

FAMILY PLANNING TRAINING NEEDS ASSESSMENT

The Government of Bangladesh (GoB) has made progress in family planning (FP) and seen reductions in the total fertility rate (TFR; from 3.4 to 2.3) and increases in the modern contraceptive prevalence rate (mCPR; from 36.6% to 51.9%) during the period 1993 to 2017 (BDHS, 2017). These gains are due in great part to commitment from the GoB in promoting access to universal health coverage, including improving quality and equitable access to services, as outlined in the 2011 National Health Policy and the Programme Implementation Plan (PIP) of 2017 – 2021 Health, Population and Nutrition Sector Program (HPNSP PIP). To accelerate progress the GOB is committed to further reduce TFR to 2.0, increase CPR from 62% to 75%, increase the share of long-acting, reversible contraceptives and permanent methods (LARC & PM) from 8.1% to 20%, decrease unmet need for family planning from 12% to 10%, and decrease discontinuation rate from 30% to 20%.





The public sector is the main provider of modern family planning methods in Bangladesh (BDHS, 2014), the private sector role in provision of family planning services is growing steadily. Services are provided at the community level and all levels of the health care system, including Community Clinics, Union Health and Family Welfare Centers, Upazila Health Complexes and Hospitals.

The main cadre for family planning services are Family Welfare Assistance (FWA) who provide services at the community level to generate demand for FP, counsel, provide oral pills and condoms, re-injection of Depo Provera and refer clients for long acting and permanent methods (LAPMs); Family Welfare Visitors (FWVs), Sub-Assistant Community Medical Officer (SACMOs) who provide short acting contraceptive methods and Intrauterine Contraceptive Devices (IUD); and Medical Officers (MOs) who provide all methods including implants and male and female permanent methods. In addition, GoB is training midwives and nurses as part of its strategy to increase access to post-partum family planning.

Despite this, on average 97.7% of union-level public facilities offer FP services every day—with significant disparity between urban and rural clinics (78.7% versus 90.0%, respectively) and across divisions (e.g., 87.5% in Dhaka and 90.0% in Mymensingh and 96.1% in Sylhet; (BHFS, 2017). One of the key factors limiting service

provision is availability of competent health workers. Nationally, the Bangladesh public health sector is understaffed, “with twice as many doctors as nurses, clustered disproportionately in urban areas while rural facilities are overburdened, understaffed, and insufficiently equipped” (BHSR 2015). Only 55.5% of clinics have staff who had ever been trained on FP (BHFS 2017).

Challenges such as insufficient training for health providers, inappropriate placement of service providers, and inadequate supervision persist and affect the performance of the health workforce. The FP training mandate is held by the Directorate General of Family Planning (DGFP) and the National Institute of Population Research and Training (NIPORT). These two entities face a shortage of family planning trainers in terms of numbers and skills mix and rely on outsourcing training to content experts on an as needed basis to conduct specific sessions. The outsourced trainers in most cases are not necessarily trained trainers. Shortage of trainers at training institutes has contributed to the persistent problem of insufficient FP trained providers as well as timely refresher training for those on the job. The GoB is seeking to address these challenges to meet its national objectives and improve the health and wellbeing of families as well as the country’s economic growth and development.

BACKGROUND AND RATIONALE FOR THE TRAINING NEEDS ASSESSMENT

The GoB in collaboration with its partners such as the USAID funded Accelerating Universal Access to Family Planning, also known as Shukhi Jibon, seeks to increase the number of health workers trained to provide quality family planning services to meet its program objectives. Family planning is included in basic pre-service education of FWVs and SACMOs.

In addition, NIPORT training institutes offer basic two-month FP training for FWAs, as well as refresher training for other cadre ranging from five to twenty-one days for medical officers to provide long acting reversible and permanent methods. Also, non-governmental organizations (NGOs) supporting family planning programs and the GoB provide targeted training on technical areas that include, post-partum family planning (PPFP), IUD insertion, post abortion care family planning (PAC-FP), mentoring and supportive

supervision and Adolescent and Youth Friendly Services (AYFS). To increasing competent FP health workforce, Shukhi Jibon's will work collaboratively with the DGFP, DGHS, DGNM, NIPORT and other stakeholders. Specifically, the project aims to build the capacity of training institutes and systems to produce providers that are competent and skilled to provide quality family planning services that are responsive to the needs of the communities they serve.

