledge of

different aspects of the FP methods. For example, only 58.5% of MOs knew when to start clients on a contraceptive method, followed by 49.3% of FWVs and 42.4% of FWAs. Moreover, the table shows that less than one-quarter of providers knew the eligibility criteria for providing condoms. Just 36.2% of MOs and 41.8% of FWVs knew the side effects and complications of different FP methods. The table also shows that approximately half of the MOs, FWVs, and FWAs knew the effectiveness of long-term methods.

Table 12: Percentage Distribution of FP Service Providers' Knowledge of Different FP Methods

Summary of Area Assessed	MO (n=38)	FWV (n=101)	Midwife (n=22)	SACMO (n=44)	FWA (n=238)	CHCP (n=46)
When to initiate contraceptive methods	58.5	49.3	28.8	35.5	42.4	31.6
Eligibility criteria for Condom use	22.0	17.8	12.3	14.6	15.9	14.9
Side effects and complications for all Contraceptive methods	36.2	41.8	26.0	31.7	32.6	23.4
When to schedule a routine visit after starting Contraceptive methods	59.3	44.8	29.7	33.9	40.0	22.2
Effectiveness of long-term Contraceptive methods	47.0	48.0	28.8	36.6	43.6	24.3

Challenges Faced by the FP Service Providers in Providing FP Services

Table 13 shows that the most commonly cited challenges faced by FP service providers were overcoming myths among clients regarding FP services, followed by clients' fear of long-acting reversible and permanent methods. More FWVs, FWAs, and CHCPs reported myths and fear among the clients about long-acting reversible and permanent method as challenges to providing FP services than did the other cadres of providers. The myth that exists in the society about long-acting reversible and permanent methods was that these reduce the body's energy and sexual power. These issues were also reflected in the qualitative data. An FWA from Dhaka stated that:

> "When I talk to the wife for the permanent method, they say my husband will reduce the power if he uses permanent method. He will lose his strength. How will he work? On the other hand, when I ask any husband to use permanent method, he feels shy. And then he says I cannot keep my wife if I use permanent method. She will leave me as it will reduce my sexual power."

This FWA also talked about a client's fear about long-acting reversible and permanent methods. She said:

> "There are religious people who do not support the use of permanent method. For example, if someone religious person have already three children and I am asking her for using ligation. This person says I'll not go to Heaven if I use this method."

Another FWV from Dhaka also talked about the myths of long-acting reversible and permanent methods. She said:

"Most of the women in the villages do not want to use implant and IUD. They think that these things will be inside their body after their death. These are foreign things. A body/a person cannot get Heaven with these foreign things inside the body. It is sin, great sin."

Table 13: Percentage Distribution* of the Challenges Faced by FP Service Providers

Variables	MO (n=34)	FWV (n=101)	Midwife (n=22)	SACMO (n=46)	FWA (n=238)	CHCP (n=44)
Myths	32.4	47.5	22.7	34.9	63.9	43.2
Fear among the clients regarding long-acting reversible and permanent methods	23.5	33.7	13.6	9.3	38.2	29.5
FP method side effects/complications	14.7	29.7	9.1	16.3	31.5	27.3
Disagreement of the elder family members	2.9	17.8	4.5	11.6	32.8	9.1
Unavailability of supply	17.6	16.8	9.1	18.6	8.8	18.2
Client load	23.5	15.8	22.7	9.3	10.1	6.8
Work climate issues (work environment)	29.4	12.9	18.2	14.0	7.6	4.5
Vacancy/inadequate support for service providers	17.6	11.9	18.2	14.0	11.3	20.5
Dissatisfied clients		9.9	4.5	4.7	12.2	13.6
Lack of competence/confidence	8.8	5.0	31.8	2.3	3.4	9.1
Inadequate supervision	8.8	1.0	13.6	2.3	1.7	2.3
Others (please specify)	26.5	13.9	18.2	23.3	8.4	11.4

*multiple responses

Around 30% of FWVs, FWAs, and CHCPs mentioned FP method side effects/complications as a challenge to providing FP services (Table 3.9). This issue was also found in the qualitative data. An FWV from Dhaka stated that:

> *"Sometimes clients come with complaint that they are getting bleeding after taking injection. Now, what can I do? I cannot take out the injection. Sometimes clients come with complaint regarding IUD. Clients get bleeding after IUD insertion. Then they come to us. We refer them to Upazila if we cannot manage this case. These clients create panic among other clients."*

Table 13 also shows that nearly one-fourth of the MOs and midwives and less than 15% of the other service providers considered client load as a challenge. Approximately, 30% of MOs mentioned the work environment as a challenge to providing FP services, while 31.8% of midwives reported a lack of competence/confidence as a challenge. Slightly over one-quarter (26.5%) of MOs reported other challenges to providing FP services including problems with nonclinical people, problems with local people, lack of training, and lack of trained colleagues. Almost one-quarter (23.3%) of SACMOs

reported other challenges for providing FP services including male patients not coming for services, the infrastructure of the health center, overall fewer patients visiting the center, too little medicine, and political problems.

Demotivating Factors for the FP Service Providers

The TNA also explored factors that demotivate FP service providers. Table 14 presents the demotivating factors that FP service providers self-reported as diminishing their desire to continue their services. The table shows that workload and lack of career development opportunities were the major demotivating factors for all FP service providers.

Table 14: Percentage Distribution* of Demotivating Factors for FP Service Providers

Demotivating Factors for the FP Service Providers	MO (n=39)	FWV (n=101)	Midwife (n=22)	SACMO (n=43)	FWA (n=237)	CHCP (n=46)
Lack of career development opportunity	21.0	35.6	13.6	37.2	40.0	26.1
High workload	21.0	20.8	18.2	14.0	19.4	19.6
Problems related to travel to work	5.3	11.0	4.5	2.3	17.7	6.5
Financial problems	7.9	8.9		4.7	12.7	8.7
Lack of social respect by community	2.6	5.0	4.5	4.7	8.0	4.3
No service point to work from		1.0	9.1		3.8	
Heavy weight bag during fieldwork		1.0			14.0	
No food subsidy (ration) system				2.3	0.4	
Others	63.2	34.7	63.6	58.1	32.5	54.3

multiple responses

Approximately, 40% of providers reported in the quantitative survey that lack of career development opportunities was a demotivating factor. However, it became a dominant theme for all cadres in the qualitative interviews. An FWA reported:

> *"I am working as an FWA after completing Bachelor (with Honors) and master's degree. My classmates who are working somewhere else with same qualification are getting promotion. But I don't have any promotion. This is demotivating me."*

A SACMO from Chattogram talked about the disadvantages of his post and how promotion-related issues could be solved. He said:

> *I am working as a SACMO. This is a block post; that means I don't have any promotion. I am getting my salary as usual. It does not matter whether I do my work good or bad. Government should have a promotion system for us. I have joined as Sub-Assistant Community Medical Officer. My authority could tell us that after 12 years of working in this position and completing some course(s), I may get promotion to Assistant Community Medical Officer. After working 18 years and completion of some course(s), my authority can promote me as Medical Officer. Then we will be motivated to learn.*

Problems related to travel to work, along with seasonality and ageing issues emerged as a theme in the qualitative analysis for those working in hard-to-reach geographical locations. An FWA from Rangamati stated:

> *"I have grown up (aged). It is difficult for me to walk in my work area during the rainy season."*

Financial problems also emerged in the qualitative data as an issue for demotivation. An FWA from Sylhet reported that:

> *"We have an issue related to salary scale. We work as Third-class employee but get salary of Fourth-class employee. This is making us hopeless."*

In the quantitative survey, approximately 4% of FWAs noted that "no service point to work from" was a demotivating issue. This finding is also reflected in the qualitative data. An FWA from Dhaka stated:

> *"We don't have an office to sit. This hurts us that we don't have any fixed office with table and chair. We feel bad for this."*

The lack of a reward and punishment system was also cited as a demotivating issue in the qualitative data. An FWA from Faridpur stated that:

> *"In this department (family planning), **kham dhorleo ek ruti choke khatleo ek ruti** (means you will get the same thing even if you are working less than the other people who are working). This department has gap related to reward and punishment. The department fails to punish the worker who are not working."*

Table 14 shows that a high number of service providers mentioned "Others" as demotivating factors for providing FP services. The major issues in the "Others" category include bureaucratic problems, lack of understanding of clients, ignorance of people on family planning, lack of training, lack of supply of FP commodities, lack of inspiration, workplace-related problems, prejudice, and managing registries.

Career Pathways of FP Service Providers and Managers in Bangladesh

The lack of career development opportunities was explored in-depth by examining the career pathways of the FP service providers and managers in Bangladesh. Some of the quotes are presented under demotivating factors. Based on an in-depth analysis of the qualitative data, career progression pathways were prepared, and the findings are presented in Table 15. The data show that frontline FP service providers do not have any career development opportunities. FWAs, FPIs, and SACMOs join in one position and retire in that same position. In contrast, FWVs can be promoted to senior FWVs. Recently, the position of senior FWV was renamed to the assistant Upazila family welfare officer (AUFWO). However, in reality, this promotion pathway exists for very few FWVs. On the other hand, currently four different types of MOs are recruited in the Family Planning Directorate, with different job descriptions and job locations. However, these MOs earn their first promotion after a long period of service, and very few of them get promoted to the second and subsequent levels.

Table 15: Career Pathways of FP Service Providers and Managers in Bangladesh

Join as	Can be Promoted to							Retire as
FWA								FWA
FPI								FPI
FWV		Senior FWV/AUFWO						Senior FWV/AUFWO
SACMO								SACMO
MO (CC)			AD (CC)		DD (FP)*		Director^	Director
MO (C)			AD (CC)		DD (FP)*		Director^	Director
MO (MCH-FP)		MO (CC)	AD (CC)		DD (FP)*		Director^	Director
MO (FW)	MO (MCH-FP)	MO (CC)	AD (CC)		DD (FP)*		Director^	Director
UFPO			AD (FP)		DD (FP)**		Director^	Director General^^

*Only one-third of the total DD (FP) positions are held by MOs. The MOs are not promoted to the DD position; instead, MOs are in charge of DDs.

**Only one-third of the total DD (FP) positions are held by UFPOs. The UFPOs are not promoted to the DD position; instead, UFPOs are in charge of DDs.

^Only four out of 19 director positions are filled by promoting DD (FP)s; the rest are occupied by members of the administration cadre.

^^According to the organogram, this position can be filled by promoting a director, but this scenario has never happened.

CHAPTER FOUR: ADOLESCENT- AND YOUTH-FRIENDLY SERVICES PROVIDED BY THE FP PROVIDERS

This section provides a brief overview on the situation of adolescent- and youth-friendly services (AYFS) that service providers deliver, including challenges they faced in delivering AYFS and whether they consider providing AYFS different from providing services to adults. It should be mentioned here that the National Strategy for Adolescent Health 2017–2030 of Bangladesh adopted the World Health Organization's definition of an adolescent of any person between 10 and 19 years of age. In contrast, the National Youth Policy 2017 of Bangladesh defined youth as anyone aged 18 to 35 years. However, the Bangladesh health system is now only addressing the health demands of adolescents by implementing adolescent-friendly health services in selected districts. The Government of Bangladesh has no health programs focused on adolescents and youths.

Types of AYFS Provided by the FP Service Providers

The following figure (Figure 2) shows the percentages of FP service providers who perceived that they were supposed to provide AYFS and those who were actually providing them. The figure shows that 67.3% of FWVs considered that they were supposed to provide AYFS, but 75% of FWVs were providing AYFS. More than 70% (73.1%) of FWAs reported that they were supposed to provide AYFS, and 69.2% of them were actually doing so. Meanwhile, 56.5% of SACMOs reported that they were supposed to provide AYFS and almost the same percentage of SACMOs (57.8%) were actually providing AYFS. More than 50% (53.2%) of CHCPs considered that they were supposed to provide AYFS, but only 13.3% of them provided these services. Surprisingly, the figure shows that most of the providers considered it their job responsibility to provide AYFS, but this responsibility was only written in the SACMO's job description ("*provide necessary counseling and reproductive health services to adolescents*"; Table 5). It should also be mentioned that though adolescent-related services were not specifically included in the FWAs' written job description, the FWA registrar has options for FWAs to record adolescent health-related services.

Provide Service   **Consider They are Supposed to Provide Services**
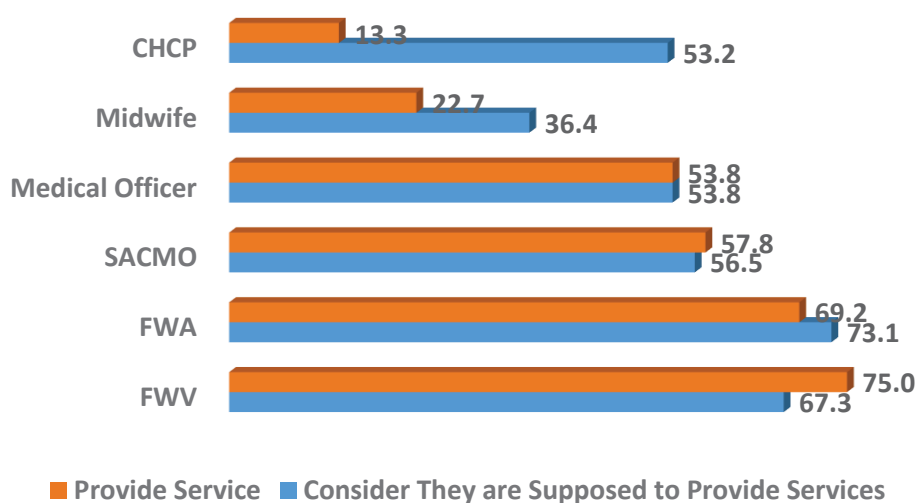
Figure 2: Percentage Distribution of FP Providers' Perception That They are Supposed to Provide AYFS and Those Who Actually Provide AYFS

Table 16 shows the types of AYFS that were provided by different FP service providers. These lists of services were developed based on the National Strategy for Adolescent Health 2017–2030 of Bangladesh and the types of services available to adolescents mentioned in the FWA registrar. It should be noted that that the National Strategy for Adolescent Health of Bangladesh has clearly restricted the provision of FP-related methods, services, and information to only married adolescents; this information was unavailable to unmarried adolescents. Due to this restriction, FP service providers normally did not consider married adolescents as adolescents; rather, they were considered as part of enlisted eligible couples.

The table shows that 82.2% of FWVs, 79.7% of FWAs, 78.7% of CHCPs, 66.7% of MOs, and 63.6% of SACMOs were providing menstrual-related services. It also shows that more than 50% of the different cadres provided services or information on nutrition issues, changes during adolescence, the demerits of child marriage, hygiene issues, and folic acid. Nearly one-third of the MOs, FWVs, FWAs, and CHCPs talked about delaying a first pregnancy and the adverse effects of adolescent pregnancy. Only a small percentage of FP service providers talked about or have provided services related to gender-based violence, infections in the reproductive organs of adolescents, or wet dreams in adolescent boys. Finally, more than 27.8% of midwives reported "Others" as their response. Further exploration of these "Others" show that these midwives were either referring the adolescents elsewhere, or they were not providing any services to the adolescents.

