

## BRIEF 5

# SPECIAL FAMILY PLANNING SERVICE DELIVERY DAYS: A Way of Expanding Access to Long-Acting Reversible Contraceptives and Permanent Methods in Bangladesh



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**INTRODUCTION** In Bangladesh, the Directorate General of Family Planning (DGFP) of the Ministry of Health and Family Welfare has long faced challenges in addressing the need for long-acting and permanent methods of contraception. Since the 1980s, the DGFP has organized family planning camps (mostly at the *upazila*<sup>1</sup> level), through which a medical officer of maternal child health and family planning (MO-MCH-FP) provided implants and permanent methods

(PMs). However, these family planning camps are not held on a regular or frequent basis. Further, human resource shortages of MO-MCH-FP constrained the capacity of the DGFP to provide long-acting reversible contraceptive (LARC) and PM services at upazila-level facilities. And, as health facilities below the upazila level offered no implant and PM services, clients were unable to access to these methods within their communities. To address this problem, EngenderHealth's Mayer Hashi II (MH-II) project, funded by the United States Agency for International Development, collaborated with the DGFP, the Directorate General of Health Services, and select local non-government organizations (NGOs) to provide LARC and PM services at upazila- and lower-level facilities by supporting a mobile service delivery initiative, which operated on specific days, known as family planning special days<sup>2</sup>. Starting in October 2013, MH-II provided technical assistance to the DGFP and Directorate General of Health Services to organize a minimum of four family planning special days each month at the upazila health complexes and at select community-level facilities.

### THE APPROACH

MH-II organized family planning special days in accordance with guidelines developed by the MH-II project, which stated that services must be conducted in a health facility. MH-II organized these family planning special days in the facilities where there was neither an MO-MCH-FP nor other similarly trained provider. MH-II worked with the following types of health facilities to implement these family planning

special days: mother and child welfare centers, upazila health complexes, upgraded union health and family welfare centers, community clinics, and NGO and private clinics.

On the family planning special day, a team comprising a surgeon and one or two paramedics provided LARC and PM services at the facility. MH-II engaged government surgeons from district-level facilities or other

<sup>1</sup> An *upazila* is a sub-district administrative unit with approximately 300,000 people.

<sup>2</sup> The DGFP previously referred to family planning special days as "family planning camps." Currently, the DGFP calls family planning special days "client fairs."

upazilas and hired retired surgeons to provide LARCs and PMs on these family planning special days. The surgeon provided implants and PMs, while the DGFP paramedics (known as family welfare visitors) and NGO paramedics provided intrauterine devices (IUDs) and injectables. In facilities with higher demand levels, MH-II helped organize family planning special services for two or more consecutive days.

To overcome constraints related to the lack of available surgeons, MH-II engaged a local NGO, Research Training and Management International (RTMI), to provide LARC and PM services in select geographic locations. RTMI deployed eight mobile service delivery teams, each of which consisted of one surgeon to provide implant and PM services, two paramedics to provide counseling and IUD services, and one field officer to coordinate the family planning special days and participate in awareness promotion activities. DGFP program managers, in consultation with MH-II staff, prioritized upazilas in which the RTMI mobile teams would provide LARC and PM services.

## ORGANIZING A FAMILY PLANNING SPECIAL DAY

### Planning and Organization

MH-II employed logistics officers to organize family planning special days and district- and upazila-level planning and advocacy meetings. At the beginning of each month, MH-II organized meetings with the district- and upazila-level DGFP managers, NGO managers, and RTMI staff to plan family planning special days for the district. District- and upazila-level DGFP managers include the deputy director,

family planning; the assistant director, clinical contraception; the upazila family planning officers; and the MOs-MCH-FP. MH-II selected sites primarily based on demand for and current lack of LARC and PM services, but also considered other factors, such as the availability of surgeons in the upazila, seasonal accessibility of roads, and any potential overlap with services provided by partner organizations.

Once dates were finalized for the family planning special days, MH-II shared the schedule with relevant service providers and fieldworkers during their regular monthly meetings. The upazila family planning officers were responsible for engaging DGFP and NGO fieldworkers to promote the family planning special days among prospective clients in the community. MH-II disseminated the date and venue details for the family planning special days among the DGFP's family welfare visitors and field supervisors via mobile phone short messaging services and requested them to refer LARC and PM clients. MH-II's logistics officers coordinated and collaborated with upazila family planning officers/facility managers, DGFP fieldworkers and their supervisors, and NGO volunteers to organize client referrals. MH-II ensured social and behavior change communication materials were available for use and distribution during the family planning counseling sessions with prospective clients.

