

Endline Report: Health Facilities Assessment

Improving Sexual and Reproductive Health and Rights in Dhaka

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Abbreviations:

BAPSA	Association for Prevention of Septic Abortion, Bangladesh
BCC	Behavior Change Communications
BKMEA	Bangladesh Knitwear Manufacturers and Exporters Association
BMRC	Bangladesh Medical Research Council
CEI	Client Exit Interview
CHO	Chief Health Officer
CRHCC	Comprehensive Reproductive Health Care Centre
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Service
DH	District Hospital
DHIS-2	District Health Information System-2
DNCC	Dhaka North City Corporation
DSCC	Dhaka South City Corporation
D&C	Dilatation and Curettage
ECP	Emergency Contraceptive Pills
FP	Family Planning
GBV	Gender-Based Violence
GoB	Government of Bangladesh
GP	General Practitioner
ISRHRD	Improving Sexual and Reproductive Health and Rights in Dhaka
IEC	Information, Education and Communication
IPC	Infection Prevention and Control
IUD	Intra-Uterine Contraceptive Device
LARC	Long-Acting Reversible Contraceptive
MCH	Medical College Hospital
MIS	Management Information System
MMR	Maternal Mortality Rate
MoHFW	Ministry of Health and Family Welfare
MoLGRDC	Ministry of Local Government, Rural Development and Co-operatives
MoU	Memorandum of Understanding

MPAC	Misoprostol for Post Abortion Care
MR	Menstrual Regulation
MRM	Menstrual Regulation through Medication
MVA	Manual Vacuum Aspirator
NCC	Narayanganj City Corporation
NGO	Non-Governmental Organization
OCC	One-Stop Crisis Centre
OCP	Oral Contraceptive Pills
ODK	Open Data Kit
OGSB	Obstetrical and Gynecological Society of Bangladesh
PA	Partnership Area
PAC	Post-Abortion Care
PAFP	Post Abortion Family Planning
PH	Public Health
PIP	Project Implementation Plan
PHCC	Primary Health Care Center
PIU	Partnership Implementation Unit
PMU	Project Management Unit
PPE	Personal Protective Equipment
PPFP	Post Partum Family Planning
R3S	Received Social Support Scale
RC	Reproductive Coercion
RHSTEP	Reproductive Health Services, Training and Education Program
RME	Research Monitoring and Evaluation
RMG	Ready Made Garment
SAE	Serious Adverse Event
SBCC	Social and Behaviour Change Communication
SDH	Social Determinants of Health
SGBV	Sexual and Gender-Based Violence
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights

UPHCSDP	Urban Primary Health Care Services and Delivery Program
VAW	Violence Against Women
VCAT	Values Clarification and Action for Transformation
WHO	World Health Organization

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Executive Summary

Bangladesh has one of the highest adolescent fertility rates in South Asia, with about 83 births per 1,000 girls. Dhaka is growing fast and is expected to become the world's 6th most populated city by 2030, with 27 million people. About 4 million people now live in more than 5,000 slums across the city, and many of them are left out of the better health care that city life usually brings. Women working in the Ready-Made Garment (RMG) sector — who make up 60% of that workforce — also face limited awareness about sexual and reproductive health and rights (SRHR) and few options for getting reproductive health care.

To address these gaps, HealthBridge Foundation of Canada along with its partner Ipas Bangladesh, implemented the Improving Sexual and Reproductive Health and Rights in Dhaka (ISRHR'D) project from May 2021 to September 2026 with funding from Global Affairs Canada. BAPSA, RHSTEP, OGSB and SERAC Bangladesh worked as the local implementing partners of Ipas Bangladesh. The project focused on improving SRHR in underserved areas across Dhaka North City Corporation, Dhaka South City Corporation, Gazipur and Narayanganj districts, supporting referral hospitals, urban primary health care clinics, garment factory clinics and General Practitioners (GPs).

A facility-level baseline assessment was carried out at 126 health facilities between October 2021 and March 2023 to find out the gaps in Menstrual Regulation (MR), Post-Abortion Care (PAC) and Family Planning (FP) services. The endline assessment was conducted between March and May 2026 at 154 facilities, including 12 referral hospitals, 37 UPHCSDP clinics, 14 garment factory clinics and 91 GP clinics. Ipas Facility Program Planning Tool was used at both baseline and endline for the facility-based centres, and a short discussion guide was used for the GPs.

The endline findings show substantial progress in various dimensions. Annual contraceptive services rose from 156,576 at baseline to 185,044 at endline. MR services went up from 6,092 to 9,520 per year by the endline. At baseline, only 46 out of 126 facilities (about 37%) were offering a full range of family planning services and 45 were providing MR-PAC. By the end of the project, all 154 facilities were providing FP services and 135 (88%) were providing MR-PAC. GPs, who were providing none of the services at baseline, are now part of the SRHR service delivery system — all 91 trained GPs are offering FP services and 77 of them are also providing MR and PAC through medication.

Quality of care also improved. Facilities meeting minimum quality standards jumped from 13% at baseline to 75% at endline. Stock-out problems dropped sharply: 146 out of 154 facilities reported no stock-out of contraceptive supplies in the last three months, compared with only 40 out of 126 at baseline. The outdated practice of Dilatation and Curettage (D&C) is no longer being used at the project-supported referral and UPHCSDP centres. The share of clients who mentioned receiving quality counselling on SRH rose from about 85% to 97%.

Public health emergency readiness improved as well. At baseline, only 38% of facilities were ready to deliver SRH services during emergencies. At endline, all 63 facility-based centres were ready. Working with the Ministry of Health and Family Welfare and the Ministry of Local Government, the project developed an Emergency Preparedness and Response Plan for urban areas, which will help keep services running during future emergencies. Uniform service registers for MR-PAC, Family Planning and GBV are now in use across all facility types, and 100% of facilities are reporting on time to the relevant authorities. An online recording application supports the GPs in recording and reporting their service data, and IEC materials on MR-PAC, Family Planning and GBV are now available in 97% of facilities.

Some gaps still need attention. Garment factory clinics still refer most MR-PAC cases, even though some have started using MRM and mPAC. SGBV case management at certain referral facilities needs further strengthening, and the country still does not have a standard system for tracking referred-in cases. Despite these gaps, the project endline assessment shows clear improvement in the availability, quality and reach of SRH services across the project area — with care that is closer to the women and girls who need it most.

Introduction

Globally, about 11% of adolescent girls aged 15-19 become mothers every year, 95% of which occur in developing countries (World Health Organization, 2011). In Bangladesh, more than half the women get married by their eighteenth birthday, and 80% of them have given birth before the age of 20 (United Nations Children's Fund, 2020). Bangladesh has a very high adolescent fertility rate of about 83 in 1000, ranking the highest in the Southeast Asian region (Pike et al., 2021). Getting married early has several implications for an adolescent girl, including limited employment and educational prospects, social pressure to give birth, lack of knowledge about contraceptives and their access, lack of agency and

autonomy to negotiate with the partner regarding delaying childbirth or using family planning methods and lack of access to health care services (Pike et al., 2021; World Health Organization, 2020).