Table 16: Percentage Distribution* of the Types of AYFS Provided by the FP Service Providers

Variables	MO (n=36)	FWV (n=101)	Midwife (n=18)	SACMO (n=44)	FWA (n=238)	CHCP (n=47)
Menstrual issues	66.7	82.2	61.1	63.6	79.7	78.7
Changes in adolescent period	61.1	68.3	16.7	56.8	71.7	63.8
Hygiene/health	50.0	63.4	38.9	59.1	63.3	57.4
Nutrition issues	50.0	62.4	33.3	45.5	66.7	72.3
Provide iron/folic acid to adolescent girl	22.2	61.4	22.2	45.5	44.3	78.7
FP counseling	52.8	45.5	38.9	27.3	33.8	51.1
Discuss disadvantages of early marriage	30.6	42.6	16.7	40.9	55.3	36.2
Sexual and reproductive health and rights issues	52.8	41.6	16.7	50.0	34.2	17.0
FP methods	27.8	29.7	27.8	4.5	21.5	19.1
Adverse effects of adolescent pregnancy	30.6	29.7	11.1	4.5	19.4	23.4
Delaying first pregnancy	25.0	28.7	16.7	13.6	30.4	25.5
Reproductive Infections among adolescents	27.8	22.8		18.2	18.6	19.1
Mental health issues	16.7	15.8	5.6	13.6	11.4	23.4
Preventing child marriage	11.1	11.9		4.5	6.3	10.6
Gender-responsive FP services	5.6	5.0	5.6		1.3	2.1
Prevention of adolescent violence		4.0		2.3	3.4	2.1
Wet dream of adolescent boy		4.0		6.8	3.4	2.1
Gender-based violence		3.0			1.3	
Referral	5.6	1.0	27.8	4.5	2.5	4.3

Variables	MO (n=36)	FWV (n=101)	Midwife (n=18)	SACMO (n=44)	FWA (n=238)	CHCP (n=47)
Don't provide any service	5.6					
Others	8.3	5.0	27.8	6.8	4.2	10.6

multiple responses

Two topics explored in the qualitative in-depth interviews were the types of AYFS provided and the types of adolescents (married or unmarried) who were served by the FP service providers. For example, an FWV from Sylhet stated that she was providing nutrition- and menstrual-related counseling to adolescents. The interviewer also asked a SACMO from Chattogram whether adolescents are coming to receive FP methods. This SACMO stated:

> "Adolescents don't visit to receive family planning methods. Those who are coming for family planning method are couple. They are couple."

The following discussion between the interviewer and a SACMO from Rangamati reflect some of the issues raised, such as who counts as an adolescent, whether adolescents are coming for FP services, etc.

> **Interviewer:** *Do you see that adolescents are coming for FP methods?*
> **SACMO:** *No, I did not get any such. Adolescents are coming for general health related problems.*
> **Interviewer:** *You told me that persons aged between 14-18 are adolescents. Are they coming for services?*
> **SACMO:** *Those who are married in this age, are coming. We give them FP methods as they are married.*
> **Interviewer:** *Who are coming of this age? Boy or girl?*
> **SACMO:** *Only girls are coming*
> **Interviewer:** *What methods the girls liked to receive?*
> **SACMO:** *They like to take oral pill. Then I counsel them that you are not suitable yet for pill. Next time bring your husband, I will help him to understand.*

Table 17 also shows the FP service providers' biases toward providing oral contraceptive pills and condoms to adolescents and youth. The percentages of the providers giving oral contraceptive pills to adolescents were 63.9%, 71.4%, 43.8%, 60.5%, 68.5%, and 51.1% among the MOs, FWVs, midwives, SACMOs, FWAs, and CHCPs, respectively. On the other hand, 86.6% of FWAs, 84.7% of FWVs, 66.7% of MOs, and 66% of CHCPs provided condoms to adolescents. About one-quarter (27.8%) of the MOs provided implant insertion services to adolescents. Among those not providing any FP services, the percentage was highest among midwives (31.3%), followed by SACMOs (25.6%), CHCPs (19.1%), and FWVs (13.3%).

Table 17: Percentage Distribution* of the FP Methods That are Provided to Adolescents and Youth by the FP Service Providers

Variables	MO (n=36)	FWV (n=98)	Midwife (n=16)	SACMO (n=43)	FWA (n=232)	CHCP (n=47)
Oral contraceptive pill	63.9	71.4	43.8	60.5	68.5	51.1
Condom	66.7	84.7	31.3	60.5	86.6	66.0

Variables	MO (n=36)	FWV (n=98)	Midwife (n=16	SACMO (n=43)	FWA (n=232)	CHCP (n=47)
Injectables	11.1	11.2		9.3	5.6	2.1
IUD insertion	5.6	9.2		2.3		
IUD removal	5.6	3.1				
Implant insertion	27.8					
Implant removal	2.8					
PPFP	5.6	4.1	12.5	4.7	1.7	
Do not provide any service	2.2	13.3	31.3	25.6	9.9	19.1

Challenges Faced by the FP Providers in Providing AYFS to Adolescents

This TNA attempted to explore the challenges faced by the FP service providers in terms of providing AYFS to adolescents. Table 18 shows that the providers reported that both supply and demand side challenges affect the provision of AYFS. SACMOs were supposed to provide services to adolescents as per their job description, yet 46.5% of them reported feeling uncomfortable talking to adolescents and youth. Approximately one-quarter or more of the FWVs, FWAs, and MOs also felt discomfort in talking to adolescents and youths. Almost 40% (38%) of FWAs who were supposed to provide FP services to adolescents according to their registrar reported that parents did not allow them to provide these services to the adolescents. The lack of training on AYFS was reported as a challenge by 24.6% of CHCPs, 23.5% of midwives, 20.8% of FWVs, and 17.7% of FWAs. Approximately 10% of all FP service providers reported that they lack training on interpersonal communication. Nearly a quarter of the FP service providers reported "Others" as challenges in providing adolescent and youth-friendly FP services, and these included: providers not having a youth corner, disinterest on the part of the mothers-in-law and husbands of adolescents, and providers feeling shy discussing adolescent health-related issues because of the age gap between the provider and the service receiver.

Table 18: Percentage Distribution* of Challenges Faced by the FP Providers in Providing Adolescent and Youth-Friendly FP Services

Variables	MO (n=31)	FWV (n=101)	Midwife (n=17)	SACMO (n=43)	FWA (n=238)	CHCP (n=47)
Feel discomfort talking to adolescents and youth	22.6	31.7	5.9	46.5	25.3	15.4
Parents don't allow the provision of services to adolescents	19.4	23.8	17.6	16.3	38.0	10.8
Lack of an enabling environment in which to discuss issues with adolescents and youth	6.5	21.8	5.9	14.0	21.1	9.2
Lack of training on AYFS	16.1	20.8	23.5	7.0	17.7	24.6
Adolescents and youth not asking questions	16.1	19.8	17.6	4.7	21.5	4.6
Adolescents and youth not coming to receive services	22.6	15.8	29.4	9.3	19.8	7.7
Lack of training on	9.7	11.9	5.9	2.8	12.7	10.8

Variables	MO (n=31)	FWV (n=101)	Midwife (n=17)	SACMO (n=43)	FWA (n=238)	CHCP (n=47)
interpersonal communication						
Service is not available at the center	9.7	7.9	5.9	7.0	8.4	
Community does not allow the provision of services to adolescents	9.7	7.9	5.9	14.0	14.3	
Don't know	6.5	1.0	17.6	4.7	1.7	
Others (please specify)	25.8	26.7	17.6	25.6	23.6	16.9

multiple responses

Received Training on AYFS

Table 19 shows that only 19.6% of SACMOs received training on AYFS, although providing these services to adolescents was part of the written job description of the SACMO position. The table shows that of the providers who had received training on AYFS, the cadre with the highest percentage was the FWVs (70.03%), followed by CHCPs (51.1%), FWAs (48.7%), MOs (41%), and midwives (31.8%). The FP service providers also reported that the AYFS training included many issues. However, this self-reported information on the issues covered in the AYFS training varied significantly by the providers. For example, approximately 50% of MOs reported that nutrition issues, hygiene/health, FP counseling, and sexual and reproductive health and rights issues were included in their AYFS-related training. Around 50% of FWVs reported that nutrition issues, changes during adolescence, menstrual issues, hygiene/health, the disadvantages of early marriage, FP counseling, and sexual and reproductive health and rights issues were included in their AYFS-related training. Overall, a very small percentage of FP service providers reported that the following issues were included in the AYFS-related trainings: delaying a first pregnancy, the adverse effects of adolescent pregnancy, mental health issues, infections in the reproductive organs of adolescents, preventing child marriage, gender-based violence, wet dreams of adolescent boys, and gender-responsive FP services.

Table 19: Percentage Distribution* of FP Providers Who Have Received Training on AYFS and Topics That Were Covered

Variables	MO (n=39)	FWV (n=101)	Midwife (n=22)	SACMO (n=46)	FWA (n=238)	CHCP (n=47)
Received any training on AYFS	41.0	70.3	31.8	19.6	48.7	51.1
Topics Covered in AYFS Training	MO (n=16)	FWV (n=71)	Midwife (n=7)	SACMO (n=9)	FWA (n=115)	CHCP (n=24)
Nutrition issues	68.8	64.8	71.4	44.4	66.1	79.2
Changes during adolescence	43.8	64.8	28.6	77.8	58.3	58.3
Menstrual issues	43.8	63.4	57.1	11.1	69.6	66.7
Hygiene/health	56.3	53.5	71.4	11.1	52.2	62.5
Disadvantages of early marriage	43.8	50.7		11.1	40.9	41.7
Provide iron/folic acid to adolescent girls	31.3	47.9	57.1	33.3	40.0	37.5
FP counseling	56.3	45.1	71.4	22.2	41.7	33.3
Sexual and reproductive health and rights issues	50.0	43.7	28.6	44.4	30.4	20.8
FP methods	37.5	36.6	42.9	11.1	32.2	16.7
Delaying first pregnancy	31.3	36.6	57.1	11.1	37.4	33.3
Adverse effects of adolescent pregnancy	31.3	23.9	28.6		31.3	12.5
Mental health issues	31.3	16.9	14.3		10.4	4.2
Infections in the reproductive organs of adolescents	18.8	16.9	14.3	11.1	26.1	16.7
Preventing child marriage	18.8	12.7			17.4	4.2
Gender-based violence	12.5	7.0		11.1	5.2	
Wet dreams of adolescent boys		4.2			5.2	4.2
Intimate partner violence	6.3	2.8			1.7	
Gender-responsive FP services	6.3	2.8	14.3		1.7	
Referral	6.3	2.8			0.9	
Prevention of adolescent violence	12.5	1.4		11.1	2.6	4.2
Others (please specify)	12.5	5.6			3.5	4.2

multiple responses

CHAPTER FIVE: RECEIVING TRAINING AND TRAINING NEEDS AMONG FP SERVICE PROVIDERS

This section provides findings on the trainings that the FP services providers have received as well as their perceived needs about training.

Trainings Received by the FP Service Providers

Figure 3 shows that a high number of FP service providers received training at some point in their careers. Ninety-seven percent of FWVs received training on providing FP services, followed by 91.2% of FWAs, 78.7% of CHCPs, 76.9 % of MOs, 71.7% of SACMOs, and 50% of midwives.

Midwife — 50.0
SACMO — 71.7
Medical Officer — 76.9
CHCP — 78.7
FWA — 91.2
FWV — 97.0
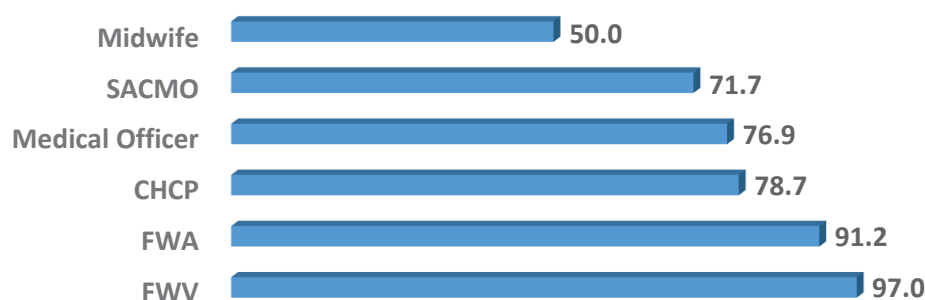
Figure 3: Percentage Distribution of FP Service Providers Who Have Ever Received Training on FP Services

FP services providers in Bangladesh received three different types of trainings on all FP methods and services: basic training, practicum, and refresher (i.e., follow-up) training. MOs, SACMOs, FWVs, and midwives received their basic and practicum training on how to provide different FP methods before joining the service and received refresher trainings while in-service. In contrast, FWAs and CHCPs received all their trainings—basic training, practicum, and refresher training—when they were in-service.

Table 20 shows that fewer MOs and Midwives received training on Counseling on FP Methods than FWVs, SACMOs, FWAs, and CHCPs. For example, while 89.8% of FWVs, 69.7% of SACMOs, 79.8% of FWAs, and 70.2% of CHCPs received basic training on counseling, only 54.5% of Midwives and 53.3% of MOs had received the same training. Although the percentage of providers receiving basic training on counseling and on short-acting, long-acting reversible, and permanent methods of FP was relatively high, the percentage receiving refresher training was low. For example, more than 80% of Midwives received basic training on short-acting methods, but only 15% received refresher training. Nearly 90% (89.2%) received basic training on short-acting methods, but less than half of them (41.4%) had received refresher training. On the other hand, 78.3% of MOs received basic training on long-acting reversible and permanent methods of FP, but only 24.4 % had received refresher training in this area.

Table 21 also shows that the FP service providers received their basic, practicum, and refresher trainings a long time ago. On average, MOs and midwives received their last refresher training on Counseling on FP Methods 9.5 years earlier, followed by FWAs (7.1 years earlier), FWVs (4.9 years earlier), SACMOs (4.4 years earlier), and CHCPs (2.9 years earlier). MOs received their last refresher training on long-acting reversible and permanent FP methods 8.6 years earlier on average, while FWVs received the same training 4.5 years earlier on average.