To better inform and target investments in capacity building for training, the project collaborated with NIPORT, DGFP and DGHS to conduct a rapid Training Needs Assessment (TNA). Shukhi Jibon conducted the TNA to understand better the opportunities and bottlenecks to the FP training of health workers and to inform strategies for strengthening the FP training systems and training institutes.



OBJECTIVES OF THE TRAINING NEEDS ASSESSMENT

The TNA sought to better understand from:

- Service Providers: the family planning related jobs of the various cadre of service providers from their perception as well as what the services they provide based on their understanding of their respective job descriptions.
- Motivation and retention factors and barriers as well as career pathways.
- Family planning training, the adequacy of their training in preparing to perform FP tasks, current levels of confidence in providing FP services with a special focus on Adolescent and Youth Friendly Services (AYFS), gender and training needs as well as client load.

- Current practices and channels for acquiring updates or new knowledge, use of mobile technology for work related purposes and adequacy of supportive supervision system.
- Willingness for alternative training approaches such as e-Learning, on the job training and mentorship

From Trainers

- Organizational, managerial, logistical and infrastructure capacity of training institutes
- Proficiency of both in-house and out-sourced trainers in developing and delivering competency-based FP training and learning resources from the perception of their supervisors and the trainers themselves.

METHODOLOGY

Data Collection Tools: Shukhi Jibon developed a series of data collection tools for 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. review of registries, policy documents and provider job descriptions and self-administered written knowledge questionnaires on FP to be completed by providers and observation of infrastructure inventory for clinical training.

The survey questions were reviewed and had feedback provided by NIPORT and MEASURE Evaluation's Bangladesh Office. The questionnaires were pre-tested at Narashingdi district during the training of data collectors.

Research team: The 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. The team was subdivided into six teams, two each, one male and one female per each of the six and each team was led by Shukhi Jibon district training officer.

A nine-day long training which included one day of pre-testing was conducted for the research team leader and IntraHealth officials.

Table 1: Study Area and Respondents

	Sample Size	
	Planned	Actual
Geographic Coverage		
Dhaka, Faridpur, Mymensingh, Sylhet, Rangamati and Chattogram	6	6
Upazila	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
CHCPs	48	47
Total Sample for FP service	504	493
IDIs Qualitative Interviews of Frontline FP service providers		
FWVs	6	5
SACMOs	6	6
FPIs	6	5
FWAs	6	5
Survey of Trainers on Training Management	34	25
KIIs of Supervisors and Trainers	63	47
Training Facility Inventory Assessments	13	10

Sample Size and Data Collection: 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, data was collected from six Districts, 16 Upazilas, and 83 Unions.

Table I presents the data collection areas and respondents that were interviewed by cadre. To assure quality completed forms were reviewed at the end of each day by the district training officers with timely sharing with team leader and clinical training manager of Shukhi Jibon plus random direct observations to randomly selected sites by core research team and Senior officials from NIPORT and Shukhi Jibon.

Data Analysis: 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 CPro 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.

KEY FINDINGS

PROFILE OF FAMILY PLANNING PROVIDER

FP services in Bangladesh are predominantly delivered by female providers, except for Medical Officers and SACMOs where 36% and 76% respectively are male. Among the MO providers 17.9% are Senior Consultant Gynecologists, 25.6% Junior Consultant Gynecologists, 30.8% are MOs working in Maternal and Child Welfare Centers (MCWC), 17.9% in Upazila Health complex, 5.1% are MOs in Family Welfare Centers, and 2.6% are Anesthesiologists.

All providers are placed according to their professional training and a number have higher academic qualifications than the entry level required. For example, FWVs have 12.9% a bachelor degree, and 8.9% have a master degree and similarly approximately 75% of CHCPs have a higher qualification, 42.6% of CHCPs have a master degree and 34% have a bachelor degree.