Abortion is a criminal offence in Bangladesh under the Bangladesh Penal Code 1860, permissible only to save a woman's life. However, Menstrual Regulation, often loosely termed as a service to establish non-pregnancy has been part of the national family planning program since 1979. In 2013, the Government of the People's Republic of Bangladesh introduced Menstrual Regulation using Medication (MRM) using the mifepristone/misoprostol combination package permitted through 9 weeks of the last menstrual period. Compared to other developing countries, the Contraceptive Prevalence Rate is relatively high (62%) however, discontinuation rates are high (37%) as is the unmet need for family planning. (National Institute of Population Research and Training (NIPORT) & ICF, 2020) Despite the permissibility of MR services, clandestine abortions remain prevalent (Directorate General of Family Planning, n.d.; Guttmacher Institute, 2017; LaChance & Hossain, 2017). About 1.2 million pregnancies were terminated outside the formal health system in 2014 (Guttmacher Institute, 2017) and 384,000 women suffered from abortion-related complications. (Singh et al., 2017)

Bangladesh's rapid urbanization has led to a massive increase in its urban population. The metropolitan Dhaka area is expected to become the 6th most populous city by 2030, hosting 27 million people (National Institute of Population Research and Training (NIPORT), et al., 2015). Currently, around 4 million people inhabit more than 5,000 slums in urban Dhaka, and they are left behind from the "urban advantage" of better health care amongst other social supports. Persistent health inequalities exist between slum and non-slum residing adolescents in Bangladesh. The human rights to life, health, and reproductive health remain adversely affected because of the structural inequalities and social and cultural conditions which shape how rights are understood, negotiated and lived (Rashid, 2004). Bangladesh's Ready-Made Garment (RMG) industry has contributed to the economic improvement of the nation's economy. The RMG industry relies heavily on women's labour with 60% of the 4.2 million workers in this sector being female (International Labour Organization, 2019). The majority of these workers are disadvantaged migrants who lack of awareness on SRHR issues and have limited access to SRHR services (SNV Netherlands Development Organisation, 2019).

Against this background, HealthBridge Foundation of Canada along with its partners: Ipas Bangladesh, Reproductive Health Services Training and Education Program (RHSTEP), Obstetrical and Gynaecological

Society of Bangladesh (OGSB), SERAC Bangladesh and Association for Prevention of Septic Abortion (BAPSA) - launched the Improving Sexual and Reproductive Health and Rights in Dhaka (ISRHR'D) project from 2021 to 2026 with funding from Global Affairs Canada. The project focused on SRHR in underserved urban areas of Dhaka North City Corporation (DNCC), Dhaka South City Corporation (DSCC), Gazipur and Narayanganj districts. The project started with plans to support 154 health facilities (9 referral health centres, 30 Urban Primary Health Care Services and Delivery Program (UPHCSDP) centres, 15 Garment Factory Clinics and 100 GPs). As the project progressed, additional health facilities were included where the need was clear. By the end, the project had supported a total of 169 facilities: 12 referral health centres, 42 UPHCSDP centres, 15 Garment Factory Clinics and 100 GPs.

A baseline facility assessment was carried out between October 2021 and March 2023 to find out where the gaps were in MR, PAC and FP services. The endline assessment was then conducted between March and May 2026 to measure the changes by the end of the project — how facility readiness, service delivery, supplies, record keeping and emergency preparedness had changed since the baseline. This report presents the endline findings in comparison with the baseline.

Objectives

The objective of the endline health facility assessment is to evaluate the overall progress of project interventions against its target in strengthening the provision of menstrual regulation (MR), post-abortion care (PAC), and contraceptive services across the supported health facilities. Specifically, the assessment aims to:

- Measure changes in facility readiness compared to the baseline, including improvements in workforce capacity, service delivery, and management systems.
- Assess the extent to which quality, accessibility, and availability of MR, PAC, and family planning (FP) services have improved during the project period.
- Evaluate changes in the availability and management of essential logistics, commodities, and infection prevention and control practices.
- Identify gaps and challenges that may affect sustained service delivery and inform recommendations for future programming and scale-up.

Methodology

Study site:

Health facilities endline assessments were conducted in the last quarter of project implementation period between March and May 2026. The project conducted facility assessments at 153 out of 169 health facilities, which includes 12 referral centres, 37 urban health centres, 14 garment factory clinics, and 91 GPs. The description of the health facilities assessed are included below.

Referral Hospitals:

A health facility planning assessment was conducted at 12 referral health centres. Most of the referral health facilities are tertiary level public health facilities. The OGSB hospital was the only referral health facility that was private. Of the twelve referral health facilities, four are in Dhaka North City Corporation (DNCC), five in Dhaka South City Corporation (DSCC), two in Gazipur and one in Narayanganj district.

Table 1: List of referral hospitals under assessment

S.N.	Name of the Facility	District	Facility Type	Date of Assessment
1	Dhaka Medical College and Hospital	Dhaka	Medical College Hospital	05 May 2026
2	Sir Salimullah Medical College and Mitford Hospital	Dhaka	Medical College Hospital	05 May 2026
3	500 Bedded General Hospital, Mugda	Dhaka	General Hospital	07 May 2026
4	Shaheed Suhrawardi Medical College Hospital	Dhaka	Medical College Hospital	15 April 2026
5	Shaheed Tazuddin Medical College and Hospital	Gazipur	Medical College Hospital	16 April 2026
6	Shaheed Ahsan Ullah Master General Hospital	Gazipur	General Hospital	16 April 2026
7	Naryanganj District Hospital/ Victoria Hospital	Narayanganj	General Hospital	06 May 2026
8	Obstetric and Gynecological Society of Bangladesh (OGSB) Hospital	Dhaka	Private Hospital	07 May 2026
9	Mohammadpur Fertility Services and Training Center	Dhaka	Maternity Institute	15 April 2026

10	Mother and Child Health Training Institute	Dhaka	Maternity Institute	07 May 2026
11	Dhaka Mohanagar General Hospital	Dhaka	General Hospital	05 May 2026
12	Nazirabazar Maternity	Dhaka	Maternity Hospital	05 May 2026

UPHCSDP clinics:

A total of 42 urban clinics were supported through this project and endline facility assessments were completed at 37 centres at the end of project implementation period. The project was initially designed to support 30 UPHCSDP clinics—10 Comprehensive Reproductive Health Care Centres (CRHCCs) and 20 Primary Health Care Centres (PHCCs)—across Dhaka North and South City Corporations. Subsequently, four additional urban centres (one CRHCC and three PHCCs) under Narayanganj City Corporation (NCC) were later added as project intervention sites based on the need. The project provided capacity-building support to these four centres. Later, one PHCC under NCC had to close their operations due to management issues.

In addition, the project extended support to four more UPHCSDP clinics (two CRHCCs and two PHCCs) in two newly added partnership areas within DNCC and DSCC during the fourth year of implementation. In the fifth year, a further four PHCCs affiliated with selected CRHCCs were incorporated under the Improving SRHR in Dhaka project but was considered under endline assessment. The list of 37 urban health facilities where the endline facility assessments were conducted is in Table 2 below.

Table 2: List of UPHCSPD clinics under assessment

S.N.	Name of the Facility	City Corporation Area	Facility Type	Date of assessment
1	Shimantik CRHCC PA 1	DSCC	CRHCC	02 April 2026
2	Shimantik PHCC 01 PA 01	DSCC	PHCC	15 March 2026
3	Shimantik PHCC 02 PA1	DSCC	PHCC	05 April 2026
4	BAPSA CRHCC PA 2	DSCC	CRHCC	15 March 2026
5	BAPSA PHCC 01 PA 2	DSCC	PHCC	16 March 2026
6	BAPSA PHCC 04 PA 2	DSCC	PHCC	10 March 2026
7	DAM CRHCC PA03	DSCC	CRHCC	02 April 2026
8	DAM PHCC 03 PA 03	DSCC	PHCC	05 April 2026
9	DAM PHCC 06 PA 03	DSCC	PHCC	08 March 2026
10	PSTC CRHCC PA 4	DSCC	CRHCC	06 April 2026
11	PSTC PHCC 05 PA 4	DSCC	PHCC	08 April 2026