### Client Awareness and Informed Counseling

Building awareness among the prospective clients about the family planning special days for accessing LARC and PM services required

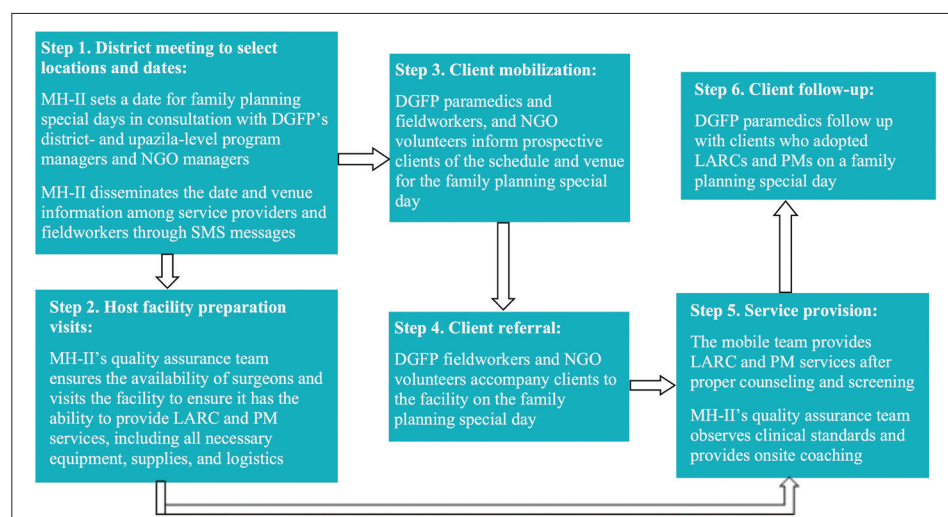


Figure 1. Steps of Organizing a Family Planning Special Day

inter-personal communication activities, which included primarily home visits conducted by DGFP fieldworkers and NGO volunteers. In addition, MH-II used community radio to disseminate key information, including event dates and locations. MH-II also displayed banners in front of the selected venues and in busy community locations to publicize the family planning special days.

On the family planning special day, family welfare visitors conducted group education sessions at the facility. They also provided rights-based family planning counseling to prospective clients.

### Quality Assurance

MH-II appointed quality assurance and family planning compliance officers to ensure facility readiness and service quality. Prior to the family planning special day, MH-II's quality assurance team visited the venue to assess facility infrastructure and cleanliness, infection prevention practices, and availability of required equipment, supplies, logistics, and Imprest funds<sup>3</sup>. On the family planning special day, the quality assurance and family planning compliance officers visited the facility to observe the quality of services and to ensure adherence to clinical standards, infection prevention best practices, and family planning counseling standards for voluntary and informed choice. These MH-II staff then addressed any gaps observed through onsite coaching. They also trained local service providers, mostly family welfare visitors, to offer basic follow-up care and referrals.

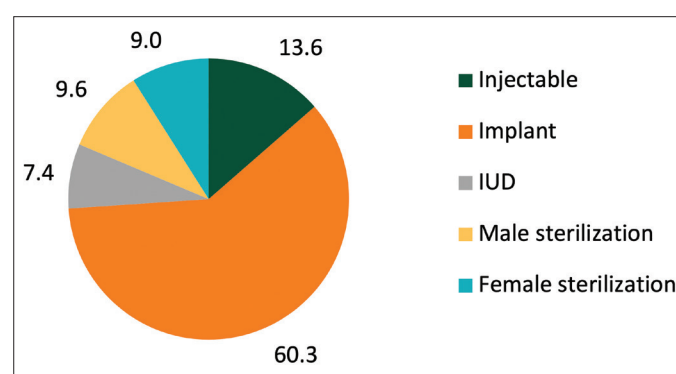
### Follow-Up Care

On the family planning special day, clients adopting a family planning method received counseling about follow-up care. Specifically, clients received a follow-up schedule with instructions to return to the same facility or another appropriate facility. MH-II assisted the DGFP in implementing structured follow-up phone calls to clients who adopted family planning methods through the family planning special days.