DURATION OF WORK EXPERIENCE OF THE FP SERVICE PROVIDERS

FP service providers have worked for quite a long time in the same position and at the same location. MOs have on average 16.7 years of work experience. FWVs have been

LIMITATIONS

The study relied mostly on self-reported information plus limited questions on contraceptive technology knowledge to assess providers' level of confidence in delivering FP services and not observation of actual performance and therefore is 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 surveyed stated that they 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. However, the assessment identified strengths and opportunities as well as areas for improvement in capacity training and service provision.

on the job for an average of 22 years, with 59.4% of FWVs having worked 25 years or more and SACMOs have on average 23 years job experience, with 63% of SACMOs having 25 years or more of work experience. FWAs have on average more than 19 years of work experience, with 52.5% having 25 years or more as an FWA. Midwives and CHCPs are relatively new cadres and both have on average only six to seven years of work experience.

SERVICE PROVIDER JOB RESPONSIBILITIES, PRACTICES, AND PERCEPTIONS OF SKILLS

Job descriptions are available, and these have been updated through circulars. Job descriptions for The FWAs working at the Ward level have their job responsibilities and descriptions clearly outlined in the FWA registrars. For the other cadres, job descriptions are broad statements that do not specify the actual FP tasks to be performed. For example, the job descriptions for midwives' state:

“ Provide family planning services and counseling to the clients.

Provide health education on family planning, post-abortion care, gender discrimination and violence against women.

”

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 have partial knowledge of their job responsibilities. The major sources of specifics on expected job tasks come from basic training and supervisor guidance. Therefore, providers have varied perceptions of the different FP services they are supposed to provide as per their job description and the services they are actually providing.

For example, counseling a critical FP task for demand generation, client centered care, voluntary method choice, understanding use of the method and continuity which every provider should provide, 74.4% of MOs perceived they are supposed to and are providing, FWVs, 79.2% perceived they are supposed to provide and 75% are actually doing so, 68.2% of midwives recognized they should provide counseling services but only 50% of them are actually doing so, and on the extreme 78.7% of CHCPs who are supposed to counsel and refer clients only 17.8% are actually doing so and less than 20% actually providing short acting methods compared to over 80% understanding that they are supposed to provide.

Thus, it can be said that there is a gap in terms of perception and provision of counseling services. Provider perceptions and actual provision of services such as AYFS, PPF, PACFP are generally lower for both perception of supposed to provide and actually providing across all cadres except for FWVs and MOs.

COMFORT WITH CURRENT LEVEL OF SKILLS FOR PROVIDING FP SERVICES

Providers perception of the services they provide and their client load are related to their knowledge on contraceptive technology and level of comfort with their skills to provide the services.

Generally, the highest level of comfort was expressed by MOs at 69%, followed by SACMOs 59%, FWAs 46%, FWV39% and CHCP 34% and lowest midwives at 18. The data shows that on average 40% of providers expressed that they were not comfortable with their current skills to counsel clients for FP.

Furthermore, MOs, the sole provider of tubectomies and NSVs, 50% and 68% respectively do not feel comfortable performing these procedures. Similarly, 59% FWVs do not feel comfortable with their skills to insert IUD. Finally, FWAs and CHCPs provide the subsequent doses of injectables at community level, but 40% of FWAs and 45.2% of CHCPs reported that they do not feel comfortable performing this task.

AVERAGE CLIENT LOAD PER MONTH BY CADRE

The monthly average client load for FP for each cadre is generally low (see Table 2 below). It is slightly higher among FWVs in comparison to others. The client load is even lower for LARC & PMs and referral from FWAs and CHCPs was found to refer on average 1 to 2 clients for LARC & PMs per month.