Table 20: Percentage Distribution* of FP Service Providers Who Received Training on Different FP Methods and Services

Training Received on	MO (n=30)			FWV (n=98)			Midwife (n=11)			SACMO (n=33)			FWA (n=217)			CHCP (n=37)		
	Basic Training	Practicum	Last Refresher	Basic Training	Practicum	Last Refresher	Basic Training	Practicum	Last Refresher	Basic Training	Practicum	Last Refresher	Basic Training	Practicum	Last Refresher	Basic Training	Practicum	Last Refresher
Counseling on FP Methods	53.3	36.7	20.0	89.8	77.6	68.4	54.5	18.2	18.2	69.7	48.5	42.4	79.8	72.4	66.0	70.2	42.6	34.0
Short-Acting Methods				99.6	89.1	80.6	81.8	21.2	15.1	88.9	48.5	50.5	95.5	79.9	75.3	89.2	45.9	41.4
Oral contraceptive pill				100.0	77.6	79.6	90.0	27.3	18.2	90.9	45.5	51.5	97.2	73.7	74.2	74.5	36.2	36.2
Condom				100.0	93.9	79.6	81.8	18.2	18.2	87.9	48.5	48.5	96.3	86.6	74.2	74.5	42.6	36.2
Injectables				99.0	95.9	82.7	72.7	18.2	18.2	87.9	51.5	51.5	93.1	72.3	74.7	61.7	29.8	25.5
Long-Acting Reversible & Permanent Methods	78.3	66.7	24.4	98.5	95.4	84.1	90.9	18.2	9.1	68.2	25.8	37.9						
IUD insertion	76.7	66.7	26.7	99.0	96.9	85.7	90.9	18.2	9.1	69.7	27.3	39.4						
IUD removal	76.7	63.3	26.7	98.0	93.9	82.7	90.9	18.2	9.1	66.7	24.2	36.4						
Implant insertion and removal	80.0	66.7	26.7															
Tubectomy	76.7	66.7	20.0															
NSV	80.0	70.0	20.0															

*multiple responses; Note: 'n' is smaller than the sample surveyed because this table is based only on the number of providers who had received training.

Table 21: Distribution of Average Number of Years Since FP Providers Received Basic, Practicum, and Refresher Trainings on Different FP Methods and Services

Training Received on	MO (n=30)			FWV (n=98)			Midwife (n=11)			SACMO (n=33)			FWA (n=217)			CHCP (n=37)		
	Basic Training	Practicum	Last Refresher	Basic Training	Practicum	Last Refresher	Basic Training	Practicum	Last Refresher	Basic Training	Practicum	Last Refresher	Basic Training	Practicum	Last Refresher	Basic Training	Practicum	Last Refresher
Counseling on FP Methods	15.5	18.1	9.5	21.9	24.1	4.9	12.0	21.5	9.5	20.1	17.9	4.4	19.7	19.5	7.1	6.3	6.2	2.9
Short-Acting Methods				24.3	24.1	5.8	9.2	14.8	9.5	21.8	18.0	6.2	19.9	23.1	7.8	6.3	6.6	3.0
Long-Acting Reversible & Permanent Methods	13.8	14.4	8.6	23.6	23.1	4.5	7.2	1.5	1.7	22.0	19.6	5.4						
IUD insertion/removal	13.1	13.6	7.8	24.2	23.7	5.1	7.4	1.5	1.7	21.0	18.4	6.4						
Implant insertion/removal	13.1	13.8	8.6	23.0	22.5	4.0	7.0		1.7	23.0	20.7	4.3						
Tubectomy	15.1	15.9	9.5															
NSV	15.3	16.0	9.5															

Note: 'n' is smaller than the sample surveyed because this table is based only on the number of providers who had received training.

Table 22 shows overall training of providers on infection prevention and on its different aspects. These questions were asked to FWVs, midwives, and SACMOs, as these three cadres were responsible for managing the infection prevention process. The table shows that 92.1% of FWVs received basic training on infection prevention, while only 41.3% of SACMOs and 27.3% of midwives received this training. Again, the table shows that the percentage of providers receiving refresher training was lower than the percentage receiving basic training.

Table 22: Percentage Distribution of FP Service Providers Receiving Training on Different Aspects of Infection Prevention

Variables	FWV (n=101)			Midwife (n=22)			SACMO (n=46)		
Received Training on Infection Prevention									
Basic Training	92.1			27.3			41.3		
Practicum	85.1			22.7			30.4		
Last Refresher	46.5			18.2			8.7		
Received Training on Aspects of Infection Prevention	Basic Training (n=93)	Practicum (n=86)	Last Refresher (n=47)	Basic Training (n=6)	Practicum (n=5)	Last Refresher (n=4)	Basic Training (n=19)	Practicum (n=14)	Last Refresher (n=4)
0.5% chlorine solution	97.8	96.5	97.8	100.0	100.0	100.0	89.4	85.7	100.0
Washing with water/cleaning	97.8	94.2	100.0	100.0	100.0	100.0	84.2	85.7	100.0
Autoclaving	93.5	90.0	91.5	83.3	100.0	100.0	178.9	92.8	75.0
Boiling	86.1	84.9	80.8	83.3	80.0	75.0	73.7	71.4	100.0
IUD Sterilizer	89.2	87.2	93.6	50.0	60.0	75.0	63.2	57.1	25.0

FP Service Providers' Perceptions of the Adequacy of the Training Received

FP Service Providers' Overall Perceptions of the Adequacy of the Training Received

Overall, few providers reported that the training they received was adequate for the services they provided (Table 23). Less than half of the Midwives reported that the training they received on oral contraceptive pills and condoms was adequate for the nature of the services they provide and one out of five FWVs perceived that their training on short-acting methods was inadequate. With regard to the training received on injectables, 52.1% of FWAs but only 16.2% of CHCPs perceived that this training was adequate. Only half of the FWVs reported that the training they received on IUD insertion and removal was adequate. On the other hand, approximately 60% of MOs reported that the trainings they received on tubectomy (60%) and NSV (53.3%) were adequate. Of the trainings received, all the cadres of service providers reported that the training on counseling was the most inadequate. The findings of this table can be used to interpret the FP service providers' levels of comfort in delivering FP services (presented in Table 11). It can be interpreted that the FP service providers' lack of comfort with different services was rooted in the inadequacy of the trainings they have received.

Table 23: Percentage Distribution* of FP Service Providers' Perceptions of the Adequacy of the Received Training Compared to the Nature of the Services They Provide

Variables	MO (n=30)	FWV (n=98)	Midwife (n=11)	SACMO (n=33)	FWA (n=217)	CHCP (n=37
Counseling						
Counseling methods	60.0	63.3	45.5	45.5	56.2	29.7
Short-Acting Methods						
Oral contraceptive pill		79.6	45.5	60.6	72.8	51.4
Condom		78.6	45.5	63.6	73.7	59.5
Injectables		73.5	36.4	51.5	52.1	16.2
LAM	63.3	63.3	45.5	39.4	41	29.7
Long-Acting Reversible and Permanent Methods						
IUD insertion	80.0	54.1	27.3	30.3		
IUD removal	70.0	50.0	27.3	30.3		
Implant insertion	70.0	24.5		18.2		
Implant removal	66.7	25.5		21.2		
Tubectomy	60.0					
NSV	53.3					
Other FP Services						
PPFP	66.7	44.9	54.5	45.5	39.6	
AYFS	60.0	59.2	36.4	36.4	44.7	43.2
PAC FP	56.7	39.8	36.4	39.4		
Gender-responsive FP services	50.0	36.7	9.1	24.2	28.6	24.3
Supervision	40.0			12.1		
Other	13.3	2.0			3.7	

*multiple responses

FP Service Providers' Perceptions of the Adequacy of the Practicum Training Received

Table 24 reflects the perceived adequacy of the practicum training received by the FP service providers. The findings reported in this table could help explain why some service providers did not feel comfortable providing services, as a relatively small percentage of FP service providers perceived that their practicum training was adequate. Of FWVs, 60% perceived that the practicum training they received for injectables was adequate, followed by FWAs (41%) and CHCPs (16.2%). On average, less than half of the MOs reported that the practicums on tubectomy (53.3%) and NSV (43.3%) were adequate, while less than half of the FWVs reported that the practicums on IUD insertion and removal were adequate. The perceived inadequacy of the practicum trainings was also reflected in the qualitative data. The following conversation with an FWV from Sylhet reflects the perceived inadequacy of the practicum training on one of the long-acting reversible methods.

> *Interviewer: What was the duration of the training on long-acting reversible and permanent methods you participated in last time?*
>
> *FWV: 12 days.*
>
> *Interviewer: How the training was conducted?*
>
> *FWV: It was on how to insert and remove IUD. There was theoretical lecture. Then they showed us video where people were inserting IUD. Then we practiced on dummy. We also went to Upazila where there was a camp. We performed practice in the camp.*
>
> *Interviewer: So, you practiced with dummy. Did you see practically that someone is inserting IUD?*
>
> *FWV: Showed one. No more.*
>
> *Interviewer: You did practical exercise. Do you think that the opportunity for doing practice was enough?*
>
> *FWV: No, it was not enough. Ten participants were exercising on one woman. That was a squiggling situation.*
>
> *Interviewer: How to increase the opportunity of doing exercise?*
>
> *FWV: If we can do practice at least one woman, then it will strength our courage that we can do it. Dummy does not show any reaction.*
>
> *Interviewer: That means you are telling that exercise was not enough and did not get enough opportunity for practical exercise?*
>
> *FWV: Yes.*

Table 24: Distribution of FP Service Providers' Perceptions of the Adequacy of the Practicum Training Compared to the Nature of the Services They Provide

Variables	MO (n=30)	FWV (n=98)	Midwife (n=11)	SACMO (n=33)	FWA (n=217)	CHCP (n=37)
Counseling	43.3	57.1	18.2	39.4	52.1	27.0
Counseling methods						
Short-Acting Methods						
Oral contraceptive pill		66.3	36.4	36.4	64.1	35.1
Condom		73.5	27.3	42.4	62.7	40.5
Injectables		60.2	9.1	30.3	41.0	16.2
LAM	46.7	45.9	18.2	33.3	31.8	18.9
Long-Acting Reversible and Permanent Methods						
IUD insertion	70.8	43.9	9.1	12.1		
IUD removal	60.0	41.8	9.1	12.1		
Implant insertion and removal	66.7	19.4		9.1		
Tubectomy	53.3					
NSV	43.3					
Other FP Services						
PPFP	50.0	39.8	27.3	30.3	35.0	

Variables	MO (n=30)	FWV (n=98)	Midwife (n=11)	SACMO (n=33)	FWA (n=217)	CHCP (n=37)
AYFS	36.7	45.9	9.1	36.4	38.2	24.3
PAC FP	40.0	36.7	27.3	27.3		
Gender-responsive FP services	36.7	27.6		21.2	24.4	13.5
Supervision	36.7			6.1		
Other	13.3	1.0			5.1	

multiple responses

FP Service Providers' Felt Needs on Training

Figure 5.2 shows that except for MOs, approximately nine out of ten of all other FP service providers felt the need for training. Conversely, only 48.7% of MOs felt the need for training. The lower percentage for the MOs might be explained by the fact that many of these MOs often work as trainers, and thus they felt that they themselves do not need any training.
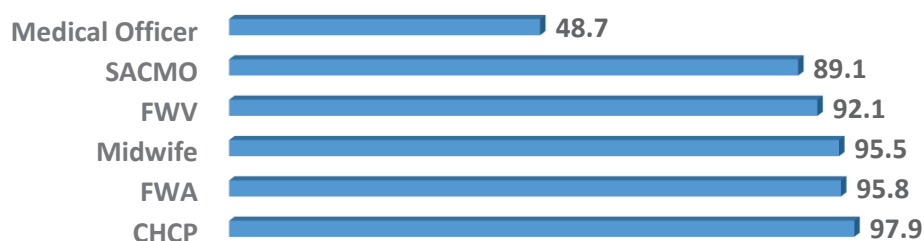
Figure 4: Percentage Distribution of Service Providers' Felt Need for Training to Provide FP Services

This TNA then explored the areas in which the FP service providers felt they needed training. The providers reported that they needed training to enhance their knowledge and skills in counseling on FP methods and providing FP services. The following tables (Tables 5.6 and 5.7) show the findings of their perceived training needs in these areas.

Table 25 shows 53% of MOs, 74% of FWVs, 76% of midwife, 63% of SACMOs, 72% FWAs and 83% of CHCPs mentioned need of knowledge on counselling FP methods. Over 44% of FWVs, 91% of midwife, 71% of SACMOs, 65% of FWAs and 79% of CHCPs mentioned need of knowledge on injectable contraceptives. While 58% of MOs mentioned need of knowledge on tubectomy 63% of them mentioned need of knowledge on NSV. Nearly 53% of MOs, 70% of FWVs, 81% of midwife, 66% of SACMOs and 75% of FWAs mentioned need of knowledge on postpartum family planning.

Table 25: Distribution of FP Providers' Felt Need of Training to Enhance Knowledge to Provide FP Services

Areas in Which Training is Needed to Enhance Knowledge	MO (n=19)	FWV (n=93)	Midwife (n=21)	SACMO (n=41)	FWA (n=228)	CHCP (n=46)
Counseling						
Counseling methods	52.6	74.2	76.2	63.4	71.5	83.0
Short-Acting Methods						
Oral contraceptive pill		31.2	85.7	46.3	43.0	59.6

Areas in Which Training is Needed to Enhance Knowledge	MO (n=19)	FWV (n=93)	Midwife (n=21)	SACMO (n=41)	FWA (n=228)	CHCP (n=46)
Condom		25.8	76.2	46.3	40.8	55.3
Injectables		44.1	90.5	70.7	64.9	78.7
LAM	31.6	62.4	66.7	58.5	59.6	66.0
Long-Acting Reversible and Permanent Methods						
IUD insertion	26.3	78.5	95.2	68.3	62.3	
IUD removal	21.1	68.8	85.7	61.0	60.1	
Implant insertion	47.4	67.7	90.5	63.4	61.4	
Implant removal	47.4	63.4	85.7	61.0	57.9	
Tubectomy	57.9	63.4	71.4	53.7	60.5	
NSV	63.2	61.3	66.7	56.1	61.4	
Other FP Services						
PPFP	52.6	69.9	81.0	65.9	75.0	
AYFS	52.6	74.2	66.7	70.7	78.1	76.6
PAC FP	52.6	59.1	71.4	58.5	63.2	
Gender-responsive FP services	47.4	65.6	57.1	63.4	59.6	72.3
Supervision	47.4	19.4	28.6	29.3		
Infection prevention	42.1	74.2	81.0	70.7	57.5	
Other		4.3			2.6	6.4

multiple responses

Table 26 shows, 53% MOs, 68% FWVs, 62% Midwife, 56% SACMOs, 65% FWAs and 83% CHCPs mentioned need of practicum training on counselling on FP methods. Over 50% of FWVs, 71% of midwife, 68% of SACMOs, 65% of FWAs and 78% of CHCPs mentioned their need for practicum for providing injectables contraceptive services. Fifty eight percent of the MOs mentioned need of practicum for both NSV and Tubectomy, around 80% of FWVs and midwife mentioned need of practicum for IUD insertion and 63% of SACMOs mentioned need of practicum for IUD insertion. Over 42% of MOs, 67% of FWVs, 62% of midwife, 51% of SACMOs and 58% of FWAs mentioned need of practicum on postpartum family planning.