12	PSTC PHCC 06 PA 4	DSCC	PHCC	10 March 2026
13	Shimantik CRHCC PA 5	DSCC	CRHCC	12 April 2026
14	Shimantik, PHCC 03 PA 5	DSCC	PHCC	15 March 2026
15	SHIMANTIK PHCC 04 PA 5	DSCC	PHCC	12 March 2026
16	ADAMS CRHCC PA-6	DSCC	CRHCC	12 April 2026
17	ADAMS PHCC-03 PA-6	DSCC	PHCC	03 March 2026
18	Nari Maitree CRHCC PA 1	DNCC	CRHCC	10 May 2026
19	Nari Maitree PHCC 02 PA 1	DNCC	PHCC	07 May 2026
20	Nari Maitree PHCC 04 PA 1	DNCC	PHCC	06 May 2026
21	Nari Maitree CRHCC PA 2	DNCC	CRHCC	05 May 2026
22	Nari Maitree, PHCC 04 PA 2	DNCC	PHCC	10 May 2026
23	Nari Maitree, PHCC 05, PA 2	DNCC	PHCC	07 May 2026
24	DAM CRHCC PA 3	DNCC	CRHCC	07 May 2026
25	DAM PHCC 02 PA 3	DNCC	PHCC	10 May 2026
26	DAM PHCC 05 PA3	DNCC	PHCC	10 March 2026
27	BAPSA CRHCC PA 4	DNCC	CRHCC	02 April 2026
28	BAPSA PHCC 01 PA 4	DNCC	PHCC	15 March 2026
29	BAPSA PHCC 03 PA 4	DNCC	PHCC	16 March 2026
30	UTPS CRHCC PA 5	DNCC	CRHCC	09 April 2026
31	UTPS PHCC 02 PA 5	DNCC	PHCC	09 April 2026
32	UTPS PHCC 04 PA 5	DNCC	PHCC	12 March 2026
33	PSTC CRHCC PA-6	DNCC	CRHCC	11 March 2026
34	PSTC PHCC-02 PA-6	DNCC	PHCC	09 March 2026
35	CRHCC, Narayanganj	NCC	CRHCC	06 May 2026
36	PHCC-1, NCC	NCC	PHCC	06 May 2026
37	PHCC-2, NCC	NCC	PHCC	06 May 2026

Garment Factory Clinics:

Facility endline assessments were conducted at 14 of the garment factory clinics out of 15 clinics supported by the project. Of these, nine garment factory clinics are in Narayanganj district, and six garment factory clinics are in Gazipur district. One garment factory clinic in Narayanganj closed their operations due to management issues in the 4th year of project implementation. The list of garment factory clinics where facility planning assessment were done is in Table 3 below:

Table 3: List of garment factory clinics under assessment

S.N.	Name of the Facility	District	Facility Type	Date of Assessment
1	Asrotex Group	Narayanganj	Garment Factory Clinic	30 March 2026
2	Robin Tex Group	Narayanganj	Garment Factory Clinic	11 March 2026
3	R. S. Composit	Narayanganj	Garment Factory Clinic	31 March 2026
4	Fakir Fashion	Narayanganj	Garment Factory Clinic	10 March 2026
6	Metro Knitting & Dyeing Mills Ltd.	Narayanganj	Garment Factory Clinic	13 March 2026
6	BKMEA Health Centre, BSCIC	Narayanganj	Garment Factory Clinic	10 March 2026
7	Knit Concern	Narayanganj	Garment Factory Clinic	12 March 2026
8	K.C. Print Ltd	Narayanganj	Garment Factory Clinic	30 March 2026
9	Square Fashion	Gazipur	Garment Factory Clinic	09 March 2026
10	Hoplun Apparel Ltd.	Gazipur	Garment Factory Clinic	10 March 2026
11	Bravo Apparel Manufacture Limited	Gazipur	Garment Factory Clinic	08 March 2026
12	Garments Export Villega Ltd	Gazipur	Garment Factory Clinic	08 March 2026
13	Mamun Knitwear Ltd.	Gazipur	Garment Factory Clinic	11 March 2026
14	MM Knitwear Ltd	Gazipur	Garment Factory Clinic	11 March 2026

General Practitioners (GPs):

A total of 100 GPs was planned to be supported through this project, and batchwise 91 GPs have been assessed in the endline. Of the 91 GPs assessed, 35 were from Dhaka South City Corporation and 56 were from Dhaka North City Corporations. The information and the date of the GP assessments is in Table 4 below.

Table 4: List of GPs under assessment

S.N.	Number of GPs	City Corporation Area	Intervention Type	Date of Assessment
1	35 GPs	DSCC	General Practitioners	April – May 2026

2	56 GPs	DNCC	General Practitioners	April – May 2026
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Description of data collection methodology

To determine the eligibility of health facilities to be project intervention sites, the selected facilities must have the Ipas Facility Program Planning Tool (**Annex 1**) completed prior to initiating any project activities. This tool was used to determine the baseline metrics which provides a way to measure progress at the end of the project. Hence, we used the same tool for completing the endline assessment at facility level which includes Referral Centers, UPHCSDP clinics and Garment Factory Clinics.

For the GPs baseline assessment, we used a short GP Assessment Checklist (**Annex 2**) considering GPs operate small chambers and do not have the physical structure and resources of a clinic or hospital. GPs are considered as single service points, with their chambers being primarily located within pharmacies and a very small number of general practitioners operating their chambers within their residence.

For the endline assessment, their service data were analyzed to track service provision. In addition, their perspectives were collected through a brief questionnaire (**Annex 3**), where GPs participated in batch discussions and jointly provided recommendations for improving the GP initiative in the future.

The assessments were conducted using paper-based surveys with the relevant tools described above. The project partner BAPSA carried out facility assessments at UPHCSDP clinics, while OGSB conducted the assessments of the garment factory health clinics. Ipas project staff were responsible for conducting endline assessments at the referral health centers as well as GP assessment. Convenience sampling was applied at baseline assessment based on the Memoranda of Understanding (MoUs) signed with the participating health facilities. However, for the endline assessment, all active project-supported health facilities were included. Facilities that had ceased operations or GPs being dropped out by the end of the project period, despite being part of the initial intervention sites, were excluded from the assessment.

Ethical Considerations

No additional ethics approval was required to conduct both the facility baseline and endline assessments. The project signed MoU's with all relevant government authorities prior to project interventions which included access and usage of health facilities data for project monitoring and evaluation purposes. The

project also signed separate MoU's with relevant government authorities such as the Directorate General of Health Services (DGHS), Directorate General of Family Planning (DGFP), Urban Primary Health Care Service Delivery Project (UPHCSDP) and BKMEA (Bangladesh Knitwear Manufacturers and Exporters Association).

Limitations

Two separate data collection tools were used for the assessment based on the service modality of different health facilities under this project. For the health facilities with physical structure, the same Ipas program planning tool (used at baseline) was also used at the endline and for the GPs who are often located in small private chambers, their service data and a brief question guide was used to capture SRH service provision. Data analysis was conducted separately for the health facilities and the GP chambers. For certain indicators, the denominators differ, as SRH service provision by GPs varies from that of structured health facilities.

Data Analysis

Service providers and facility in-charges from each facility were interviewed to complete the relevant tool. The completed tools were submitted to project monitoring and evaluation staff to conduct the following steps:

- Reviewing forms for completeness and verifying for accuracy
- Creating facility entities into relevant database
- Setting-up the database to enter the data from the paper-based tool.
- Analysing the data entered
- Preparing and finalizing report to presenting comprehensive information on the facilities.

The project staff collected health facility assessment information through facility visits and submitted all the filled-out assessment forms to monitoring and evaluation team. A database was developed using Open Data Kit (ODK) software and all assessment information was entered. Following data entry, the information was exported into MS Excel templates. The analysis of this health facility assessment was then conducted using features in MS Excel.