Table 2: Average Number of FP Clients

Types of FP Services	Average Number of FP Clients Served by Each					
	MO	FWV	Midwife	SACM	FWA	CHC
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 and removal	3.4	3.3	0.9	0.5		
Implant insertion and removal	1.6	0.7		0.5		
Tubectomy	3.5					
NSV	0.6					
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

Average Number of FP Clients Served in December 2018



CURRENT CONTRACEPTIVE TECHNOLOGY

A written assessment was administered that showed providers' current knowledge of contraceptive technology. The knowledge levels were low, as shown in the below Table, for removal of barriers to family planning and information given to clients about side effects, a major reason for discontinuation of FP methods and return visits.

Percentage of FP Service Providers Who Answered Correctly on Contraceptive Technology Assessment

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

CHALLENGES FACED BY PROVIDERS IN PROVIDING METHODS

Demand, supply, and factors affecting provider performance were assessed. Demand side factors mentioned by 30% of all providers included myths about family planning methods, fear of side effects, and influence of older family members against family planning. On the supply side, in addition to their level of comfort with their skills, knowledge levels and perceptions of whether they should provide the service and low client loads, providers mentioned lack of supplies, high workload and shortage of providers plus inadequate supervision. Also, over 30% of the providers stated individual performance factors that hinder service provision - these included lacks of career development as main demotivating factor and others included lack of incentives, travel to work and lack of respect by community members.

Career pathways that was frequently cited as a demotivating factor by front line cadres are nonexistent for FWA's, CHCP and SACMOs. FWVs have one opportunity to be promoted from FWV to Senior FWV at one point in their employment, MOs can progress to Assistant Director, Deputy Director and Director levels in the course of their work life, these positions are however not that many. Also, promotion means discontinuation from direct service delivery.

PROVISION OF AYFS

On average 60% of the providers, except midwives and CHCPs, who stated that they are supposed to provide adolescent and youth friendly services and are actually providing AYFS. It appears providers have received training on AYFS, the FWVs (70.03%), followed by CHCPs (51.1%), FWAs (48.7%), MOs (41%), and midwives (31.8%). Menstruation related services are provided by 82.2% of FWVs, 79.7% of FWAs, 78.7% of CHCPs, 66.7% of MOs, and 63.6% of SACMOs. Around 50% of the different cadres provide services or information on nutrition issues, changes during adolescence, the disadvantages of child marriage, hygiene issues, and folic acid. Nearly one-third of the MOs, FWVs, FWAs, and CHCPs give information about delaying first pregnancy and the adverse effects of adolescent pregnancy.

Providers showed misperceptions about provision of certain FP methods for adolescent clients. Oral pills are the predominant method provided to adolescent clients by 63.9%, MOs, 71.4%, FWVs, 43.8% midwives, 60.5%, FWAs, 68.5%, SCAMOs, and 51.1% CHCPs. This was followed by provision of condoms with an average 75% of providers providing condoms. Provision of injectables and IUD to adolescent clients is very low with 11% of MOs and FWV, 9% of SCAMOs and 5% of FWAs providing injectables and 5% MOs and 9% FWVs providing IUD.



And, only 27.8% of the MOs, the sole provider of implants, mentioned providing this method to adolescent clients.

CHALLENGES FACED BY THE FP PROVIDERS IN PROVIDING AYFS TO ADOLESCENTS

Approximately 25% of the FWVs, FWAs, and MOs feel comfortable in talking to adolescents and youths, the exception are SACMOs, 47% of whom expressed feeling comfortable talking to adolescent clients. Other challenges cited by providers included lack of training on AYFS and interpersonal communication.

Client related issues included parents and community members not allowing services to adolescent clients and lack of demand for services by adolescents. This was more an issue among FWAs. Topics covered in the AYFS training varied significantly by provider - 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 and approximately 50% of FWVs, FWAs and CHCPs reported that nutrition issues, change in adolescence period, 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. Topics not covered include gender and gender-based violence including intimate partner violence, and wet dreams for adolescent boys.