Table 26: Distribution of FP Providers' Felt Need to Acquire Skills/Practicum to Provide FP Services

Areas in Which Training is Needed to Acquire Skills/Practicum	MO (n=19)	FWV (n=93)	Midwife (n=21)	SACMO (n=41)	FWA (n=228)	CHCP (n=46)
Counseling						
Counseling methods	52.6	67.7	61.9	56.1	65.4	82.6
Short-Acting Methods						
Oral contraceptive pill		26.9	57.1	48.8	39.9	50.0
Condom		25.8	47.6	43.9	37.7	45.7
Injectables		50.5	71.4	68.3	65.4	78.3
LAM	26.3	53.8	42.9	48.8	45.6	50.0
Long-Acting Reversible and Permanent Methods						
IUD insertion	26.3	80.6	81.0	63.4	37.3	

Areas in Which Training is Needed to Acquire Skills/Practicum	MO (n=19)	FWV (n=93)	Midwife (n=21)	SACMO (n=41)	FWA (n=228)	CHCP (n=46)
IUD removal	21.1	73.1	71.4	56.1	36.0	
Implant insertion	47.4	51.6	66.7	53.7	32.5	
Implant removal	47.4	48.4	61.9	51.2	32.0	
Tubectomy	57.9	40.9	47.6	46.3	28.1	
NSV	57.9	39.8	42.9	46.3	29.4	
Other FP Services						
PPFP	42.1	66.7	61.9	51.2	57.5	
AYFS	36.8	68.8	33.3	61.0	62.3	69.6
PAC FP	47.7	60.2	52.4	43.9	50.0	
Gender-responsive FP services	42.1	59.1	47.6	63.4	46.5	67.4
Supervision	47.7	18.3	23.8	24.4		
Infection prevention	36.8	73.1	71.4	75.6	54.4	
Other		3.2			3.1	2.2

*multiple responses

CHAPTER SIX: TRAINERS' AND TRAINING INSTITUTES' CAPACITY TO PROVIDE TRAINING

This section provides findings on the capacity of the training institutes from which the FP service providers received training on different FP methods and services. A structured questionnaire was developed to assess the capacity of these institutes. Additionally, a self-administered questionnaire was used to assess the training management capacity of the trainers. This chapter also incorporates data collected from the FP service providers regarding these training institutes.

Training Institutes that Provide Training to FP Service Providers

Table 27 provides the percentage of training institutes from which the FP service providers have received training on short-acting FP methods. It shows that there were specific types of training institutes from which the different cadres of FP service providers received training. For example, FWVs and SACMOs received training mostly from FWVTIs/RPTIs, while Midwives received training mostly from medical college hospitals. In contrast, FWAs mostly received training from the RTCs of NIPORT, while CHCPs mostly received training from the Upazila Health Complexes (UHCs).

Table 27: Percentage Distribution of Training Venues from Which FP Service Providers Have Received Training on Short-Acting FP Methods

Training Venues*	FWV			Midwife			SACMO			FWA			CHCP		
	Basic Training (n=98)	Practicum (n=87)	Last Refresher (n=79)	Basic Training (n=10)	Practicum (n=4)	Last Refresher (n=2)	Basic Training (n=30)	Practicum (n=16)	Last Refresher (n=17)	Basic Training (n=207)	Practicum (n=172)	Last Refresher (n=164)	Basic Training (n=34)	Practicum (n=17)	Last Refresher (n=17)
MCHTI	3.1	3.8	2.5				3.4	6.3			0.6	0.6	2.9		
MFSTC		1.1	2.5						5.9	1.9	1.2	0.6			
RTC										90.3	92.5	81.0			
FPCS QIT			1.3							0.5	1.2	0.6			
Field Training Centre							3.4	6.3		0.5					
Medical college hospital		1.1	5.1	50.0	75.0	50.0				1.0	0.6	0.6			
District hospital										0.5			5.9	11.8	
FWVTI/RPTI	86.6	81.3	68.9				51.1	68.8	58.8			9.1			
UHC	1.0	1.9	3.8				9.1	12.5	17.6	4.3	2.9	15.9	76.5	82.4	76.5
MCWC	2.0	3.8	3.8	10.0		50.0				0.5	0.6				
Others	1.0			30.0	25.0		6.8								
Can't recall	6.1	8.4	11.5	10.0			26.1	12.5	11.8	0.5	0.6	0.6	14.7	5.9	23.5

Table 28 provides the percentage of training institutes from which the FP service providers received training on long-acting reversible and permanent methods. Like short-acting methods, this table also shows that there were specific types of training institutes from which the different cadres of FP service

providers received training. MOs received training mostly from medical college hospitals, MCWCs, the Family Planning Clinical Supervision and Quality Improvement Team (FPCS QIT), MFSTC, MCHTI, and NIPORT Headquarters (HQ). In contrast, FWVs and SACMOs received training mostly from FWVTIs/RPTIs, while Midwives received training mostly from medical college hospitals.

Table 28: Percentage Distribution of Training Venues from Which FP Service Providers Have Received Training on Long-Acting Reversible and Permanent Methods of FP

Training Venues*	MO			FWV			Midwife			SACMO		
	Basic Training (n=26)	Practicum (n=21)	Last Refresher (n=8)	Basic Training (n=97)	Practicum (n=94)	Last Refresher (n=83)	Basic Training (n=10)	Practicum (n=2)	Last Refresher (n=1)	Basic Training (n=23)	Practicum (n=9)	Last Refresher (n=13)
MCHTI	11.5	23.8	50.0	4.1	4.8	4.8				8.9	11.1	
MFSTC	7.7	14.3	12.5			2.4						
FPCS QIT	15.3	9.6				2.4						
Field Training Centre	3.8	4.8										
Medical college hospital	15.4	9.5	12.5		2.1	6.1	50.0	100.0				
District hospital	3.8	4.8										9.1
FWVTI/RPTI	26.9	14.3		87.1	80.2	63.6				55.5	77.7	21.6
UHC				1.0	2.1	3.6				4.4		15.4
MCWC	11.5	14.3	25.0	1.0	3.2	9.7	10.0		100.0			
Others	3.8					1.2	30.0			8.9		
Can't recall				6.7	8.6	9.7	10.0			22.2	11.1	15.4

* Multiple responses

Table 29 provides the percentage of training institutes from which the FP service providers received training on Counseling on FP Methods. Like the training venues from which FP service providers received training on short-acting and long-acting reversible and permanent methods of FP, this table also shows that there were specific types of training institutes from which the different cadres of FP service providers received training. MOs received counseling training mostly from medical college hospitals, MCWCs, MFSTC, MCHTI and FWVTIs/RPTIs, while FWVs and SACMOs have received this training mostly from FWVTIs/RPTIs; Midwives received training on this topic mostly from medical college hospitals and MCWCs. FWAs received training mostly from the RTCs, while CHCPs mostly received training from UHCs. The table also shows that a group of FWVs, SACMOs, and CHCPs could not recall the venues where they had received training on Counseling on FP Methods.

Table 29: Percentage Distribution of Training Venues from Which FP Service Providers Have Received Training on Counseling FP Methods

Training Venues*	MO			FWV			Midwife			SACMO			FWA			CHCP		
	Basic Training (n=16)	Practicum (n=11)	Last Refresher (n=6)	Basic Training (n=88)	Practicum (n=76)	Last Refresher (n=67)	Basic Training (n=6)	Practicum (n=2)	Last Refresher (n=2)	Basic Training (n=23)	Practicum (n=16)	Last Refresher (n=14)	Basic Training (n=190)	Practicum (n=157)	Last Refresher (n=143)	Basic Training (n=33)	Practicum (n=20)	Last Refresher (n=16)
MCHTI	12.5	18.2	50.0	3.4	3.9	1.5				4.3				0.6				
MFSTC	12.5	18.2	16.7	1.1	1.3	3.0							2.1	1.3				
RTC													80.6	83.4	72.1			
FPCS QIT	6.3												0.5	1.9	0.7			
Field Training Centre	6.3	9.1											0.5					
Medical college hospital	12.5	9.1	16.7		1.3	6.0	33.4	100.0	50.0				1.1		0.7			
District hospital												7.1				6.1	10.0	
FWVTI/RPTI	37.6	37.4		81.8	72.2	67.2				50.8	68.8	27.2	7.4	7.0	9.1			
UHC				1.1	3.9	3.0				8.7	12.5	21.4	6.8	4.5	16.8	78.8	65.0	75.0
MCWC	12.5	9.1	16.7	1.1	2.6	4.5	16.7		50.0				0.5	0.6				
Others				1.1			50.0			4.3								
Can't recall				10.2	14.5	14.9				21.7	18.8	14.3	0.4	0.6	0.7	5.2	25.0	25.0

Organizational and Management Capacity of the Training Institutes

Tables 27, 28, and 29 show that most of the FP service providers received training on different FP methods and services from the following training institutes: NIPORT HQ, MCHTI, MFSTC, RTCs, FPCS QIT, medical college hospitals, FWVTIs/RPTIs, MCWCs, and UHCs. However, MCWCs and UHCs are not considered to be regular training venues; rather, these places were used as practical training venues when necessary.

Thus, the organizational and management capacities of the following ten training institutes were assessed in this TNA: the Rangamati, Dhaka, Faridpur, and Sylhet FWVTIs; MFSTC; and the Bhanga (Faridpur), Iswarganj (Mymensingh), Kaptai (Rangamati), Sitakunda (Chattogram), and Dhamrai (Dhaka) RTCs. The heads of these training institutes or their representatives were interviewed using a structured questionnaire as part of assessing their institutes' organizational and management capacities. Therefore, the sample size for this assessment was ten.

Types of Trainings Provided by the Surveyed Training Institutes

Table 30 shows the types of trainings provided by the surveyed training institutes in the last year (January to December 2018). It shows that all training institutes typically provided trainings on maternal health, but only three had provided training on this topic in the last year. On average, each training institute trained 11.7 batches of trainees on maternal health, where the average number of participants in each batch was 21.7 people. In contrast, usually all ten training institutes provided training on FP methods, but last year, only four provided this training. On average for this topic, each of the training institutes trained 8.8 batches of participants, where on average, 20.2 people participated per batch. Although seven training institutes usually provided training on Counseling on FP Methods, last year, only three provided training on this topic. On average, each training institute provided counseling training to 10.7 batches, where each batch was composed of 25.7 people on average.

Six out of ten training institutes usually provided training on quality improvement, although only three institutes provided training on the topic in the last year. On average, each of these three training institutes trained ten batches of participants, with an average of 20.3 participants per batch. The table also shows that usually six out of ten training institutes provided training on supportive supervision/mentoring, but last year, only two provided training on this topic. On average, these two training institutes trained 2.5 batches, where each batch included an average of 25 people. Five out of ten training institutes usually provided training on e-learning, but only two provided this training in the last year. On average, both training institutes provided ten trainings, with an average of 25 people participating in each. Overall, the table shows that the training institutes surveyed had a very low load in terms of providing training in the last year. However, a senior official from NIPORT reported that the training institutes were not getting enough time for training. He said:

> *"Five years back we used to train 5,000 staff in a year. Now our capacity has increased. This year (2018-2019 fiscal year) we have trained 27,000 staff and next year we will train more than 30,000 staff. "*

Table 30: Detailed Information about the Types of Trainings Provided by the Training Institutes in the Last Year (January–December 2018) (n=10)

Training Topics	Number of Training Institutes Usually Providing Training	Detailed Information about the Trainings Provided in the Last Year (January–December 2018)				
		Number of Institutes That Provided Training Last Year	Average Number of Batches Trained by Each Institution	Average Number of Participants in Each Batch	Average Number of Months Ago that the Last Training was Provided on this Topic	Average Duration of Training (in Days)
Clinical and Program Topics						
Maternal health	10	3	11.7	21.7	6.3	5.0
Child health	9	3	6.0	21.1	2.3	5.0
Early childhood development	9	7	3.6	20.1	8.0	5.0
Comprehensive newborn care	9	4	5.0	19.0	3.8	5.0
FP methods	10	4	8.8	20.2	5.6	5.0
Adolescent health	7	3	10.0	22.7	3.5	5.0
Counseling	7	3	10.7	25.7	5.3	5.0
Sexual and reproductive health	10	7	5.6	20.1	3.0	5.0
Gender-responsive FP services	7	3	10.7	20.6	5.3	5.0
Behavior change communication	8	4	8.5	30.1	6.4	5.0
Essential newborn care	8	4	6.3	15.2	6.3	5.0
Health System Strengthening Topics						
Quality improvement	6	3	10.0	20.3	5.3	5.0
Program management	2	1	6.0	25.0	2.0	5.0
Office management	4	2	7.0	37.3	3.0	5.0
Reporting	2	2	10.0	25.0	4.5	5.0
Monitoring and supervision	8	4	2.8	25.0	3.3	5.0
Supportive supervision/mentoring	6	2	2.5	25.0	5.5	5.0
Digital health	2	1	14.0	25.0	7.0	5.0
Record-keeping	4	2	8.0	25.0	4.5	5.0
Management and leadership	5					
Financial management	4					
Training Methods						
E-learning	5	2	10.0	25.0	4.5	5.0
Computer training	1					

This TNA also reviewed the Training, Research, and Development (TRD) Operational Plan of the 4th Health, Population and Nutrition Sector Programme (HPNSP), which is implemented by NIPORT. The TRD Operational Plan includes the following activities:

- Basic training (for FWVs, FWAs, FPIs, and HAs)
- Orientation training (for newly recruited MOs(MCHFP), UFPOs, AFPOs and SACMOs
- Refresher (in-service) training (for program managers, paramedics, and field workers)
- Reproductive and child health training (for MOs, paramedics, and field workers)
- Skills development training (for community skilled birth attendants, CHCPs, paramedics, and field workers)
- Efficiency and capacity development training (for program managers, MOs, and field supervisors)
- e-Governance training for NIPORT faculty
- Capacity development (in-country and abroad) for the training faculty
- Revision of curriculum and instructional materials
- Training monitoring and follow-up

The TRD Operational Plan states that the following topics are included in the basic, orientation, and refresher trainings:

- Counseling training
- IUD and infection prevention training
- Comprehensive newborn care training
- Early childhood development training
- Midwifery skills practice training
- Management training
- Computer training
- ToT

Training Load of FP-Related Methods and Services of the Surveyed Training Institutes

Only four training institutes out of ten reported that they had arranged any training on FP services and methods in the last year. In addition, of these four training institutes, only two had provided basic training in the last year, while three had provided refresher training in the last year. About the basic trainings, each training institute trained on an average of 3.5 batches of participants on short-acting FP methods and an average of six batches on long-acting reversible and permanent methods of FP. In terms of the refresher trainings, on average, each training institute trained 1.8 batches on short-acting FP methods and 4.3 batches on long-acting reversible and permanent FP methods.

Table 31: Detailed Information about the Basic and Refresher Trainings Provided on Different FP Methods and Services in the Last Year (January–December 2018) (n=4)

Training Topics	Average Number of Batches Trained by Each Institute	Average Number of Participants in Each Batch	Average Duration of Training (in Days)
Basic and Practicum Training			
Short-Acting Methods	3.5	25.0	5.0
Long-Acting Reversible and Permanent Methods			
IUD insertion/removal	6.0	18.9	5.0
Implant insertion/removal	6.0	18.9	5.0
Tubectomy	6.0	18.9	5.0
NSV	6.0	18.9	5.0
Last FP Refresher Training			
Short-Acting Methods	1.8	25.0	5.0
Long-Acting Reversible and Permanent Methods			
IUD insertion/removal	4.3	16.2	5.0
Implant insertion/removal	4.3	16.2	5.0
Tubectomy	4.3	16.2	5.0
NSV	4.3	16.2	5.0

Surveyed Training Institutes' Capacity to Provide Training

Table 30 shows the staffing strength of the training institutes in terms of having in-house trainers for different FP methods. It shows that only one out of ten training institutes had an in-house trainer to conduct trainings on counseling, while the other institutes provided this training by both in-house and outsourced trainers. In terms of providing training on short-acting FP methods, three institutes provided training on injectables only by outsourced trainers, while five institutes provided training using both in-house and outsourced trainers. In terms of providing training on long-acting reversible and permanent FP methods, the table shows that three out of ten training institutes provided training on IUD insertion/removal, implant insertion/removal, tubectomy, and NSV using only outsourced trainers, while six or seven training institutes provided training using both in-house and outsourced trainers. The table also shows that two out of ten training institutes provided training on AYFS and gender-responsive FP services, with both using only outsourced trainers.