## OUTCOME

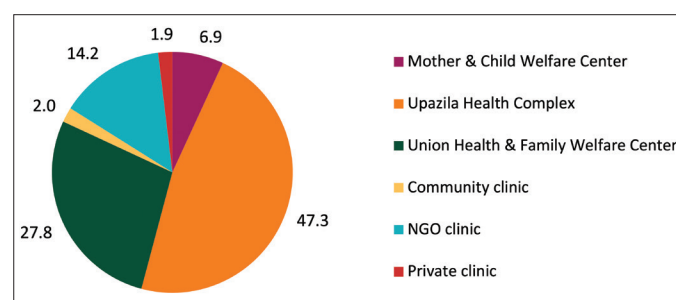
Between July 2014 and June 2018, the MH-II project organized 33,618 family planning special days in which 520,529 clients adopted

LARCs, PMs, and injectables. On average, 16 clients received family planning methods on a family planning special day. The main family planning method adopted by clients was the implant (Figure 2), with a total of 60% of clients adopting this method, followed by injectables (14%). The majority of clients requested an implant; they received the method only after being screened for eligibility. When clients were screened and found "not eligible" for a LARC or PM, they were offered injectables as an interim method. Nearly, one-fifth of the family planning method acceptors chose PMs (male and female sterilization). IUD uptake among clients was the lowest at 7%.



**Figure 2.** Percent Distribution of Clients Who Adopted Methods on Family Planning Special Days

Figure 3 shows that 30% of the family planning special day services were delivered at the government's community-level service centers, which include union health and family welfare centers (28%) and community clinics (2%). These facilities were situated within approximately two kilometers of clients' residences. Upazila health complexes provided 47% of the family planning special day services. These upazila health complexes did not have an MO-MCH-FP in place; organizing family planning special days helped them close the gap in LARC and PM service delivery at the upazila level.



**Figure 3.** Percent Distribution of Service Delivery Centers which Held Family Planning Special Days

<sup>3</sup> An "Imprest fund" is an advance of money paid to an organization or an individual for providing LARC and PM services. Imprest money is used to reimburse clients for travel, food, and wage loss; pay the costs of transportation for the referrer, and cover fees for service providers.

## CHALLENGES

- **Inadequate facility-based counseling.** On the family planning special day, family welfare visitors were responsible for screening and counseling clients at the facility. However, they were often unable to conduct high-quality counseling due to significant client attendance rates and their involvement in client screening.
- **Lack of implant removal services at lower-level facilities.** Service providers at union health and family welfare centers and community clinics were unable to offer implant removal services, which was highly inconvenient for implant users who visited these community-based facilities for removals.
- **Low adoption of IUDs.** On the family planning special day, the family welfare visitor—the key DGFP provider for IUD services—was responsible for completing client registrations, conducting counseling services, and assisting the surgeon. Therefore, it was difficult for the family welfare visitor to provide IUDs on the family planning special day. Moreover, IUD clients were less likely to seek services during the family planning special days, since they could access IUD services from the family welfare visitor.

## SUSTAINABILITY

The DGFP has recently deployed district-based family planning clinical supervision and quality improvement teams. This team comprises one surgeon and one nurse with a vehicle assigned to each team to conduct regular monitoring visits. The DGFP is equipped to use these teams to provide LARC and PM services in upazilas where another trained service provider is not available. These teams can build clinical

capacity of service providers on LARCs and PMs at different levels. Leveraging the MH-II experience, the DGFP has designed the job profiles for the district clinical supervision and quality improvement teams so that they can provide LARC and PM services at lower-level facilities and in hard-to-reach areas or in locations where there is no trained provider at present.

## CONCLUSION

EngenderHealth's mobile team approach was successful in minimizing the LARC and PM service delivery gap at the upazila level and below by making these services available in facilities closer to the community. Further, the mobile team approach successfully promoted LARC and PM services through family planning special days and contributed to an increased uptake of LARCs and PMs. Additionally, MH-II's quality assurance team, particularly the supportive clinical supervision offered by the quality assurance and family planning compliance officers helped ensure informed consent and voluntarism and improved service quality.

This mobile team approach is an effective but temporary solution to addressing the unmet need related to implants and PM services at the upazila level created by the vacancies of MO-MCH-FP. The DGFP needs to ensure trained medical officers are available at upazila-level facilities to conduct frequent and regular family planning camps. Alternatively, DGFP can use the mobile team approach as a long-term solution to respond to needs in remote areas and to provide LARC and PM services at community-based facilities where it would not be cost efficient to equip and employ fulltime providers (e.g., surgeons).

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**Citation:** EngenderHealth. 2018. Special Family Planning Service Delivery Days: A Way of Expanding Access to Long-Acting Reversible Contraceptives and Permanent Methods in Bangladesh. *Mayer Hashi-II Brief No. 5*. Dhaka: EngenderHealth.

This publication was made possible by the generous support of the American people through the U.S. Agency for International Development (USAID), under the terms of the Associate Cooperative Agreement No. AID-388-LA-13-00002. The contents are the responsibility of the Mayer Hashi-II project/EngenderHealth and do not necessarily reflect the views of USAID or the United States Government.

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