Findings by Outcome

Intermediate outcome 1100: Increased use of SRH services that uphold the rights of women and adolescent girls and are responsive to the needs of underserved and vulnerable groups living in urban slums in Dhaka, including during public health emergencies.

Number of contraception services provided disaggregated by client category, type of method and age category (KPI)

Baseline value:	156,576 (annual)
Target	164,405 (annual)
Endline value:	185,044 (annual)

During health facility assessment visits, information on contraceptive services performed in the last three completed months was collected from each of the health facilities excluding the GP chambers. Based on the data from the three-month period, the annual number of contraception services provided by the health facilities was calculated to be 156,576 (baseline) and 185,044 (endline). Disaggregation by client category, age category was not possible to collect during facility baseline assessment visits as they do not maintain service reporting disaggregated by client and age category. As we calculated an annual number for contraceptive services based on a three-month period, it was not possible to accurately disaggregate by method for both the baseline and endline. However, for monitoring and evaluation these figures were all disaggregated in reporting.

Number of MR services provided (and description of service safety) disaggregated by age category and diagnosis.

Baseline value:	6,092 (annual)
Target	48,505 (cumulative)
Endline value:	9,520 (annual)

During health facility assessment visits, information on MR and PAC services performed in the last three completed months was collected from each of the health facilities with the exception of GP chambers. The number of MR-PAC services provided by the health facilities was calculated to be 6,092 (annually) in baseline and 9,520 (annually) in endline. Disaggregation by age category was not possible to collect during

facility assessment visits as facilities do not maintain service reporting disaggregated by age category. Disaggregation by diagnosis was not possible to provide as we collected MR-PAC service information only for the last three completed months and then calculated for an annual number for both the baseline and endline. However, disaggregation by diagnosis were provided in the reporting for monitoring and evaluation purposes.

As the target for this indicator represents the cumulative total number of MR services provided over the entire project period, progress against this indicator will be reported in the end-of-project report.

Immediate outcome 1110: Improved availability and accessibility to quality SRH services for women and adolescents living in urban slum areas even in times of public health emergencies including pandemics such as COVID-19.

Number of facilities providing services by type and geographical location of facility (North and South city corporations and Narayanganj and Gazipur)

	<i>Number of facilities providing FP services:</i>	<i>Number of facilities providing MR-PAC services:</i>
<i>Baseline value:</i>	<i>46/126</i>	<i>45/126</i>
<i>Target</i>	<i>154/154</i>	<i>154/154</i>
<i>Endline value:</i>	<i>154/154</i>	<i>87/154</i>

Table 5: List of facilities providing FP and MR/PAC services by facility type

Type of health facility assessed in baseline	Baseline		Type of health facility assessed in endline	Endline	
	FP service provision	MR-PAC service provision		FP service provision	MR-PAC service provision
Referral centres (n=12)	12	11	Referral centres (n=12)	12	12
UPHCSDP – CRHCC (n=11)	10	11	UPHCSDP – CRHCC (n=13)	13	13
UPHCSDP – PHCC (n=23)	20	23	UPHCSDP – PHCC (n=24)	24	24
Garment factory clinics (n=10)	4	0	Garment factory clinics (n=14)	14	9
GPs (n=70)	0	0	GPs (n=91)	91	77
Total (N=126)	46 (36.5%)	45 (36%)	Total (N=154)	154 (100%)	135 (88%)

Family planning service provision:

The endline assessment findings on provision of family planning services showed that all 12 (100%) of the referral facilities and 13 UPHCSDP- CRHCCs in Dhaka and Narayanganj district provide a full range of family planning services. All facilities provides both interval and post-partum/postabortion family planning (PAFP).

24 out of 24 UPHCSDP – PHCCs in Dhaka and Narayanganj district were found to be providing short-acting FP methods and long-acting reversible contraceptives (LARC) i.e., Implant and Intra-Uterine Contraceptive Devices (IUD). In the baseline, the three centres under Narayanganj district were not providing any FP services due to unavailability of FP commodities. But now all the UPHCSDP – PHCCs are providing FP services.

Of the 14 garment factory clinics assessed at endline, all of 14 garment factory clinics are providing short acting FP methods (Oral Contraceptive Pills (OCP), Condoms and Injectables) and five (05) garment factory clinics found providing LARC specifically Implants. All of 91 GPs assessed at the endline found providing FP services during the time of endline assessment where none were providing FP services at the baseline.

MR, PAC service provision:

The baseline assessment found that seven of the referral facilities provided both MR and PAC services for gestational ages between 8 to 12 weeks; four referral facilities provided only PAC services, and one referral facility was found not providing MR nor PAC services. The endline assessment found that all the 12 referral health facilities are now providing MR and PAC services. Both the baseline and endline found that eight of the 12 referral facilities reported offering second-trimester PAC services. These facilities were primarily tertiary-level Medical College Hospitals, along with one maternity institute and a private hospital.

At baseline, 10 UPHCSDP-CRHCCs were found providing both MR and PAC service for gestational ages between 8 to 12 weeks. 20 UPHCSDP – PHCCs were providing only MR services and no PAC services based on UPHCSDP's project design where PAC cases are referred to the CRHCCs. However, endline findings indicate that all project-supported facilities—13 UPHCSDP-CRHCCs and 24 UPHCSDP-PHCCs—now have the capacity to provide both MR and PAC services and are doing so accordingly.

None of the ten-garment factory clinic assessed at baseline were providing MR and PAC services. But at the endline, 9 out of 14 garment factory clinics are providing MR and PAC services through using medications.

Similarly, none of the GPs were providing MR/PAC services at the time of baseline assessment. However, the endline assessment found that 77 out of 91 GPs are now providing MR and PAC service using medication.

Provision of other SRHR services at the health facilities:

SGBV Service Provision:

At baseline, only three out of the 12 referral health facilities (25%) reported providing case detection and counselling and medical support to SGBV cases at the baseline. They reported managing SGBV cases such as early marriage, dowry, rape, reproductive coercion (RC), physical assault etc. These cases at referral health facilities are seen by doctors. Nine (75%) of the referral health facilities reported that they do not deal with SGBV cases. However, five of the 12 referral facilities (42%) reported providing referral services for GBV cases.

At the endline, six out of 12 referral health facilities (50%) were providing GBV case detection, counselling, and necessary medical support to survivors. Two referral facilities had dedicated One-Stop Crisis Centers (OCCs), and 10 out of 12 facilities were providing referral services for GBV cases, primarily referring survivors to these OCCs.

The baseline found that all of the UPHCSDP CRHCCs and PHCCs in Dhaka North and South City Corporations and urban clinics of Narayanganj City Corporation provide Violence Against Women (VAW) services which includes case detection, counselling, medical support, and referral as the project was designed to address GBV cases. At endline, all UPHCSDP centers – both 13 CRHCCs and 24 PHCCs continued to provide VAW services in accordance with project guidelines.

At baseline, of the ten garment factory clinics, only four factory clinics reported providing case detection and counselling. The remaining six factory clinics reported that they provide referrals for GBV services following their own referral mechanism. However, the endline assessment found that only two out of 14 factory clinics providing case detection and counselling while the remaining 12 factory clinics were providing referral services only.