Table 32: Types of Trainers at the Training Institutes who Provide Trainings on Different FP Methods and Services (n=10)

Training Topic	Training Provided Only by In-house Trainers	Training Provided Only by Outsourced Trainers	Training Provided by Both In-House and Outsourced Trainers
Counseling			
Counseling	1	2	6
Short-Acting Methods			
Oral contraceptive pill		2	6
Condom		2	6
Injectables		3	5
LAM		2	6
Long-Acting Reversible and Permanent Methods			
IUD insertion		3	7
IUD removal		3	7
Implant insertion and removal		3	7
Tubectomy		3	6
NSV		3	6
Other Services			
PAC FP		3	5
Infection prevention		3	6
AYFS		2	5
Gender-responsive FP services		2	4

Table 32 shows the average number of in-house and outsourced trainers at each training institute who were trained on different training methodology-related topics. It should be noted that the data regarding the in-house trainers were influenced by one outlier training institute that has 40 in-house trainers. Thus, the averages were calculated both with and without this outlier. Furthermore, five out of the ten training institutes could not provide outsourced trainer-related information. Thus, for calculating the averages regarding the outsourced trainers, five training institutes were considered instead of ten.

The table shows that these training institutes depended heavily on outsourced trainers. While an average of 3.3 in-house trainers per training institute were trained on applying principles of adult learning, 17.4 outsourced trainers on average were trained on this topic. The table also shows that on average, three in-house trainers were trained on different aspects of training methodology-related topics, while more than ten outsourced trainers were trained on these same topics.

Table 33: Distribution of Training Institutes' Capacity in Terms of Having In-House and Outsourced Trainers who are Trained on Training Methodology-Related Topics

Training Methodology-Related Topic	In-House Trainers			Outsourced Trainers*		
	Average Number of Trainers per Training Institute	Average Number of Trained Trainers per Training Institute	Average Number of Untrained Trainers per Training Institute	Average Number of Trainers per Training Institute	Average Number of Trained Trainers per Training Institute	Average Number of Untrained Trainers per Training Institute
Apply principles of adult learning	7.0 (3.3) **	6.9 (3.2)	0.1	17.4	17.4	0.0
Pedagogy	7.0 (3.3)	6.9 (3.2)	0.1	16.4	16.4	0.0
Design training course	6.6 (2.9)	6.4 (2.7)	0.2	12.4	12.4	0.0
Develop training materials (adapt and write learning objectives, develop session plans)	6.8 (3.1)	6.4 (2.7)	0.4	10.4	10.4	0.0
Interactive skills	6.5 (2.8)	6.4 (2.7)	0.1	10.6	10.6	0.0
E-learning	6.9 (3.2)	6.7 (3.0)	0.2	10.4	10.4	0.0
Develop knowledge, skills, and attitudes assessment tools	7.0 (3.3)	6.4 (2.7)	0.6	12.4	12.4	0.0
Training monitoring and evaluation tools	6.9 (3.2)	6.3 (2.6)	0.6	7.6	7.6	0.0
Facilitation skills	7.0 (3.3)	6.8 (3.1)	0.1	12.4	12.4	0.0
Use training session plans	7.0 (3.3)	6.9 (3.2)	0.1	12.4	12.4	0.0
Use competency-based training methods	7.0 (3.3)	6.8 (3.1)	0.2	12.4	12.4	0.0
Use PowerPoint and teaching aids	6.5 (2.8)	5.9 (2.1)	0.6	12.4	12.4	0.0
Conduct clinical practicum training	6.5 (2.8)	6.3 (2.6)	0.2	10.4	10.4	0.0
Training follow-up using competency/skills checklists	6.5 (2.8)	6.3 (2.6)	0.2	10.4	10.4	0.0
Monitor and evaluate learning (knowledge, skills, and attitudes) and modify learning to meet the participants' learning needs	6.5 (2.8)	6.3 (2.6)	0.2	10.4	10.4	0.0
Modify learning to meet the participants learning needs	6.5 (2.8)	5.5 (1.7)	1.0	10.4	10.4	0.0
Prepare training reports – initial and follow-up training	6.4 (2.7)	5.6 (1.8)	0.8	10.4	10.4	0.0
Supportive supervision/mentoring	6.5 (2.8)	5.3 (1.4)	1.2	10.4	10.4	0.0

*Five out of ten training institutes could not provide any data on the outsourced trainers

**One training institute should be considered an outlier, as it has 40 trainers. The figures in brackets are the averages without this outlier training institute.

The data presented in Tables 6.6 and 6.7 clearly show that the surveyed training institutes depended largely on outsourced trainers. Approximately one-third of the training institutes were fully dependent on outsourced trainers because three out ten training institutes had vacancies in key training-related faculties. Table 34 shows that the position of lecturer in the social sciences was vacant in three out of ten training institutes and that this position had been vacant for 14 years on average. Moreover, the training officer position had been vacant in three training institutes for 8.5 years on average. This vacancy issue was also reflected in the qualitative data. For example, an official from NIPORT said:

> "Manpower is a big challenge. We have vacancy in every position. Actually, we did not have a recruitment rule for long time and thus we could not recruit many vacant positions until 2016. For example, in the NIPORT HQ, the positions of five Senior Instructor is vacant, one Instructor position is vacant, one Deputy Director position is vacant. Thus, we have to mostly rely on the outsourced trainer. On the other hand, training opportunity for skill development among the NIPORT trainer is also limited."

Table 34: Distribution of Training Institutes' Trainer Vacancies

Name of Vacant Position	Number of Training Institutes in Which there is a Vacancy	Average Number of Years of Vacancy Per Institute
Home economist	2	18.5
Lecturer in the social sciences	3	14.0
Medical lecturer	2	7.5
Training officer	3	8.5
Assistant trainer	1	2.0
Lecturer in nursing and midwifery	3	11
Lecturer in primary health care	2	6.3
Nurse midwife	3	14.7
Field trainer	1	4.0

The survey of the training institutes showed that four out of ten training institutes did not prepare a training calendar for implementing training-related activities. The remaining six training institutes implemented their training calendars for 2018 and also prepared a calendar for 2019 (data not shown). This TNA explored the process of preparing and implementing a training calendar and found that the TRD Operational Plan includes a five-year (January 2017–June 2022) plan for implementing its training-related activities. Table 35 shows the TRD Operational Plan's targets under the 4th HPNSP.

Table 35: Activity Targets of the TRD Operational Plan (January 2017–June 2022)

Sl No.	Training Topic	Number of trainees (Target)
1	Basic training for FWVs, FWAs, FPIs, and HAs	6,245
2	Orientation training for MOs, FPOs, and SACMOs	3,150
3	Refresher training for FWVs, FWAs, FPI, HAs, and SACMOs	28,000
4	Reproductive and child health training for MOs, nurses, FWVs, and SACMOs	9,500
5	Clinical management for nurses, FWVs, FWAs, SACMOs, and HAs (female [F])	1,368

SI No.	Training Topic	Number of trainees (Target)
6	Management training for program managers [civil surgeons, DDs (FP), deputy civil surgeons, ADs (FP), etc.], staff, FPIs, health inspectors, assistant health inspectors, and sanitary inspectors	10,575
7	e-Governance training for NIPORT faculty	461
8	Water, sanitation, and hygiene training for MOs, nurses, FWVs, FWAs, SACMOs, and HAs (F)	5,350
9	Gender and leadership training for program managers and MOs	300
10	Instructional system design training for NIPORT faculty	650
11	Capacity development training for NIPORT faculty	108
12	In-country training or NIPORT faculty and other relevant activities	20
13	Pre-service training for government/nongovernment personnel	525
14	Preparing, upgrading, and revising curriculum and instructional materials	24
15	Training aids	1,652
	Total	**67,928**
	Source: Program Implementation Plan of 4th HPNSP (Vol. I), p. 273	

The analysis of the qualitative data shows that NIPORT has adopted a top-down approach in terms of preparing and implementing the training calendar. As one of the senior NIPORT officials stated:

> "NIPORT headquarters prepares the training plan. For example, now we are planning training plan for the next fiscal year (2019-2020). We have drafted how many trainings will be there, on what topic and who will participate. We will send this training plan to RTC and FWVTI/RPTI. Then RTC and FWVTI/RPTI will request the respective Deputy Director (Family Planning) or Civil Surgeon to send the required training participants. RTC and FWVTI/RPTI do not select the training participants. It is the DD or CS who are selecting the training participants based on the request of the Training Officer of the RTC or Principal of FWVTI/RPTI."

This statement by the NIPORT official suggests that although some of the training institutes reported that they prepared the training calendar, this could not be the case, as the training plans were prepared by NIPORT HQ. However, this same official reported that NIPORT was trying to make the process participatory. He said:

> "We are developing the digital registration system (DRS). DRS will be a web-based system where we will place our training calendar. The potential participant will be able to show their interest of attending a particular training through this system."

Trainers' Competency in Developing and Delivering Competency-Based FP Training

Two sources of data were used to assess the trainers' competency at developing and delivering competency-based FP training. The first source was a capacity assessment of the training institutes that included interviews with the heads of those training institutes (either the training officers of the RTCs or the principals of the FWVTIs/RPTIs). These heads provided information on the proficiency of the trainers working at their respective institutes. This capacity assessment was conducted in ten

training institutes, and the findings are presented in Table 36. The second data source was a self-administered questionnaire of trainers on training management-related issues. A total of 25 trainers completed the questionnaire and the findings are presented in Table 37.

The heads of the training institutes perceived that both their in-house and outsourced trainers had good or excellent training skills in the following basic training areas: facilitation skills, applying principles of adult learning, using training session plans, using competency-based training methods, conducting clinical practicum trainings, training follow-up using competency/skills checklists, using PowerPoint and teaching aids, monitoring and evaluating learning (knowledge, skills, and attitudes), modifying learning to meet the participants' learning needs, and preparing training reports – initial and follow-up training.

However, the heads of the training institutes perceived that their trainers had inadequate proficiency in training management, knowledge and skill assessment areas. Some of these areas included: sending invitations to the right participants for the right training, budgeting, managing the training database, conducting on-the-job training and follow-up of clinical providers, developing FP clinical labs, selecting and developing practicum training sites, conducting on-the-job mentorship of clinical providers, and reporting on and using supervision findings.

Table 36: Heads of Training Institutes' Perceptions of Their Trainers' Proficiency with Different Training Skills (n=10)

Area of Proficiency	Perception of In-House Trainers			Perception of Outsourced Trainers		
	Inadequate	Good	Excellent	Inadequate	Good	Excellent
Basic Training						
Facilitation skills		6	4		5	4
Apply principles of adult learning		7	3		5	4
Use training session plans		5	5	4	5	
Use competency-based training methods		6	4		6	3
Conduct clinical practicum training	2	5	3		7	2
Training follow-up using competency/skills checklists	2	5	3		6	3
Use PowerPoint and teaching aids	2	5	3		5	4
Monitor and evaluate learning (knowledge, skills, and attitudes)		7	3		6	3
Modify learning objectives to meet the participants' learning needs	1	6	3		5	4
Prepare training reports – initial and follow-up training	2	6	2	2	5	2
Training Management						
Venue preparation		6	4	3	3	3
Invite right participants for the right training	3	4	3	2	2	5
Budgeting	3	4	2	6	1	2
Reporting	1	7	2	4	3	2

Area of Proficiency	Perception of In-House Trainers			Perception of Outsourced Trainers		
	Inadequate	Good	Excellent	Inadequate	Good	Excellent
Manage training database	5	3	2	5	2	2
Follow up with training participants	1	5	4	2	5	2
Monitor and evaluate training		6	4	2	5	2
Knowledge and Skills Assessment						
Pre- and post-knowledge testing	1	5	3	3	4	2
Skills and attitudes assessment of trainers and clinical providers	2	4	4	1	6	2
Use a variety of training methods – prepare questionnaires, case studies, problem-based questions, etc.	2	5	3	1	7	1
Evaluate training (oral)		7	3		7	2
Evaluate training (written)		7	3	3	5	1
Monitor training – prepare and use competency skills checklists for trainers, clinical providers, and mentors	2	7	2	1	6	2
Conduct on-the-job training and follow-up of trainers	2	6	2	2	6	1
Conduct on-the-job training and follow-up of clinical providers	8	2	1	2	5	1
Develop FP clinical labs	8	1		4	5	
Select and develop practicum training sites	3	5	2	2	5	2
Document training	4	5	1	4	4	1
Problem-solving skills		5	5		6	3
Supportive supervision		7	3		6	3
On-the-job mentorship of clinical providers	7	3		2	6	1
Report and use supervision findings	5	4	1	4	5	
Facilitate peer-to-peer collaborative learning		7	3		7	2

The trainers' self-reported knowledge and skills related to training are presented in Table 37. The findings were quite similar to those of their supervisors. For example, 28% of the trainers reported that their knowledge regarding the selection and development of clinical practicum training sites was inadequate, while 25% of trainers reported that their skills in conducting training follow-up were also inadequate. In addition, 20% of the trainers reported that their clinical practicum training skills are inadequate, and 21.7% reported that their e-learning facilitation skills were also inadequate. Overall, nearly two-thirds of the trainers reported that their training-related knowledge and skills were good, while another one-third reported their knowledge and skills were excellent.