PROVIDER TRAINING ON FP

Refresher update training to enhance knowledge and skills was expressed as a need by almost all providers except MOs, over 50% of whom expressed no need for training. Most of the training is provided during basic training with 53% MOs, 90% FWVs, 70% SACMOs, 80% FWAs and 70% CHCP reporting having received FP training during this period. Also, FWVs and SACMOs receive FP training during their pre-service education programs. The percentage reporting having received practicum training was lower; 89% of FWVs, 49% SACMOs, 80% FWA and 46% CHCPs stating that they received practicum training on short acting methods. Practicum training seems to be lower for the FP methods that require higher levels of competencies from provider 66% of the MOs stated that they received practicum training on LARC & PMs and 25% of SACMOs have received training on IUD insertion. Practicum training is higher for IUDs among FWVs with

Areas Identified as Needing Improvement at Training Institutes:



Leadership and Management



Partnerships and External Relations



Performance Reviews



Trainee Selection and Behavior Change



Training Information Management system



Evaluation and Knowledge Management

ON-THE-JOB TRAINING, SUPPORTIVE SUPERVISION, AND MENTORING

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, PFPF and PACFP.

A very high number of providers - 80% MOs and over 95% for the rest of the cadre with FWAs and midwives - receive supervision at their workplaces. However, 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. Feedback is written in the facility register. A high number of providers stated that monthly or quarterly meetings are a venue for receiving updates on family planning.

E-LEARNING OPPORTUNITIES AND PRACTICE

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.

SUMMARY CONCLUSIONS AND RECOMMENDATIONS

- ④ The recent cohorts of frontline providers, FWVs, FWAs and CHCP have higher academic skills for their jobs than their previous. This has implications for their capacity to be trained and could offer an opportunity to expand their scope of FP service provision to further increase the health workforce for provision of FP methods such as LARCs and PMS.
- ④ Approximately 60% of frontline FP service providers have more than 25 years of work experience. This data shows that a significant number of service providers are likely reaching retirement age. Also, 40% of the provider positions are vacant. Recruitment and training all new providers should be accelerated.
- ④ Most of the providers received their last FP refresher training at least five to ten years ago and express lack of confidence to provide services possibly contributing to low client load per provider with consequences for knowledge and skill loss due to limited practice. Refresher trainings targeted at performance gaps in knowledge and skills for all cadre of providers is necessary. Blended learning approaches should be developed to address these performance gaps quickly, minimize costs and service disruption and to enhance sustainability.
- ④ Job descriptions are available but the job expectations for the FP cadre are broad and do not specify FP services expected of each cadre, possibly contributing to the discrepancies in the job tasks each provider believes they should provide. Job descriptions require reviewing to be specific on FP related job expectations for each cadre and should be disseminated. The refresher training recommended above should be aligned with the updated job descriptions.
- ④ Demand side challenges such as myths about FP, fear of side effects among clients regarding LARCs & PMs and influence against FP and refusal to allow providers to reach adolescent clients need to be addressed through behavior change communication and improved counseling by providers to reduce discontinuation and increase demand for FP services.
- ④ The lack of career development opportunities is one of the most frequently mentioned demotivating factors among providers. Therefore, the current career

development pathways should be reviewed and aligned to create opportunities and increase motivation.

- ④ Monthly supervision for all providers is a strength that provides an opportunity for onsite performance support and on the job training, however there is need to improve the quality of supervision to enhance job performance.
- ④ Training institutions have capacity for training, however there is need for further assessment of the actual skills of individual trainers - including outsourced trainers - in training design, delivery using competency based training methods, monitoring and evaluation of trainings and to strengthen practicum training.
- ④ Current trainings are mostly didactic classroom-based trainings with limited practicum training and lack provider follow-up by trainers. In addition, there is limited capacity in practicum training, development of e-learning and blended learning activities. The availability and use of mobile phones among providers as well as their willingness for e-learning provides opportunities for introduction of different training approaches need to be explored.



95% stating they received practicum training. About 20% of the providers have not received any FP training for an average of 15 to 20 years since their basic training expect the newer cadres' midwives and CHCPs. Close to 45% of the providers indicated having received refresher training in the last 4 to 6 years. However, refresher training is significantly lower for a quarter of MOs who received refresher training almost 10 years ago.