Referral Service Tracking:

At the baseline, none of the referral health facilities and garment factory clinics and 26 out of the 30 selected UPHCSDP centres and four urban clinics under Narayanganj City Corporation reported that they have any record keeping system for tracking received referrals related to FP, MR and PAC from community/ GPs or any other sources. Four out of the 12 referral centres reported that they maintain referral mechanisms with Government of Bangladesh (GoB)/ Non-Governmental Organizations (NGO) facilities. Mostly they refer GBV cases to the One-stop Crisis Centre (OCC) of Dhaka Medical College Hospital. Only one facility reported they refer to Gynaecology Indoor for medical services, and to the police for legal support issues. The UPHCSDP centres refer GBV cases mostly to the OCC of Dhaka Medical College Hospital, the female and child abuse centre (Eskaton), the Police Stations for legal aid, and the Ward Counsellor for mutual aid at family level.

At the endline, it is found that all the referral health facilities, garment factory clinics and the UPHCSDP – CRHCCs and PHCCs now have introduced record keeping provision of tracking referred-out cases for each of FP, MR-PAC and GBV cases. However, tracking of referred-in cases remains limited, as no standardized or systemized referral tracking mechanism has yet been established at the national level.

Number of health care facilities that provide quality care as identified by the established criteria (disaggregated by facility type)

Baseline value:	41 out of 56 facilities (73%)
Target	54 out of 54 facilities (9 Referral Centers, 30 UPHCSDP clinics, 5 BGMEA health centers, 10 garment clinics)
Endline value:	49 out of 65 facilities (75%)

During the baseline assessment, 41 health care facilities were providing quality care as identified by criteria developed by Ipas and used for the project. Out of 41 facilities providing quality care, 11 were referral centres and 30 were UPHCSDP centres. One referral centre, 4 UPHCSDP clinics, all 10 garment factory clinics were not providing quality care at the time of the baseline assessment. GPs were not included to calculate this indicator as SRH service provision by GPs varies from that of structured health facilities.

At the endline, 49 health facilities found providing quality care which includes 8 referral health facilities, 8 garment factory clinics and 33 UPHCSDP centers. Four referral centre, 5 UPHCSDP clinics, 7 garment factory clinics were not providing quality care at the time of the endline assessment.

Although the target for this indicator was originally established based on the 54 health facilities included in the Project Implementation Plan (PIP), additional health facilities were incorporated during project implementation. As a result, the denominator used for the endline assessment differs from the original target denominator.

Number of facilities reporting no stock-out of contraceptive commodities in the last 3 months (disaggregated by type of stock)

Baseline value:	40 out of 126 facilities
Target	154 out of 154 facilities
Endline value:	146 out of 154 facilities

Disaggregated by type of stock at baseline: (Emergency Contraceptive Pills (ECP): 39, Condom: 42, OCP: 43, Injectables: 43, Implant: 38, IUDs: 37)

Disaggregated by type of stock at endline: (ECP: 144, Condom: 146, OCP: 150, Injectables: 149, Implant: 72, IUDs: 48)

For this indicator, information was collected from each of the facilities as to whether there was a stock out during past three months. This indicator is based on no stock out of "all contraceptive commodities" listed below as it's expected that facilities will offer full range of contraceptive services to its clients. The facilities reporting no stock-out of contraceptive commodities by each of the facility types (referral, CRHCCs, PHCCs, garment clinics and GPs) can be found below in Table 8 - Table 10. Table 6 and Table 7 is a summary table which reflects the facility status with no stock-out reported at baseline and endline respectively.

Table 6: Summary of reported "no stock-out" status at baseline

Name of contraceptives	Number of facilities reported NO stock-out during past three months					Baseline Total (N=126)
	Referral (n=12)	CRHCC (n=11)	PHCC (n=23)	Garment (n=10)	GPs (n=70)	
ECP	12	7	20	0	0	39
Condoms	12	7	19	4	0	42

Oral pills	12	7	20	4	0	43
Injectables	12	7	20	4	0	43
Implant	12	6	20	0	0	38
IUDs	12	5	20	0	NA	37

The summary table shows that 40 facilities out of 126 facilities reported no stock out of contraceptives.

The number of facilities reporting no stock-out disaggregated by contraceptive stock type are –

ECP = 39, Condom = 42, OCP = 43, Injectables = 43, Implant = 38, IUDs = 37.

Table 7: Summary of reported "no stock-out" status at endline

Name of contraceptives	Number of facilities reported NO stock-out during past three months					Endline Total (N=154)
	Referral (n=12)	CRHCC (n=13)	PHCC (n=24)	Garment (n=14)	GPs (n=91)	
ECP	6	12	21	14	91	144
Condoms	12	12	18	13	91	146
Oral pills	12	13	21	13	91	150
Injectables	11	13	21	13	91	149
Implant	7	6	12	10	37	72
IUDs	8	11	17	12	NA	48

The summary table shows that 146 facilities out of 154 facilities reported no stock out of contraceptives.

The number of facilities reporting no stock-out disaggregated by contraceptive stock type are –

ECP = 144, Condom = 146, OCP = 150, Injectables = 149, Implant = 72, IUDs = 48.

Number of primary service delivery points with at least 3 modern methods of contraception available on the day of the assessment visit (disaggregated by facility type)

Baseline value: 35 of 126 health facilities (referral centres = 9 and UPHCSDP centres = 26)

Target: 79 of 154 health facilities

Endline value: 82 of 154 health facilities (referral centres = 10, UPHCSDP centres = 24, Garment Clinics = 11 and GPs = 37)

For this indicator, the numerator is considered as the number of facilities that answer “YES” to having at least three modern methods available on the day of assessment and at least one of which is an IUD or

Implant. The denominator is considered as the total number of Ipas supported intervention facilities (including referral hospitals, UPHCSDP clinics, garment factory clinics and GPs).

On the day of facility assessments (baseline and endline), we looked at the availability and supplies of contraceptive commodities of the health facilities. At baseline, 35 health facilities were found to have at least three modern methods of contraception available on the day of the assessment visit. (Referral centres = 9 and UPHCSDP centres = 26).

At endline, 45 health facilities were found to have at least three modern methods of contraception available on the day of the assessment visit. (Referral centres = 10, UPHCSDP centres = 24 and garment clinics = 11.)

For GPs, service data were analyzed to assess whether they provided at least three modern contraceptive methods (two short-acting methods and one LARC). Not all GPs were expected to meet this criterion, as they typically only provide short-acting methods. Only those who receive clients seeking implant services and have the capacity to provide implants in their chambers would be able to meet this requirement. At baseline, none of the GPs provided any type of FP services; however, at the endline, 37 GPs were found to have met this criterion.

The status of the availability and supply of contraceptive commodities are presented below by type of health facilities (referral centres, UPHCSDP centres and garment clinics).

Table 8: Availability and supply of contraceptive commodities at referral hospitals

Name of contraceptives	Percentage of referral facilities reported availability of contraceptive supplies			
	Baseline (n=12)		Endline (n=12)	
	Supply available	Never stock	Supply available	Never stock
ECP	42% (n=5)	58% (n=7)	17% (n=2)	83% (n=10)
Condom	83% (n=10)	17% (n=2)	100% (n=12)	0% (n=0)
Oral contraception	83% (n=10)	17% (n=2)	100% (n=12)	0% (n=0)
Injectables	92% (n=11)	8% (n=1)	100% (n=12)	0% (n=0)
Implant	75% (n=9)	25% (n=3)	67% (n=8)	33% (n=4)
IUDs	83% (n=10)	17% (n=2)	75% (n=9)	25% (n=3)

Table 9: Availability and supplies of contraceptive commodities at UPHCSDP centres.

Name of contraceptives	Percentage of UPHCSDP Clinics reported availability of contraceptive supplies			
	Baseline (n=34)		Endline (n=37)	
	Supply available	Never stock	Supply available	No/ Never stock
ECP	21% (n=7)	79% (n=27)	0% (n=0)	100% (n=37)
Condom	79% (n=27)	21% (n=7)	95% (n=35)	5% (n=2)
Oral contraception	79% (n=27)	21% (n=7)	97% (n=36)	3% (n=1)
Injectables	82% (n=28)	18% (n=6)	97% (n=36)	3% (n=1)
Implant	76% (n=26)	24% (n=8)	54% (n=20)	46% (n=17)
IUDs	79% (n=27)	21% (n=7)	86% (n=32)	14% (n=5)

Table 10: Availability and supplies of contraceptive commodities at the garment factory clinics.