*Table 37: Percentage Distributions of Trainers' Self-Reported Knowledge and Skills Related to Training (n=25) ***

Knowledge and Skills Related to Training	Inadequate (%)	Good (%)	Excellent (%)
Level of Knowledge and Skills of Training Methods			
Knowledge and application of adult learning principles (n=25)	8.0	68.0	24.0
Knowledge of selecting and developing clinical practicum training sites (n=25)	28.0	44.0	28.0
Knowledge of the problem-solving process (n=25)	8.0	60.0	32.0
Knowledge of formulating training goals and SMART[3] learning objectives (n=24)	8.4	66.6	25.0
Knowledge of the role of a trainer (n=24)	4.2	54.2	41.7
Knowledge of group process/dynamics (n=24)		62.5	37.5
Knowledge of how to use both verbal and non-verbal communication (n=24)	4.2	70.8	25.0
Skills in conducting training follow-up (n=24)	25.0	54.2	20.8
Skills in writing training reports (n=24)	12.5	37.5	33.3
Level of Communication to Express Feelings			
Knowledge of how to provide praise and encouragement in training (n=25)	4.0	60.0	36.0
Knowledge of how to provide feedback (n=25)	12.0	64.0	32.0
Comfort with giving negative feedback (n=25)	4.0	72.0	24.0
Knowledge of how and when to use open- and closed-ended questions (n=25)	16.0	64.0	32.0
Level of Skills in Designing and Using Training Methods			
Small group discussion (n=24)		62.5	37.5
Demonstration/return demonstration (n=24)	8.3	62.5	29.2
Field trips (n=24)	4.2	60.5	32.0
Classroom simulation (n=22)	4.5	72.7	22.7
Case studies (n=23)	4.3	60.8	34.8
Clinical practicum training (n=20)	20.0	48.0	16.0
Large group discussion (n=23)	4.3	60.8	34.8
Role-play (n=22)	4.5	72.7	22.7
Lecture (n=24)	12.5	87.5	
Group work (n=23)		52.1	47.8
Level of Competency to Design Training			
Design training course (n=23)	8.7	43.5	44.0
Use TNA findings to develop training materials (n=23)		73.9	26.1
Adapt or write learning objectives (n=23)		56.5	43.5
Develop session plans (n=23)		60.9	39.1
Develop knowledge, skills, and attitudes assessment tools (n=22)		68.1	31.8
Develop training, monitoring, and evaluation tools	9.0	54.5	36.4

[3] SMART = Specific, Measurable, Achievable, Realistic, Time-Bound

Knowledge and Skills Related to Training	Inadequate (%)	Good (%)	Excellent (%)
Facilitation Skills for Learning			
Interactive skills (n=24)		45.9	54.2
Use competency-based training methods (n=24)	4.2	58.3	37.5
Pedagogy (n=23)		56.5	43.5
E-learning (n=23)	21.7	47.8	30.4

For some statements/items, 'n' is less than the sample size due to non-response of trainers

Facilities Inventory of the Training Institutes

The heads of the training institutes provided information regarding the availability of space and resources at their facilities. Table 38 shows that the surveyed training institutes had moderate to good physical infrastructure. However, the training institutes lacked clinical practice facilities and the required dummies and models for practicums. The findings of this inventory assessment show that the training institutes were inadequately prepared to provide clinical trainings and classroom practicums.

Table 38: Distribution of Available Facilities, Required Resources, and Infrastructure at the Surveyed Training Institutes (n=10)

Facilities/ Infrastructure	Available	Training Logistics	Available
Training classroom	9	Multimedia projector	10
Trainers' room	10	Screen	10
Skill labs or demonstration rooms	5	Sound system	8
Library	4	Computer/laptop	10
Computer lab	3	Easel board	10
Meeting room	9	Pointer	6
Trainers' chair	8	Whiteboard	8
Trainers' desk	7	Wall clock	10
Adequate participants chair	9	Adequate board marker	10
Availability of male toilet	7	**Required Dummies, Anatomic Models, and Tools for Practicums on FP**	
Availability of female toilet	6	Penile model	2
Students/Trainees dormitory	7	Arm model	3
Trainers dormitory	5	Pelvic model	4
Dining space	10	Tubectomy set	3
Instant power supply	6	NSV set	3
Generator	2	Joye model	0
Access to Internet/Wi-Fi	9	Blood pressure machine	2
Air conditioning	6	Adult weighing scale	3
Fans	7	Stethoscope	1
Electricity sockets	8	Thermometer	3

Table 39 shows the training management capacity of the surveyed training institutes. It shows that all the surveyed training institutes had the capacity to conduct training needs assessments, while nine out of ten training institutes had the capacity to develop a training schedule. However, only three training institutes had the capacity to develop training manuals/curricula and/or adapt training curricula.

Table 39: Training Management Capacity of Surveyed Training Institutes (n=10)

Aspects of Training Management Capacity to:	Available
Manage training information	8
Conduct training needs assessment	10
Develop training schedule	9
Develop training manuals/curricula	3
Adapt training curricula	3
Develop a training evaluation plan	4

Challenges, Bottlenecks, Strengths, and Priority Areas of the Training Institutes

To generate qualitative data, the heads of the training institutes were asked to comment on the areas in which they thought the training institutes needed to improve. The comments they provided were analyzed and are summarized in Table 40. The areas in need of improvement were leadership and governance, external relations, trainer-related issues, trainee-related issues, and evaluation and knowledge management.

Table 40: Training Institutes' Areas for Improvement

Dimensions	Areas for Improvement
Leadership and governance	• Continuation of conducting training needs assessment • Increasing the quality of education • Increasing the availability of regular training officers • Improving interpersonal skills
External relations	• Improving networking • Arranging coordination meetings with relevant stakeholders • Arranging monthly meetings with stakeholders
Trainers	• Providing counseling and motivational training • Ensuring friendly instruction in the training • Determining work based on the skills of the trainer • Arranging ToTs • Recruiting to fill vacant positions
Trainees	• Changing the behavior and mindset of the trainees • Improving ways of learning • Inviting trainees by rotation • Improving selection of trainees to reduce repeats
Evaluation and knowledge management	• Evaluating trainers • Evaluating courses • Conducting pre- and post-tests • Conducting pre- and post-monitoring • Developing a training management information systems

CHAPTER SEVEN: ON-THE-JOB TRAINING, (SUPPORTIVE) SUPERVISION AND MENTORING

This section provides the findings on receiving on-the-job training, training during supervisory visits by higher officials, e-learning, and mentorship.

FP Service Providers' On-The-Job Training[4]

Table 41 shows that 49.5% of the FWVs have received on-the-job training sometime in their careers, while more than two-thirds of the MOs, midwives, SACMOs, and FWAs did not receive on-the-job training. The rate of not receiving on-the-job training was highest among CHCPs (93.6%).

Table 41: Percentage Distribution of FP Service Providers Ever Having Received On-the-Job Training

Receiving on-the-job training	MO (n=39)	FWV (n=101)	Midwife (n=22)	SACMO (n=46)	FWA (n=238)	CHCP (n=47)
Yes	33.3	49.5	27.3	26.1	35.7	6.4
No	66.7	50.5	68.2	71.7	63.4	93.6
Don't know			4.5	2.2	0.8	

Table 42 shows the particular FP methods on which the providers received on-the-job training in the first half of last year (January–June 2018). It shows that nearly one fifth of the FWVs and FWAs surveyed and only 7.7% of MOs had received on-the-job training on counseling. Moreover, 23.1% of MOs reported that they had received on-the-job training on IUD insertion/removal and implant insertion/removal, while only 15.4% had received on-the-job training on tubectomy and NSV.

Table 42: Percentage Distribution* of FP Service Providers Receiving On-The-Job Training on Different FP Methods in the First Half of Last Year (January–June 2018)

Methods on Which FP Service Providers Received On-The-Job Training	MO (n=13)	FWV (n=50)	Midwife (n=6)	SACMO (n=12)	FWA (n=85)	CHCP (n=3)
Counseling						
Counseling on FP methods	7.7	22.0	16.7	25.0	20.0	33.3
Short-Acting Methods						
Injectables		18.0		16.7	22.4	
Long-Acting Reversible and Permanent Methods						
IUD insertion/removal	23.1	32.0		16.7		
Implant insertion/removal	23.1					
Tubectomy	15.4					
NSV	15.4					

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[4]*On-the-job training is defined as an employee receiving training at his/her place of work while he/she is doing his/her actual job. Usually a professional trainer (or sometimes an experienced employee) serves as the course instructor, using hands-on training often supported by formal classroom training.*

Methods on Which FP Service Providers Received On-The-Job Training	MO (n=13)	FWV (n=50)	Midwife (n=6)	SACMO (n=12)	FWA (n=85)	CHCP (n=3)
Infection prevention		14.0	16.7	8.3		
Other FP Services						
PPFP	23.1	24.0	16.7	33.3	35.3	33.3
AYFS	7.7	20.0		16.7	8.2	
PAC FP	7.7	8.0				
Gender-responsive FP services		2.0		16.7		

Multiple responses

Supervisory Visits of The FP Service Providers

Supervision of the FP Service Providers

Figure 41 shows that all the FP service providers were being supervised at their workplace. However, the figure shows that the frequency of the supervision varies by cadre. The lowest rate of supervision was found among the MOs.

Figure 5: Percentage Distribution of FP Service Providers

Table 43 shows that the majority (72.7%) of midwives were supervised daily, while 64.3% of FWAs were supervised weekly. In contrast, MOs, FWVs, SACMOs, and CHCPs were mostly supervised monthly.

Table 43: Percentage Distribution* of the Frequency of FP Service Providers' Supervision at Their Workstation

Frequency of Supervision	MO (n=31)	FWV (n=100)	Midwife (n=22)	SACMO (n=43)	FWA (n=236)	CHCP (n=47)
Daily	20.0	24.2	72.7	11.6	12.8	2.1
Weekly	16.7	25.3	18.2	20.9	64.3	10.6
Fortnightly	13.3	15.2	13.6	16.3	22.6	21.3
Monthly	46.7	45.5		62.8	18.3	63.8
Quarterly	3.3	5.1		2.3	0.9	14.9
Annually	3.3					2.1

multiple responses

Figure 6 shows that the percentage of FP service providers receiving training during a supervisor's field visit was highest among FWVs, FWAs, and midwives. More than half of these FP service providers

reported receiving training during a supervisor's field visit. In contrast, the percentage of MOs, SACMOs, and CHCPs receiving training during a supervisor's field visit was low.
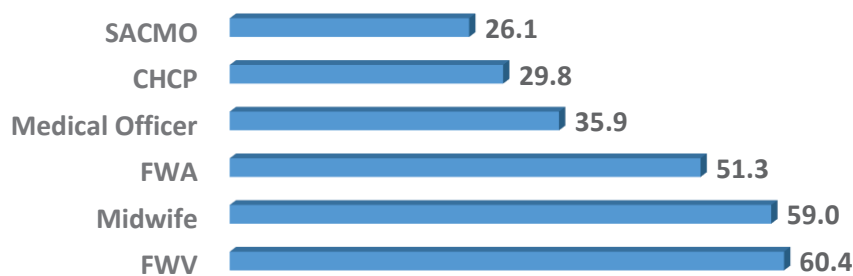

Figure 6: Percentage Distribution of FP Service Providers Receiving Training During a Supervisor's Field Visit

Supportive Supervision[5] of the FP Service Providers

The use of a checklist is an important tool used in conducting supportive supervision. Table 44 shows that 72.3% of CHCPs reported that their supervisor had used a checklist during their field visit, followed by FWAs (72%) and FWVs (57%). The percentage of providers who reported that their supervisor used a checklist during supervision was lowest among midwives (27.3%), followed by MOs (29%), and SACMOs (41%).

Table 44: Distribution of FP Service Providers Reporting That the Supervisor Used a Checklist During Their Field Visit

Use of Checklist by Supervisor During Their Visit	MO (n=31)	FWV (n=100)	Midwife (n=22)	SACMO (n=43)	FWA (n=236)	CHCP (n=47)
Yes	29.0	57.0	27.3	41.0	72.0	72.3
No	67.7	43.0	63.6	55.8	27.5	21.3
Can't recall	3.2		9.1	2.3	0.4	6.4

Figure 7 shows the percentages of FP service providers who asked work-related questions of their supervisors during their visits. Among the FP service providers who had been visited by their supervisor, nearly 70% of the MOs had asked a question, while all the midwives and CHCPs, and almost all the FWAs and FWVs, had posed questions to their supervisor. The figure also shows that more than 90% of FWAs, FWVs, midwives, and CHCPs asked for any support from their supervisor to facilitate their work, while only 69.2% of MOs sought support from their supervisors.

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[5] *Supportive supervision is a process of helping staff to continuously improve their own work performance. It is carried out in a respectful and nonauthoritarian way, with a focus on using supervisory visits as an opportunity to improve the knowledge and skills of health staff (Ref needed).*

Asked Supervisor Any Questions Related to Work
Ask Supervisor for Any Support to Facilitate Your Work

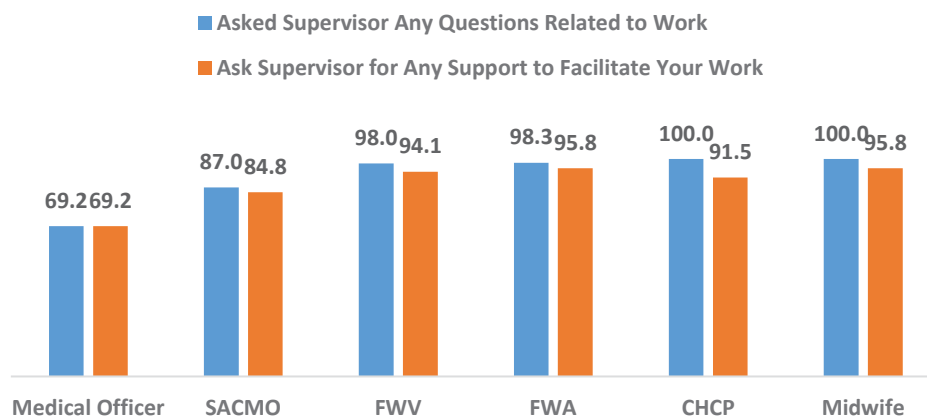|	Medical Officer	SACMO	FWV	FWA	CHCP	Midwife
Asked Questions	69.2	87.0	98.0	98.3	100.0	100.0
Ask Support	69.2	84.8	94.1	95.8	91.5	95.8

Figure 7: Percentage Distribution of FP Service Providers who Asked Questions of Their Supervisors During Their Visit and who Asked Their Supervisors for Any Support to Facilitate Work

Table 45 shows that among the FP service providers who had asked questions of the supervisors during their visits, the cadre that most reported that they always got an answer from their supervisor was that of MOs (85.2%), followed by SACMOs (82.5%), FWVs (77.8%), midwives (77.3%), FWAs (70.9%), and CHCPs (61.7%), although the rate of asking questions was higher among the midwives, CHCPs, FWAs, and FWVs (Figure 7).

Table 45: Percentage Distribution of FP Service Providers Getting Answers to the Questions They Asked of Their Supervisor

Get Answer from Supervisor	MO (n=27)	FWV (n=99)	Midwife (n=22)	SACMO (n=40)	FWA (n=234)	CHCP (n=47)
Yes, always	85.2	77.8	77.3	82.5	70.9	61.7
Yes, sometimes	14.8	21.2	22.7	17.5	28.6	38.3
Never		1.0			0.4	

Table 46 shows that among the FP service providers who had asked for support, 77.8% of MOs reported always receiving support from their supervisors, followed by SACMOs (74.4%), FWVs (70.5%), FWAs (68.9%), midwives (66.7%), and CHCPs (60.5%).

Table 46: Percentage Distribution of FP Service Providers Getting Support from Their Supervisor to Facilitate Their Work

Get Support from Supervisor	MO (n=27)	FWV (n=95)	Midwife (n=21)	SACMO (n=39)	FWA (n=228)	CHCP (n=43)
Yes, always	77.8	70.5	66.7	74.4	68.9	60.5
Yes, at times	22.2	28.4	33.3	23.1	30.7	39.5
Never		1.0		2.6	0.4	

The topic of supportive supervision was also explored qualitatively. The qualitative data suggest that the concept was new to the FP service providers and that most did not fully understand it. However, some FWVs and SACMOs did have some understanding of supportive supervision. For example, an FWV from Mymensingh reported that she heard about supportive supervision. She said:

> *"I know about supportive supervision. Our MO (MCH) provides supportive supervision. She never said anything negative. She always thinks about how we can improve our work. We don't get scared whenever she is visiting us. She never said that we did*

something faulty. She never said that we did something incorrect. Rather she will say, what we have done is good, but she will provide suggestions to do that work in a better way. If she sees anything wrong, she will correct me."