CAPACITY OF TRAINING INSTITUTES

TRAINING OFFERED AT TRAINING INSTITUTES

The following institutes provide basic, refresher, or practicum training to different cadres of FP providers: NIPORT-HQ, Maternal and Child Health Training Institute, Regional Training Centers, Medical College, District Hospitals and FWV Training Institutes, Upazila Health complex (UHC) and Mohammadpur Fertility Services & Training Centre (MFSTC), MCWC, Family Planning Clinical Supervision and Quality Improvement Team (FPCS-QIT). Most of the FP training is provided by FWVIT for FWVs 85% for basic, 74% for practicum and 61.2% for refresher training; RTCs provide over 75% of the basic, practicum and refresher training for FWAs; and Upazila Health complex provide over 75% of basic, practicum and refresher training for CHCPs. Midwives are mostly trained by the Medical Colleges.

All the other training institutes offer less than 5% of the FP trainings for different cadres. In addition to family planning, the training institutes provide a wide variety of training courses on Maternal Newborn and Child Health (MNCH), quality improvement, behavior change communication, and program and financial management. Between January to December 2018 at least 4 of the 10 surveyed training institutes offered 5 -day FP training courses to an average of 250 providers, in batches of 22 trainees per batch. Of note for capacity building, 5 of the Training Institutes offer a 5-day Training of Trainers course, but only one actually conducted a ToT (for 8 participants) in 2018.

TRAINERS AT THE TRAINING INSTITUTES WHO PROVIDE TRAININGS ON DIFFERENT FP

All 10 Training institutes surveyed have an average of 3 FP trainers and 6 to 7 outsourced trainers.

The training institutes depend on both in-house and outsourced trainers due to shortage of trainers. Five training institutes provide training using both in-house and outsourced trainers and seven training institutes provide training using both in-house and outsourced trainers and three use only outsourced trainers for LARC & PMs. One out of ten training institutes has an in-house trainer to conduct training on counseling the rest rely on both inhouse and outsourced trainers.

Training on AYFS and gender are provided by outsourced trainers and few inhouse trainers at all 10 training institutes.

PERCEPTIONS OF TRAINER COMPETENCY IN DIFFERENT TRAINING SKILLS

The assessment obtained information on perception of trainer competency from the heads of the training institutes and the trainers themselves. In addition, a written self-administered questionnaire was used to assess the trainers' knowledge on contraceptive technology. Heads from 5 training institutes indicated that their in-house and outsourced trainers had good facilitation as well as training monitoring and evaluation skills, 3 said their trainers had excellent facilitation skills, and 2 said their inhouse trainers had inadequate skills to conduct practicum training including use of checklists.

Other areas reported as inadequate by over 50% of the training institutes included, on-the-job training and follow-up of clinical providers, development of FP clinical labs, on-the-job mentorship of clinical providers, and managing training data base. Four of the training institutes expressed that they had good management capacity and 3 expressed that they had excellent capacity. While all training institutes expressed capacity to conduct training needs assessments only 3 mentioned that they had the capacity to develop training schedules, curricula, materials.

This might be because NIPORT-HQ prepares these among the 25 trainers who responded to questions about their training skills, over 60% mentioned that they had good skills to design, deliver, monitor and evaluate training and less than 30% expressed that their skills in these areas were excellent. Inadequate skills were expressed by 20% of the trainers in conducting clinical practicum training, selecting and developing clinical practicum training sites, and conducting training follow-up and E-learning.



Accelerating Universal Access to Family Planning Project (AUAFP)

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 to expand access to quality FP services through a collaborative health system capacity-building partnership with the Government of Bangladesh.

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This brief is a synopsis of the Training Needs Assessment report prepared by Department of Population Sciences, University of Dhaka. The Department worked closely with the Shukhi Jibon project team under the guidance of IntraHealth International. This assessment was undertaken in collaboration with the National Institute of Population, Research, and Training (NIPORT) and the Directorate General of Family Planning (DGFP) and Directorate General of Health Services (DGHS).

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