Name of contraceptives	Percentage of Garment Clinics reported availability of contraceptive supplies			
	Baseline (n=10)		Endline (n=14)	
	Supply available	Never stock	Supply available	No/ Never stock
ECP	0% (n=0)	100% (n=10)	0% (n=0)	100% (n=14)
Condom	40% (n=4)	60% (n=6)	93% (n=13)	7% (n=1)
Oral contraception	40% (n=4)	60% (n=6)	93% (n=13)	7% (n=1)
Injectables	40% (n=4)	60% (n=6)	100% (n=14)	0% (n=0)
Implant	0% (n=0)	100% (n=10)	79% (n=11)	21% (n=3)
IUDs	0% (n=0)	100% (n=10)	79% (n=11)	21% (n=3)

Additional information on availability and supply of MVA aspirators and MR-PAC drugs are given below.

Table 11: Availability and supply of MVA aspirators and MR and PAC drugs

Indicator	Baseline			Endline		
	Ref (n=12)	UPHCSDP (n=34)	Garments (n=10)	Ref (n=12)	UPHCSDP (n=37)	Garments (n=14)
MVA Plus device available	83%	15%	0%	100%	100%	NA
Single-valve MVA device available	17%	97%	0%	0%	0%	NA
MRM kit available	33%	0%	0%	100%	89%	93%
MPAC kit available	41%	0%	0%	92%	95%	93%
Sharp curettage (D&C) practiced	58%	27%	0%	0%	0%	0%
Cannula sizes available - full range	92%	90%	0%	100%	100%	0%

MVA aspirator stock-out in past 3 months	58%	43%	0%	0%	5%	NA
Pain management used in MVA cases	92%	100%	0%	100%	100%	NA

Availability of MVA Plus increased significantly from 83% to 100% in referral facilities and from 15% to 100% in UPHCSDP facilities. Garment clinics don't have MVA service provision. Availability of single-valve MVA devices has decreased to 0% at endline across referral facilities and UPHCSDP clinics from previously high levels in UPHCSDP clinics (97%). This likely indicates a shift from single-valve MVA devices to MVA Plus devices. Availability of Cannula sizes (Full Range) has increased to 100% in both referral health centers and UPHCSDP clinics at endline. This reflects improved completeness of MVA service equipment. Practice of providing pain management in MVA cases has achieved 100% usage at endline across referral health centers and UPHCSDP clinics, up from already high baseline levels, which demonstrates consistent adherence to quality-of-care standards.

Availability of MRM Kit has improved significantly from 33% to 100% in Referral facilities, 0% to 89% in UPHCSDP clinics, and 0% to 93% in Garment factory clinics. This indicates strong scale-up of MRM service readiness across all facility types. Availability of MPAC Kit has increased from 41% to 92% in referral health facilities and 0% to 95% in UPHCSDP clinics and reached 93% in Garment factory clinics. This shows significant enhancement in post-abortion care readiness. The project also ensured the provision of MRM/mPAC supplies to all active General Practitioners (GPs), who do not receive these commodities from any other source.

Practice of Sharp Curettage (D&C) has reduced from 58% to 0% in referral health facilities and 27% to 0% in UPHCSDP clinics. This is a highly positive outcome, indicating a shift toward safer, recommended procedures. MVA aspirator stock-out (past 3 Months) has substantially reduced from 58% to 0% in Referral centers and 43% to 5% in UPHCSDP clinics; indicates strong improvement in supply chain management.

Number of health care facilities provided with reproductive health commodities, supplies, and materials continually (including IPC & PPE)

Baseline Value:	9 (referral hospitals: 6, UPHCSDP clinics: 3)
Target	54 (9 Referral Centers, 30 UPHCSDP clinics, 5 BGMEA health centers 10 garment factory clinics)

Endline Value:	63 (referral hospitals: 12, UPHCSDP clinics: 37, Garment Clinics: 13)
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For this indicator, whether the health facilities that were continually provided with reproductive health commodities and supplies including the supplies for Infection Prevention and Control (IPC) and Personal Protective Equipment (PPE) were assessed. The table shows a substantial increase in the number of health facilities continuously provided with reproductive health commodities, supplies, and materials (including IPC and PPE) from baseline to endline. At baseline, only 9 facilities met the criteria, including 6 referral hospitals and 3 UPHCSDP clinics. By endline, this number rose sharply to 63 facilities, comprising 12 referral hospitals, 37 UPHCSDP clinics, and 13 garment clinics.

Percentage of targeted service delivery sites meeting minimum quality standard (disaggregated by health facility type)

Baseline Value:	13% (7 out of 56 facilities: Referral centers: 3, UPHCSDP clinics: 4)
Target	75% of sites meet minimal site quality standard
Endline Value:	75% (49 out of 65 facilities: Referral centers: 8, UPHCSDP clinics: 33, Garment Clinics: 8)

This indicator has been calculated for facility-based health centres only i.e., referral hospitals, UPHCSDP clinics and garment factory clinics. GPs were excluded in the assessment as SRH service provision by GPs varies from that of structured health facilities. The table shows a substantial improvement in the proportion of targeted service delivery sites meeting minimum quality standards from baseline to endline. At baseline, only 13% of facilities (7 out of 56) met the required standards, including 3 referral centers and 4 UPHCSDP clinics. By endline, this increased significantly to 75% (49 out of 65 facilities), comprising 8 referral centers, 8 Garment clinics, and a notable 33 UPHCSDP clinics. This marked increase demonstrates significant progress in improving quality of care across facility types, particularly among UPHCSDP clinics.

Percentage of women reporting received quality counselling on SRH

Baseline value:	85.48% (471 out of 551 clients in 1st round of CEI)
Target	92% of women reported receiving quality counselling on SRH
Endline value:	97.41% (376 out of 386 clients in 3rd round of CEI)

The table presents the percentage of women who reported receiving of quality counseling on SRH at baseline and endline. This indicator was analyzed through assessing clients' perceived quality of contraceptive counseling received at project-supported health facilities using Client Exit Interview (CEI) questionnaire. At baseline, 85.48% of clients (471 out of 551) reported receiving quality counseling during the first round of CEI. By endline, this proportion increased to 97.41% (376 out of 386 clients) in the third round of CEI. This notable improvement indicates a substantial enhancement in the quality of counseling services provided at project-supported facilities. The findings suggest that a significantly higher proportion of clients received comprehensive, understandable information, adequate privacy, and guidance on side effects at endline, reflecting strengthened provider performance and improved client experience.

Social support score of women and girls who access abortion (MR & PAC) services at project supported facilities relative to the poverty line and age.

Baseline value:	<i>Received social support mean score: 38.89 (CEI – 1st round)</i>
Target	<i>Received social support mean score 40 out of 45</i>
Endline value:	<i>Received social support mean score: 39.68 (CEI – 3rd round)</i>

Three rounds of Client exit interviews (CEIs) were conducted with service-users/ clients at project-supported facilities. For this indicator, the level of social support received by those who underwent MR and PAC services was assessed using the Received Social Support Scale (R3S), which comprises three sub-scales: emotional support, instrumental support, and informational and appraisal support. The results from the three rounds of CEIs show mean social support scores of 38.89 (1st round), 36.05 (2nd round) and 39.68 (3rd round) respectively out of a possible score 45. These are favorable results on the high-end of the scale.