Receiving Feedback from the Supervisors' Field Visits

Figure 8 shows that except for MOs, approximately nine out of ten service providers received feedback from the supervisor's field visit. In contrast, only about three-fifths of MOs received feedback from the supervisor's field visit. Table 47 shows that around 43% of FWAs and CHCPs received feedback from their supervisor through writing in their registrar, while approximately a quarter of FWAs received feedback over the phone. The FWAs also reported receiving feedback directly from face-to-face conversations and CHCPs through written comments in the community clinic's visiting book; these feedback modalities were included in the 'Others' option.

Figure 8: Percentage Distribution of FP Service Providers Receiving Feedback from Their Supervisors' Field Visit

Table 47: Percentage Distribution of Supervisory Feedback Modalities as Reported by FP Service Providers

Modality of Reporting Supervisory Feedback	FWA (n=238)	CHCP (n=40)
Over the phone	25.4	15.0
Mobile SMS	1.7	2.5
Writing in the registrar	42.2	45.0
Letter to the directorate	0.4	
Others	38.8	50.0

multiple responses

FP Service Providers Receiving Training from Someone Besides Their Supervisor During Field Visits

Table 48 shows the people other than FP service providers' supervisors who provided training during the field visit. It shows that 68.9% of SACMOs reported that there were no such visits by any such person, followed by CHCPs (68%), MOs (66.7%), and FWAs (54.2%). In contrast, 50% of midwives reported that they had been visited by their senior technical supervisors. The table shows that over 10% to 19% of respondents reported 'Others' as their response; in this category, the following responses were given: 'do not know,' 'cannot remember,' and 'visited by nongovernmental organization officials.'

Table 48: Percentage Distribution of FP Service Providers Reporting on Receiving Training from Someone Other Than Their Supervisor During the Field Visit

The Non-Supervisor Who Visited the FP Service Provider During the Field Visit	MO (n=39)	FWV (n=101)	Midwife (n=22)	SACMO (n=46)	FWA (n=238)	CHCP (n=47)
Trainer		3.0			2.5	
Senior technical supervisor	13.9	39.6	50.0	17.8	33.6	21.3
Nobody ever visited	66.7	49.5	36.4	68.9	54.2	68.0
Others	19.4	11.0	13.6	15.6	11.3	10.7

Table 49 shows the line of technical supervisors of the FP service providers who were interviewed in this TNA. The major technical supervisor cadres are: ADCC, FPCS QIT, MO (MCH-FP), Upazila Health and Family Planning Officer, and FPI. Midwives included in the positions of senior staff nurse and nursing superintendent in the 'Others' option, while CHCPs included as assistant health inspector and health inspector as 'Others.' The rate of responses indicates there is not always a consistent supervisory structure for each cadre. For example, FWAs reported many different supervisors.

Table 49: Percentage Distribution of the People Whom the FP Service Providers Reported as Their Technical Supervisor

People Whom the FP Service Providers Reported as Their Technical Supervisor*	MO (n=35)	FWV (n=99)	Midwife (n=18)	SACMO (n=40)	FWA (n=231)	CHCP (n=36)
Civil surgeon	11.4					
DD (FP)	8.6					
ADFPO	8.6					
AD (CC) / FCPS QIT	48.6					
MO (CC)		3.0				
Senior Consultant (Gyn)	2.9		11.1			
MO (MCH-FP)		51.5	11.1	70.0	13.0	5.6
MO (Clinic)		13.1	11.1	7.5	2.6	2.8
MO (FW)		7.1		7.5	3.9	
Junior Consultant (Gyn)		1.0	11.1			
Upazila health and family planning officer		1.0	5.6	7.5	1.3	22.2
UFPO		2.0		2.5	2.2	2.8
Assistant UFPO		1.0			2.6	
Assistant FWO		11.1			0.9	
Midwife					0.4	
FPI					58.0	
SACMO					2.2	
Others	18.0	9.1	50.0	5.0	12.6	66.7

FP Providers Receiving Orientation on FP Services during Fortnightly/Monthly Meeting

Figure 9 shows that most of the FWVs, FWAs, and SACMOs have an orientation on FP services during their fortnightly/monthly meeting. The figure shows that the cadre with the highest percentage receiving orientation on FP services was that of FWVs (86%), followed by FWAs (79%), SACMOs (61%), and CHCPs (51.1%).
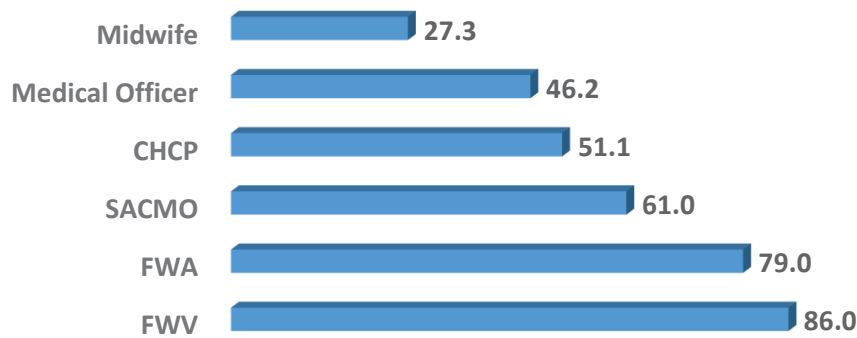

Figure 9: Percentage Distribution of FP Service Providers who Received Orientation on FP Services during Quarterly/Monthly Meeting

Mentoring Practice and Opportunity Among the FP Service Providers

Mentoring is a system of guidance whereby one person shares his/her knowledge, skills, and experience to assist others with progressing their lives and careers. Mentors are normally readily accessible and prepared to offer help as the need of the mentee arises. David Clutterbuck (2004) has coined an acronym for what mentors do: **M**anage the relationship; **E**ncourage; **N**urture; **T**each; **O**ffer mutual respect; and **R**espond to the learner's needs[6]. As such, mentoring is more than just a means of providing guidance. It is a kind of relationship—one that is very difficult to measure. Thus, this TNA used some proxy questions to assess the practice of mentoring among the FP service providers and their supervisors and trainers.

Table 50 shows the FP service providers' responses regarding what they did when their clients ask a question that they (the FP service providers) could not answer. It shows that 70.2% of FWVs reported that they asked their supervisors for the answer. Midwives, SACMOs, FWAs, and CHCPs asked their supervisors, colleagues, and senior technical officials for answers, while MOs also searched answers of the questions on the Internet. Some of the MOs also reported that they knew everything (implying they do not need to solicit outside help), that they used reference books, and that they solicited answers from gynecologists—these responses were included in the 'Others' category. In addition, some CHCPs also asked questions of the Upazila Health and Family Planning Officer, which was included in the 'Others' response category.

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[6] Clutterbuck, D. (2004). *Everyone Needs a Mentor: Fostering Talent in Your Organization.* London: Chartered Institute of Personnel and Development

Table 50: Percentage Distribution* of FP Service Providers' Responses Regarding What They Do When a Client Asks a Question, They Cannot Answer

Responses	MO (n=39)	FWV (n=101)	Midwife (n=22)	SACMO (n=45)	FWA (n=238)	CHCP (n=47)
I ask my supervisor for the answer	28.2	66.3	59.1	60.0	70.2	59.6
I ask my colleague for the answer	20.5	39.6	59.1	17.8	48.3	32.0
I ask senior technical officials for the answer	15.4	27.7	31.8	26.7	24.8	19.1
I search the Internet to get the answer	28.2		4.5	2.2	0.4	4.3
I scold/yell at the client						19.1
I skip/avoid the question		2.0		4.4	2.1	6.4
Refer clients	5.1	6.0	9.1	6.7	5.9	59.6
Others	20.5	3.0	4.5	4.4	4.6	32.0

multiple responses

Table 51 shows the responses of the FP service providers regarding what they did if they faced complicated FP cases while providing services. It shows that FP service providers mainly preferred to contact their supervisors, technical supervisors, and colleagues. FWVs and midwives also preferred to contact MOs, while MOs try to obtain information by searching the internet.

Table 51: Distribution* of FP Service Providers' Responses Regarding What Resources/People They Consult If They Face Complicated Cases While Providing FP Services

Persons FP Service Providers Contact	MO (n=35)	FWV (n=99)	Midwife (n=22)	SACMO (n=45)	FWA (n=238)	CHCP (n=44)
Supervisor	25.7	42.4	22.7	40.0	37.8	34.1
Technical supervisor	20.0	16.2	27.3	11.1	4.6	4.5
Colleague/peer	20.0	12.1	18.2	4.4	7.6	4.5
FWV		4.0	9.1	2.2	41.2	16.0
Senior FWV		3.0		2.2	4.6	6.8
MO	8.6	39.4	45.5	26.7	28.2	18.2
SACMO		1.0		2.2	3.8	2.3
Obstetric/Gynecological specialist	31.4	3.0	18.2		0.4	
Resources Consulted by FP Service Providers						
Reference books	2.9	1.0		4.4	0.4	
The Internet	25.7			2.2		
Others	20.0	9.1	9.1	13.3	10.5	29.5
Don't know	20.0			2.2	0.8	

multiple responses

The qualitative interviews suggested that the concept of mentoring was very new to FP service providers. Most frontline FP service providers had not heard of 'Mentoring' as its own concept; they mostly considered 'Mentoring' to be 'Monitoring'. This conversation between the interviewer and an FWA from Rangamati reflects this reality:

> *Interviewer: Have you heard about mentoring?*
> *FWA: Yes*
> *Interviewer: What is mentoring?*
> *FWA: Monitoring [respondent said monitoring not mentoring] is…. I am not able to tell this.*
> *Interviewer: Not monitoring. Mentoring. Mentoring is like do you like someone as Guru. Someone, who is expert, someone from whom you can learn, someone whom you can ask any question whenever you are in need.*
> *FWA: Oh, I can contact my FPI. My FPI cooperates me. I can talk to him on any work-related issues.*

CHAPTER EIGHT: E-LEARNING OPPORTUNITIES AND PRACTICE

This section provides findings on the experience of FP providers in using technology and their interest in participating in technology-enabled learning opportunities.

Possession of Information Technology (IT) Materials by the FP Service Providers

Table 52 shows which IT materials the FP service providers possess. More than 70% of midwives and CHCPs and 87% of MOs had a smartphone. In contrast, 63% of SACMOs and only approximately 40% FWVs and FWAs possessed a smartphone. This lower rate of smartphone possession might restrict the e-learning opportunities for those cadres. Moreover, while 70.2% of CHCPs reported that they possessed a laptop, these laptops were not personal laptops. Those were given to the CHCPs by their office and are kept in the community clinic.

Table 52: Percentage Distribution* of FP Service Providers Possession of IT Materials

IT Materials Possessed by FP Service Providers	MO (n=39)	FWV (n=101)	Midwife (n=22)	SACMO (n=46)	FWA (n=238)	CHCP (n=47)
Mobile phone (feature)	59.0	83.2	68.2	82.6	83.6	72.3
Smartphone	87.2	42.6	72.7	63.0	37.8	74.5
Tablet	28.2	1.0		2.2	2.1	8.4
Laptop	69.2	5.0	4.5	15.2	5.9	70.2
Computer	71.8	3.0	4.5	8.7	5.0	

*multiple responses

Communication Modality with Supervisors, Colleagues, and Clients

Table 49 shows the FP service providers' communication modality with their supervisors, colleagues, and clients for work purposes. It shows that more than eight out of ten FP service providers communicated with their supervisors by mobile phone for work purposes. The same situation existed for their communication with their colleagues and their FP services clients.

Table 53: Percentage Distribution of FP Service Providers' Communication Modality with Their Supervisors, Colleagues, and Clients for Work Purposes

Communication Modality of FP Service Providers	MO (n=39)	FWV (n=101)	Midwife (n=22)	SACMO (n=46)	FWA (n=238)	CHCP (n=47)
Communicate with Supervisor by Mobile Phone for Work Purposes						
Yes	87.2	98.0	86.4	100.0	97.5	93.6
No	12.8	2.0	3.6		2.5	6.4
Communicate with Colleagues by Mobile Phone to Discuss FP Services Provided						
Yes	89.7	100.0	100.0	93.5	97.9	100.0
No	10.3			6.5	2.1	
Communicate with FP Services Clients by Mobile Phone						
Yes	84.6	100.0	81.8	93.5	97.9	95.7
No	15.4		18.2	6.5	2.1	4.3

FP Service Providers' Attitudes Toward and Practices of Reading Work-Related Materials Online

Table 54 shows that 89.4% of CHCPs reported that they liked to read work-related materials online, as do most MOs (84.6%) and midwives (72.7%). In contrast, only one-third of FWVs and FWAs reported that they liked to read work-related materials online. However, the table shows that for some FP service providers, there was a gap between their attitudes toward reading work-related materials online and their actual practices. For example, of the 89.4% of CHCPs who reported liking to read materials online, only 59.6% of them actually did so. In contrast, the MOs who reported that they liked to read work-related materials online also reported reading work-related materials online.

Table 54: Percentage Distribution of FP Service Providers' Attitudes Toward and Practices of Reading Work-Related Materials Online

Attitudes vs. Practices Regarding Reading Materials Online	MO (n=39)	FWV (n=101)	Midwife (n=22)	SACMO (n=46)	FWA (n=238)	CHCP (n=47)
Want to Read Work-Related Materials on Mobile Phone/Tablet						
Yes	84.6	36.6	72.7	50.0	37.0	89.4
No	15.4	63.4	27.3	50.0	63.0	10.6
Have Ever Read Any Work-Related Materials on Mobile Phone/Tablet						
Yes	84.6	18.8	59.1	34.8	16.8	59.6
No	15.4	81.2	40.9	65.2	83.2	40.4

The issue of reading/checking any work-related materials online was also reflected in the qualitative data. An FWA from Faridpur explained how she uses Facebook for her work-related problems. She said:

> *"We have a Facebook page for FWAs and FPIs. Hundreds of FPIs and FWAs are following this page. Different people are writing on different issues. They report their experiences; they share their problems. They write about FP methods. They write about five danger signs in pregnancy. So many problems. It helps me a lot."*

Another FWA from Sylhet explained how she uses Facebook to learn about different methods of FP. She stated:

> *"I visit Shukhi Poribar page in Facebook. There are so many videos in this page. On different methods. You can see new video every day. How can an FWA counsel a newlywed couple by visiting door to door? What to do to delay the pregnancy? What method you should use currently? I see videos on these FP methods related topic."*

FP Service Providers' Willingness to Take Online Training Courses on FP Issues

Table 55 shows that CHCPs are the most willing to take online training courses on FP, with 81% reporting their willingness, followed by MOs (79.5%), FWAs (70.2%), midwives (68.2%), SACMOs (67.4%), and FWVs (65.3%).

Table 55: FP Service Providers' Willingness to Take Online Training Courses on FP-Related Issues

Willingness to Take Online Training on FP-Related Issues	MO (n=39)	FWV (n=101)	Midwife (n=22)	SACMO (n=46)	FWA (n=238)	CHCP (n=47)
Yes	79.5	65.3	68.2	67.4	70.2	81.0
No	20.6	34.7	31.8	32.6	29.8	19.0

The willingness of the different cadres to take online courses was also explored in the qualitative data. The following discussion between an FWV from Dhaka and the interviewer shows the willingness and effectiveness of online coursework.

The qualitative interview data show that older FP service providers who did not or could not use smartphones were relatively less willing to participate in this type of online training course than their younger, more smartphone-savvy counterparts. However, some frontline providers suggested that not having a smartphone would not be a barrier to doing this type of online course, if doing the course was mandatory for professional development. In this scenario, the provider would buy a smartphone and learn how to use it because taking the online course would be connected to professional achievement, e.g., securing a promotion or gaining certification in providing a specific FP method. This discussion between the TNA interviewer and a SACMO from Chattogram reflected this issue:

> *Interviewer: If there is a mobile phone based free online course available for you, what will be your opinion?*
> *SACMO: It will be effective. If you say you have to do this course. If you give me reward for this. If you say, OK, you want to do vasectomy. Your precondition for doing vasectomy will be that you have to complete this course online. You have to appear in the examination after completing the course. If you pass the course, then you can do the vasectomy. Then you will see that everyone is doing this course.*
> *Interviewer: Do you have any interest to do this type of course?*
> *SACMO: A lot.*
> *Interviewer: You said that you don't have any android/smartphone. Then how you will do this course?*
> *SACMO: No, I don't use android phone. But if my office is asking, then how long I'll say no? Ten years back, I was not even using phone. But now I am using phone to communicate in my office.*

An FWA from Sylhet described one advantage of online courses. She said:

> *"We go for training. They give us training. We come back to our job and apply the acquired knowledge. But it is fixed; we don't have any update of the knowledge. If it is online, then we can update ourselves every day."*

CHAPTER NINE: KEY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

Based on the findings presented in Chapters Two to Eight, this chapter presents a summary of key findings, conclusions and offers some recommendations on ways to strengthen the FP workforce and access to quality FP services.

Family Planning Health Workers: Education and Experience

Findings

- The recent cohort of frontline FP service providers are entering their jobs with more educational qualifications than is required for their position. Approximately 60% of the frontline FP service providers have more than 25 years of work experience. This implies that a significant number of service providers will retire soon and currently 40% of frontline FP service provider positions are vacant.

Recommendations

- The higher than required educational experience of frontline providers particularly FWAs and CHCPs reflects capacity for more complex training and therefore offers opportunity to review their scope of work and redesign training programs to expand their scope of work from the current resupply of oral Pills, reinjection of DMPA and supply of condoms. The FP program could also explore introduction of learning task sharing intervention to include additional tasks for this community based high educational entry level cadre.
- There is need for analysis of health worker registrars and planning for recruitment and deployment that is aligned with retirement to ensure that vacancies are filled immediately to reduce delays in filling vacancies and disruption in service provision due to retirement and delayed timely recruitment and deployment.

Family Planning Health Workers: Job Descriptions

Findings

- Job descriptions are important for health workers to guide expectations for health worker performance, deployment and to inform training as well as supportive supervision. The service providers' FP tasks for each cadre are not specifically written in their job descriptions. FP service providers, particularly frontline workers have incomplete knowledge of their job responsibilities hence the discrepancies between what is written in the FP service providers' job descriptions, the FP service providers' perceptions about the services they are supposed to provide, and the actual services they are providing. In addition the providers mentioned that they get information about their job responsibilities from many sources such as circulars, supervisors or during meetings, which seems to have created some confusion and contradiction.

Recommendations

- There is need for review of job descriptions to include all expected FP related tasks for each cadre and these should be disseminated in writing and orally during recruitment, on-boarding, training and supervision. Training and supportive supervision should be based on the providers' job expectations.

- Review of job descriptions should be accompanied with review of providers' career development pathways, should be reviewed and aligned to create opportunities and increase motivation.

Training of Service Providers and Confidence to Provide Services

Findings

- While providers expressed that their trainers were adequately prepared to conduct FP training, most mentioned that the training fell short in terms of practicum and adequate preparation for service provision in skills such as counseling. There were at times gaps between basic, which seemed to be mostly didactic and lack practicum training.
- A majority of providers received FP training during the basic training and most received their last FP refresher training at least five to ten years ago, depending on the FP method or service. At the same time, the providers expressed a high degree of perceived need for training.
- The FP service providers' higher-than-required level of education, their exposure to IT materials, and their willingness to take online training courses create opportunities for e-learning.

Recommendations

- Training Institutes need to develop training materials and rapidly deploy refresher training using a variety of blended training approaches to reach many providers within a reasonable and most efficient way such as low off-site and high frequency on-site learning, e-learning and mentorship and continuous education.
- A continuing medical education system should be developed for the FP service providers—one that incorporates updated training curricula, practical laboratory sessions, and teaching methods.
- The FP service providers' higher-than-required level of education, their exposure to IT materials, and their willingness to take online training courses create opportunities for e-learning.

Service Provision-Demand and Supply Side Factors

Findings

- Providers expressed lack of confidence in such critical tasks such as counseling, management of side effects for FWVs giving injections and infection prevention.
- Some providers due to barriers such as myths and misconception rergarding contraceptive methods and social norms limiting access to service provision for adolescent clients.
- Services such as PPFP, PAC-FP, Implant insertion and removal and permanent methods are underutilized either due to lack of provider training for PPFP and PAC-FP in particular lack of training of midwives who are key positioned to provide these services, Implant insertion and removal and tubal ligations limited only to the few trained medical officers who have other job responsibilities in addition to FP.
- Providers expressed that they face a number of challenges that hinder demand for FP services such as myths and misconceptions about FP methods, fear of side effects, this in turn contributes to low client load, affects performance and contributes to low confidence in performaing some of the FP tasks.

AYRH

- Few providers mentioned providing AYRH services and those providers provide services are not

aware of what constitutes a package of AYRH services. The provision of AYRH services is also restricted by the marital status of the adolescent. Thus, initiatives should be taken to prepare a complete package of AYFS that considers the marital status of the adolescent and the types of providers who serve adolescents.

- FP service providers expressed that they face challenges in terms of providing AYFS due to their lack of training and confidence in dealing with adolescent issues, lack of AYRH services at their facilities and the adults in some communities preventing the contact between providers and adolescent clients.

- FP service providers are not recording their clients' status as 'adolescent' due to the FP restriction of serving married adolescents only. Thus, the record-keeping system for all providers should be revised so that the client's status as an adolescent can be ascertained irrespective of his/her marital status.

Supervision

- There is a supervisiory system in place with a majority of providers coming into contact with their supervisor at least once a month. In addition there is in place a system for monthly meetings that seem to serve as sources of information. Supervisors though they were cited as a source of information but they are not using any standard checklists during supervision and not give feedback routinely after supervision.

Recommendations

Accelerate:

- Social behaviour change activities at community level and improving counseling skills among providers to generate demand, dispel rumours and misconceptions and increase provider confidence.

- Implement targeted training of providers for underutilized services such as midwives for PPFP and PAC-FP and to explore introduction and learning from task sharing initiatives to expand availability and method choice to include Implant insertion for example by FWV and SACMOs.

- Develop and disseminate a specific package of AYRH services to be provided at each level of health care from community to the highest facility level by cadre of health worker and to design training to prepare providers to deliver AYRH services.

- Supervision provides a great opportunity to improve and sustain porvider performance, address work related hindarences for quality of services and provide updates for providers as well as link other health systemss components that support service delivery. Supervison will therefore require strengthening to utilize standarized tools, standaridize on-site supportive supervision and reporting.

Capacity of Training Institutions to Conduct FP Training
Findings

- The Training Institutes rely on out-sourced trainers due to high trainer vacancies however there are no specific standards, guidelines and expectations for the selection and management of out-sourced trainers and linkages with in-house trainers to ensure standardization and quality of training.

- The competency of trainers to conduct training is generally self reported as good to excellent for

didactic classroom teaching. The assessment was based on head of Institute and trainer perceptions and not specific training standards. There were expressed limitations by both in-house and outsourced trainers to conduct practicum clinical training as well as follow-up of participants to support transfer skills and learning acquired during training to the job. Limitations in practicum training is further supported by providers who expressed that the practicum training did not adequately prepare them to be confident in performance of tasks such as counseling, management of side effects and to respond to clients' requests for information.

- Among the surveyed Training Institutes only 5 had conducted ToTs, only one had conducted a ToT in the last year prior to the TNA and very few have the capacity to develop or adapt training curricula and training plans, prepare training reports and use training information. In addition with so few of the Training Institutes conducting ToTs and only one ToT conducted in the last one year there did not seem to be any formal mechanisms for continuous knowledge and skills update of trainers in both clinical FP and training skills.

- An aspect of training management capacity included structuring of training activities and selection of participants for refresher, praticum and in-service training. Participants are selected for trainings through a top-down approach, such that the training needs of the participants often remain unfulfilled.

Recommendations

- The ideal would be to fill the trainer vacancies and rapid training of trainers, however this is often a long term solution as it involves other departments such as government Human Resources and willingness of potential employees to relocate for employment purposes. A short term recommendation would be to maximize utilization of out-sourced trainers. There is need to develop training standards and guidelines that include trainer profile for various FP trainings, streamline procedures for engagement of out-sourced trainers and clarify expectations for selection of out-sourced trainers for the various FP training, linkages with in-house trainers for complementarity as well as continuous learning for both trainers. This will help to standardize utilization of the limited numbers and training skills among in house and outsourced trainers and contribute to quality of training.

- Training teams including current outsourced trainers need follow-up and documentation of observed training skills on the job and management capacity for targeted interventions to be developed and planned to improve the competency of trainers, management of the training institutes and quality of training with a focus on practicum training and follow-up.

- There is need to focus on mechanisms for development of trainer competencies and continuous learning for both in-house and out-sourced trainers with a focus on competency based training and other training quality improvement techniques as well as improving the management capacity of training institutes.

- In order to streamline participant selection and improve need based training a web-based training management information system should be developed that links the FP service providers, the training institute managers, and the administrative and technical supervisors of the FP service providers.

- Initiatives are required to introduce an e-learning platform to organize, monitor, and provide follow-up trainings. This platform could also act as a mode of communication through which the trainees could reach their trainers and supervisors.

Limitations

This Training Needs Assessment relied mostly on self-reported information plus limited knowledge questions on contraceptive technology to assess providers' level of confidence to FP services and not observation of actual performance and therefore subject to over or under presentation of individual actual performance. Questions such as adequacy of the training have generalizability limitations as a full reflection of the adequacy of current training and possibly subject to recall bias as most of the providers had not received any in-service FP training for many years since their pre-service education. This could also be said for findings from the knowledge assessment as the scientific knowledge have changed since they received training and they are not updated due to lack of refreshers training. However, the assessment identified strengths and opportunity and areas for improvement in the capacity development training and service provision.

APPENDIXES

District	District Level	Upazila Level	Union Level
Dhaka	• Model FP Clinic, Dhaka Medical College Hospital • MCWC Hazaribagh, Dhaka	**Dohar** • Upazila Health Complex, Dohar • MCH-FP Unit, Dohar Upazila	• Sutarpara • Raipara • Mahmudpur • Nayabari • Moksedpur • Kusumhati
		Dhamrai • Upazila Health Complex, Dhamrai • MCH-FP Unit, Dhamrai Upazila	• Sutipara • Chauhati • Suapur • Rowail • Shomvag • Shanora • Kusura
		Keraniganj • Upazila Health Complex, Keraniganj • MCH-FP Unit, Keraniganj Upazila	
Faridpur	• District Hospital, Faridpur • MCWC, Faridpur	**Nagarkanda** • Upazila Health Complex, Nagarkanda • MCH-FP Unit, Nagarkanda Upazila	• Ramnagar • Kodalia Shahid Nagar • Kaichail • Dangi • Talma • Laskardia • Fulshuti • Char Jasordi
		Madhukhali • Upazila Health Complex, Madhukhali • MCH-FP Unit, Madhukhali Upazila	• Jahapur • Dumain • Kamarkhali • Roypur • Gazna • Meghchami • Bagat
		Sadar Upazila	• Gedda • Koijuri

District	District Level	Upazila Level	Union Level
Mymensingh	• Model FP Clinic, Mymensingh Medical College Hospital • MCWC, Mymensingh	**Haluaghat** • Upazila Health Complex, Haluaghat • MCH-FP Unit, Haluaghat Upazila	• Sakuai • Amtail • Bildoara • Dhara • Bhubonkura • Koichapur • Narail • Haluaghat Sadar
		Gauripur • Upazila Health Complex, Gauripur • MCH-FP Unit, Gauripur Upazila	• Mylakanda • Bhangnamari • Sahanati • Bokainagar • Douhkhola • Maoha • Ochintopur/Shahaganj • Valukapur • Gouripur Sadar
		Trishal • Upazila Health Complex, Trishal	
Chattogram	• Model FP Clinic, Chattogram Medical College Hospital • MCWC, Chattogram	**Hathazari** • Upazila Health Complex, Hathazari • MCH-FP Unit, Hathazari Upazila	• Nangalmora • Fatehpur • Dhalai • Mirzapur • Chikondondi • Forhadabad • Gorduara
		Mirsarai • Upazila Health Complex, Mirsarai • MCH-FP Unit, Mirsarai Upazila	• Khaiyachhara • Haitkandi • Ichhakhali • Katachhara • Shaherkhali • Osmanpur • Baroiarhat • Dhum
Rangamati	District Hospital, Rangamati MCWC, Rangamati	**Naniarchar** • Upazila Health Complex, Naniarchar • MCH-FP Unit, Naniarchar Upazila	• Naniarchar • Burighat • Ghila Chhari • Sabekhyong

District	District Level	Upazila Level	Union Level
		Kaptai • Upazila Health Complex, Kaptai • MCH-FP Unit, Kaptai Upazila	• Kaptai Union • Raikhali • Chondroghona • Waggya • Chitmaran
		Jurachari • Upazila Health Complex, Jurachari • MCH-FP Unit, Jurachari Upazila	• Banjugi Chhara • Jurai Chhari • Maidang • Dumdumya
		Kaukhali • Upazila Health Complex, Kaukhali	• Kaukhali Sadar • Betbunia • Ghagra
Sylhet	• District Hospital, Sylhet • MCWC, Sylhet	**Beanibazar** • Upazila Health Complex, Beanibazar • MCH-FP Unit, Beanibazar Upazila	• Mathiura • Mollahpur • Charkhai • Muria • Alinagar • Kurar Bazar
		Kanaighat • Upazila Health Complex, Kanaighat • MCH-FP Unit, Kanaighat Upazila	• Bara Chatul • Kanaighat • Shatbank • Purbo Dighirpar • Poschim Lakkhipasha • Dakkhin Manigram • Zhingabari

Note: The areas highlighted in yellow were not included in the original proposal. These areas were included during the data collection phase to increase the sample size