Immediate outcome 1130: Improved public health emergency preparedness and response to ensure access to & uninterrupted delivery of essential SRH services & supplies during PH emergencies, including pandemics such as COVID-19.

Percentage of sites assessed that are prepared to provide SRH services during Public Health (PH) emergencies.

Baseline value: 38% (20 out of 52 health facilities) (Referral centers = 9 and UPHCSDP centers = 11)

Target: 100% (54 health facilities excluding GP chambers) [Referral centres = 9 UPHCSDP = 30 Garment factories= 15]

Endline value: 100% (63 out of 63 health facilities) (Referral centers = 12, UPHCSDP centers = 37 and Garment clinics = 14)

For this indicator, only facility-based health centers were considered. During baseline only 38% (20 out of 52 health facilities) facilities assessed were found to be prepared to provide SRH services during public health emergencies. The endline result showed all 100% of the project supported health facilities are prepared to provide SRH services during emergencies. A more detailed of the baseline finding on preparedness during PH emergencies is given below.

Public Health Emergency Preparedness:

All of the project referral health facilities reported that they have guidelines on MR, PAC, FP and SGBV services during public health emergencies. 67% of the referral health facilities reported they have guidelines on infection prevention and control (IPC) specific to public health emergencies and 50% of the facilities reported that their service providers received training on IPC to deal with emergency situations. Regarding supplies, 83% of the facilities reported they have adequate supplies related to IPC including Personal Protective Equipment (PPE) for service providers to use during emergencies. Source of IPC related supplies to facilities are Government (67%), NGOs (25%), City Corporation (8%) and Private (8%). Only 33% of the referral facilities reported they received local support (beyond government system e.g., managed by local representatives, donations etc.) in emergency situations.

All of the UPHCSDP health centers reported that they have guidelines on MR, PAC, FP and SGBV services during public health emergencies. 85% of the UPHCSDP centers reported they have guidelines on Infection Prevention and Control (IPC) specific to public health emergencies and 74% of the UPHCSDP centers reported that their service providers received training on IPC to deal with emergency situations. The majority of centers (97%) reported they have adequate supplies related to IPC for service providers during emergencies. Source of providing IPC related supplies to facilities are the UPHCSDP Project management Unit (PMU) (59%), City Corporation (16%), Government of Bangladesh (13%) and NGOs (12%).

None of the garment factory clinics reported that they have guidelines on MR, PAC, FP and SGBV services during public health emergencies. Only two garment factory clinics reported that their service providers received training on IPC to deal with emergency situations and have adequate supplies related to IPC for service providers during emergencies which they managed privately.

The baseline assessment was conducted just after the COVID-19 pandemic and found that 38% of facilities were prepared to provide SRH services during public health emergencies. But during the endline assessment it is found that 100% of the facilities were prepared to provide SRH service during emergencies. s Service providers, managers and relevant support staff of the project supported facilities are trained on infection prevention and control (IPC) specific to public health emergencies. Although early preparedness and response are critical to protecting the health of underserved women and adolescent girls during public health emergencies, no comprehensive national Emergency Preparedness and Response Plan (EPRP) existed for urban populations—especially for SRHR services before the project. Acknowledging the vulnerability of slum dwellers, low-income residents, and gender-diverse groups, the Improving SRHR in Dhaka project, in collaboration with the Ministry of Health and Family Welfare (MOHFW), the Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC) developed an Emergency Preparedness and Response Plan for urban areas to ensure uninterrupted access to essential SRH services and supplies during public health emergencies. This plan is expected to guide health facilities to provide SRH services during public health emergencies.

Additional Findings:

Record keeping and reporting:

Baseline findings show that reporting systems were largely functional across facility types, with all referral hospitals regularly reporting FP, MR, PAC, and SGBV data to multiple national and local MIS platforms.

However, record-keeping practices were inconsistent and often incomplete, particularly in referral facilities. Only 58% of referral facilities found maintained MR–PAC registers satisfactorily, while 42% had gaps in proper documentation. For family planning, 75% of referral facilities found maintained registers correctly, leaving 25% with incomplete records. SGBV documentation was also limited—most referral facilities did not manage such cases, and only 2 out of 4 active facilities maintained updated records.

Among UPHCSDP centers, record keeping was comparatively stronger. The majority used standardized government MR and FP registers, with 88% maintaining both MR–PAC and FP records satisfactorily.

However, existing registers lacked provisions for documenting MR–PAC services using medication, indicating a structural limitation.

In urban clinics of Narayanganj district and garment factory clinics, record-keeping systems were weaker. These urban clinics had minimal or no FP records due to lack of commodity supply, while garment clinics used DGFP registers for short-acting methods but only 30% maintained them satisfactorily. General Practitioners had no service record keeping and reporting system.

Overall, while routine reporting mechanisms were well-established, data quality and completeness of facility-level registers varied significantly, highlighting the need for strengthening standardized record-keeping practices across all facility types.

Based on the baseline findings, the Improving SRHR in Dhaka Project initiated measures to strengthen urban HMIS and establish linkages with the government HMIS. In this regard, uniform service registers for MR–PAC, family planning, and GBV case recording were introduced across different tiers of health facilities, including referral centers, UPHCSDP clinics, and garment factory clinics.

All service providers, counselors, relevant MIS officers, statisticians, and facility managers were oriented on the use of these registers and monthly reporting mechanisms. To ensure alignment, essential modifications were incorporated into the UPHCSDP HMIS (DHIS2), including the integration of key MR–PAC, family planning, and GBV indicators.

As a result, the endline assessment found that 100% of health facilities were maintaining service registers accurately and consistently, and reporting in a timely manner (monthly) to the relevant authorities. In addition, an online service recording app was developed to support general practitioners for easier record keeping and reporting, which was effectively utilized under the project to capture SRH services provided by the GPs.

Communication materials and outreach workers:

At baseline, communication materials were limited and unevenly distributed across facilities, with most focusing only on family planning (FP) and less attention to MR–PAC and SGBV.

In referral facilities, only one-quarter had materials for both MR–PAC and FP, while most had FP materials only (three-fourth), and some had no materials at all (17%). Health education sessions were largely absent, with only one facility offering FP-related sessions. No community outreach activities were reported, and SGBV materials were rarely available.

In UPHCSDP centers, a similar pattern was observed. Very few (9% only) had materials covering both MR–PAC and FP, while most relied-on FP-only materials (77%), and some had none (15%). Around one-third of centers did not conduct any health education sessions, indicating gaps in client awareness efforts.

In garment factory clinics, communication support was weakest, with only a small proportion having FP-related materials (30%) and no evidence of MR–PAC materials or education sessions.

Overall, the findings suggest that client communication and education were weak at baseline, particularly for MR–PAC and SGBV services, highlighting the need for improved IEC materials and structured health education across all facility types.

Based on the baseline gaps, the project implemented several measures to strengthen communication and client education across facilities:

Introduction of standardized communication materials: Appropriate Information Education Communication (IEC)/Behavior Change Communications (BCC) materials on MR–PAC, family planning (FP), and GBV (e.g., flip charts, posters, brochures, festoons, flash cards and FP kit boxes) were distributed across referral facilities, UPHCSDP centers, garment factory clinics and General Practitioners to ensure consistent messaging.

Capacity building of service providers: Service providers, counselors, outreach workers and relevant facility staff were oriented and trained in the effective use of communication materials to improve client counseling and awareness.

Strengthening health education sessions: Facilities were supported to incorporate MR/PAC and GBV issues into their regular health education sessions at the community level, ensuring that clients receive information beyond one-on-one counseling.

Expansion across facility types: Efforts were made to ensure that all tiers of facilities, including previously underserved garment factory clinics, had access to communication materials and improved client education practices.

These interventions contributed to improved availability and use of communication materials, enhanced client awareness, and improved quality counseling at endline. The endline assessment showed that 97% of health facilities had IEC materials on MR-PAC and family planning, including flipcharts, posters, and FP kit boxes. Only 3% of facilities reported having IEC materials solely on family planning. It was also found that service providers in 90% of health facilities used IEC materials—primarily flipcharts—for GBV support. However, in 10% of facilities, service providers were not using any IEC materials to support GBV cases.

Serious Adverse Event management and referral:

At baseline, systems for reporting serious adverse events (SAE) were weak and inconsistent across facility types.

Referral facilities: Only 42% (5 out of 12) had an SAE reporting system in place; some supported by Ipas and others functioning independently, while the majority (58%) had no reporting system at all. Referral practices were also limited: only two facilities reported referring SAE cases to higher-level government hospitals, and just 42% provided referral slips, indicating gaps in continuity of care.

UPHCSDP centers: About 38% had an SAE reporting system, implemented without Ipas support, while 62% lacked any system, showing significant gaps in monitoring and accountability.

Garment factory clinics: None had an SAE reporting system, representing a major gap in patient safety oversight.

Overall, the findings highlight that reporting of SAE and referral mechanisms were inadequate and fragmented at baseline, underscoring the need for standardized systems and strengthened referral practices to ensure patient safety.

Based on the baseline gaps, the project implemented several measures to strengthen SAE reporting and referral systems across facility types:

Standardized SAE reporting system: A uniform reporting mechanism for FP, MR, and PAC-related adverse events were introduced across referral facilities, UPHCSDP centers, and other service delivery points. Service providers and facility managers were trained in identifying, documenting, and reporting SAE cases, including proper use of reporting formats, informing proper reporting channels and proper referrals.

Strengthening referral linkages: Facilities were guided to follow standard referral protocols, including the use of referral slips and linkage with higher-level government hospitals for managing complicated cases.

Improved supervision and accountability: Regular monitoring, supportive supervision, and coordination with government authorities and partners were strengthened to ensure compliance with SAE reporting requirements.

These interventions contributed to improved documentation, reporting, and management of adverse events, ultimately enhancing client safety and accountability across the project-supported facilities.

General Practitioners' Insights on SRHR Service Delivery, Community Engagement, and System Strengthening

The consultation with trained General Practitioners (GPs) under the Improving SRHR in Dhaka Project highlights significant progress in service delivery, particularly in expanding access to family planning, menstrual regulation, post-abortion care, and GBV-related services at the community level. GPs reported increased confidence and competence following training, especially in providing long-acting contraceptive methods and MR/PAC services in line with national protocols. A notable outcome has been the growing trust among clients, including adolescents and women, fostered through respectful, confidential, and non-judgmental care. This has contributed to increased client satisfaction and a visible rise in the number of female clients seeking SRHR services at GP chambers. The introduction of VCAT sessions was also recognized as transformative in addressing provider attitudes and enhancing willingness to deliver sensitive services. Referral linkages across different tiers—from community actors and pharmacies to GPs,

and from GPs to Urban Primary Health Care Centers and tertiary hospitals based on service needs have strengthened continuity of care, while timely reporting practices reflect improved accountability.

At the community level, GPs emphasized the critical role of drug sellers and pharmacy owners in increasing client flow through accurate information dissemination, respectful engagement, and active referral of clients to trained providers. Youth volunteers were identified as an important resource for awareness generation and demand creation, particularly through peer-led communication, community outreach sessions, social media engagement, and observance of health-related events. However, several operational and systemic challenges persist like GPs being a single provider handling patient loads alone, time constraints, complex reporting processes affect routine data entry and reporting. Sensitivity around GBV data and logistical issues with digital tools further complicate record-keeping. GPs expressed a need for simplified reporting mechanisms, ongoing refresher training, supportive supervision, and simplified data entry system to enhance efficiency and accuracy.

Despite progress, GPs continue to face barriers in increasing client uptake of SRHR services. These include limited community awareness, entrenched social stigma, financial constraints among clients, and preferences for informal or traditional healers. Concerns around privacy within chamber settings and weak referral networks in some areas also hinder service utilization. To address these challenges, GPs highlighted the importance of intensified community outreach, improved privacy and client-friendly environments, stronger collaboration with pharmacies, and strategic use of communication materials and digital platforms to promote services. Expanding outreach initiatives, organizing free health camps, and distributing GP contact information were also suggested as practical approaches to reach underserved populations. Overall, the findings reflect both the effectiveness of the project interventions and the need for continued system strengthening to ensure sustained improvements in SRHR service uptake and quality.

Conclusion

When the project began, the gaps were wide. Only a small share of facilities offered the full range of Family Planning services. MR and PAC were concentrated in a few centres. Garment factory clinics were doing almost no MR-PAC work. GPs were not part of the formal SRH system at all. Stock-outs were common, record keeping was uneven, and few facilities were ready for a public health emergency. The endline findings show that most of these gaps have closed in real ways.

The number of facilities providing a full range of family planning services rose from 46 out of 126 at baseline to all 154 at endline. MR-PAC service points went from 45 to 135. The annual number of contraceptive services rose from about 156,000 to 185,000, and MR-PAC services rose from about 6,000 to 9,500. All 91 trained GPs are now providing Family Planning services and 77 of them are also offering MR and PAC using medication — none of the GPs were doing this work at baseline. This change has opened up an important new access point for women and girls in low-socio economic urban areas, who often turn to GPs first at the community.

Quality and safety have also improved. Three out of four facilities now meet minimum quality standards, up from about one in eight at baseline. The unsafe practice of D&C is no longer being used at the project-supported referral health facilities and UPHCSDP centres. MVA Plus devices, MRM kits and mPAC services are now widely available at facility types where they were rare or missing before. The share of clients reporting good-quality counselling has gone up from 85% to 97%. Stock-outs of contraceptive supplies are now uncommon — 146 out of 154 facilities reported no stock-out in the last three months at endline.

Record keeping and reporting are in much better shape. Uniform registers for MR-PAC, Family Planning and GBV are now in use across the different facility types, and key indicators have been built into the UPHCSDP HMIS (DHIS2) to keep it aligned with the national HMIS. An online recording app helps the GPs keep their service data updated. Communication materials on MR-PAC, FP and GBV are now available in 97% of health facilities, and service providers have been trained to use them with clients.

Emergency readiness has moved from 38% of facilities at baseline to 100% at endline. The Emergency Preparedness and Response Plan, developed together with the Ministry of Health and Family Welfare and the Ministry of Local Government, gives the urban health system a working plan to keep SRH services going during future public health emergencies.

Some challenges still remain. Garment factory clinics continue to refer most MR-PAC cases out, even though some have started using MRM and mPAC. SGBV case management at certain referral facilities still needs to be strengthened, and the country does not yet have a standard system for tracking referred-in cases. The GPs face workload and reporting pressures and would benefit from refresher training and simpler reporting tools.

On the whole, the project has helped put a stronger and more uniform SRH service system in place across the project area, with care that is closer to the women and girls of low socio-economic group who need it most. The gains made through training, supply support, register reform and the building of an emergency response plan give a clear path for the government, partners and other stakeholders to build on. To keep these results going and grow them further, continued investment in supplies, supportive supervision and community engagement — especially with adolescents and garment workers — will be essential.

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Annexes:

Annex 1: Ipas Facility Program Planning Tool



Ipas Facility
Planning_Assessment

Annex 2: GP Assessment Checklist



GP Assessment
Checklist_Final.pdf

Annex 3: Short Question Guide for GPs



Short Question Guide
for GPs_Endline Asses