Sexual and Reproductive Health Working Group Joint Monitoring Report 2024

Assessment Period: April 2024 - July 2024

Executive Summary

This report presents the findings of a joint monitoring assessment conducted to evaluate access to, the quality and effectiveness of sexual and reproductive health (SRH) services within the Rohingya response areas of Ukhia and Teknaf. The assessment involved an in-depth review of SRH service delivery processes, consultations with key stakeholders, and extensive site visits to various health facilities. The primary objectives were to examine and enhance the accessibility of services, improve the quality of care provided, assess staff capacity and readiness, and promote effective integration of SRH services across facilities. This report outlines critical gaps in current service provision, identifies successful interventions, and provides a set of actionable recommendations aimed at strengthening SRH services for the affected population.

Introduction

Since the onset of the Rohingya refugee crisis in 2017, Cox's Bazar, Bangladesh, has become a central hub for humanitarian efforts addressing the critical Sexual and Reproductive Health (SRH) needs of this vulnerable population. Led by UNFPA, the SRH Working Group has been implementing joint assessments but without a detailed assessment tool. A joint assessment tool was developed and the conducting of a joint assessment was conducted in response to requests from working group partners who highlighted the need for more structured monitoring visits by the SRH Working Group. The assessment technical team that included representatives from all UN agencies, various NGOs, INGOs, and government health counterparts was established including; UN agencies— UNFPA, UNICEF, UNHCR, IOM, and WHO—as well as multiple NGOs and INGOs such as Save The Children (SCI), International Rescue Committee (IRC), Médecins Sans Frontières (MSF), Ipas- Bangladesh, Handicap International (HI), BRAC, Friendship, Research Training Management International (RTMI), Bapsa, Partners in Health and Development (PHD), GonoSasthyo Kendra(GK: Health Center for all), and Nari Moitri.

This collaborative approach aims to strengthen leadership and accountability within the SRH Working Group, enhance coordination among and participation of partners, and inform targeted capacity- building initiatives for healthcare providers. The findings from the assessment will guide future interventions, ensuring that the reproductive health needs of the Rohingya population are of quality and are met effectively and sustainably.

Objectives

- **Evaluate the Quality and Accessibility** of Sexual and Reproductive Health and Rights (SRHR) Services: Conduct a comprehensive assessment of the effectiveness and accessibility of SRHR services within the facility, including the readiness and capacity to manage antenatal, postnatal, delivery, voluntary family planning, and gender-based violence (GBV) services.

- **Capacity Assessment**: To assess the capacity of health service providers as well as the capacity of health facilities to deliver quality sexual reproductive health services

- **Ensure Compliance with Standards**: Assess the availability, and utilisation of national and international standards and protocols governing the delivery of SRHR services.

- **Opportunities for Improvement**: Identify specific areas for improvement, focusing on the quality of interactions between health workers and patients to ensure respectful, dignified, and responsive health care is provided.

- **Assess Resources Availability**: Evaluate the availability, adequacy, and functionality of essential supplies, equipment, and medications necessary for the comprehensive delivery of SRHR services.

- **Facilitate Continuous Quality Improvement:** Recommend strategic initiatives for ongoing monitoring and enhancement of service quality based on assessment findings.

- **Make Recommendations:** To make recommendations for improving the quality and integration of SRH services.

Methodology

The assessment was conducted using a joint assessment tool developed by the quality assurance technical team of the Sexual and Reproductive Health (SRH) Working Group. This tool was designed in alignment with international standards to ensure a comprehensive evaluation of the services provided.

- **Site visits**: The assessment was conducted by ten inter-agency teams visiting a total of 109 health facilities including 59 health posts, and 50 PHCs.

- **Process of Observation and Data Collection**: The data collection process involved a combination of direct observation and structured interviews. Observers meticulously documented the procedures and practices in real-time, ensuring an accurate reflection of the service delivery environment. In instances where direct observation of certain procedures was not possible, data were collected by asking targeted questions to the relevant staff members. This approach ensured that all critical aspects of service delivery were assessed, even when direct observation was not feasible.

- **Data Reviews**: During the assessment, a comprehensive data review was carried out by meticulously examining the registers to ensure the appropriate validation and accuracy of the data. This process was essential for verifying the integrity of the information collected and for identifying any discrepancies that needed to be addressed.

The assessment combined direct observation with in-depth interviews of service providers to gather insights on service delivery. In cases where procedures couldn't be observed, targeted questions were used to capture detailed information. Data from interviews were cross-checked with registers to ensure accuracy, providing a well-rounded understanding of the services.

Key Findings Summary

Service Accessibility and Coverage

Free comprehensive SRH services were found to be available and accessible in most of the assessed PHCCs as well as health posts. However, midwifery-led care was found to be in 90% of the PHCCs as compared to health posts as many health posts were found to use other cadres of health service providers such as medical assistants, nurses, and paramedics.

More PHCCs were found to adhere closely to national and international standards regarding the practices in patient communication, privacy, and monitoring, fostering a supportive, patient-centered environment. Some health facilities had structural access for persons with disabilities for example rumps at the walkway or washrooms.

- **Quality of Care**

PHCCs were generally found with health care providers with strengthened capacity to provide quality SRH services in comparison with health posts. There is a need to strengthen the capacity of midwives in Health Posts, particularly in emergency obstetric care and risk management, to ensure consistent and quality care. In addition, the PHCCs were generally better staffed as compared to health posts in relation to the ESP.

Essential drug availability was found more available in the PHCCs compared to the health posts. Additionally, some of the health facilities faced stock out of at least one modern family planning method within the last month before the assessment.

The availability of critical diagnostic services like ultrasound and basic laboratory tests such as RDTs for dengue, Hemoglobin Percentage testing, pregnancy tests, and urine dipsticks was found to be limited, particularly at Health Posts, compromising comprehensive care for pregnant women and those in reproductive age groups.

Infection prevention and control (IPC) measures and practices, including hand hygiene and privacy during examinations, need improvement across both PHCCs and Health Posts to ensure patient safety and care quality.

Capacity of Health Workers

The capacity of **service providers** at PHCCs (which are mostly midwives) was found to be more highly skilled in providing comprehensive maternal and child health services, covering ANC, NVD, and PNC services as compared to that of health service providers in health posts (where m**ost of them are not midwives but paramedics and other cadres)**. Their training in emergency obstetric care and family planning methods is a strong asset in service delivery. Health workers at PHCCs also had a better understanding of respectful maternity care, patient counseling, and managing high-risk pregnancies, contributing to improved patient satisfaction and outcomes by reducing obstetric violence.

Integration of Services

PHCCs demonstrate good integration of maternal health services with family planning, provision of clinical management of rape(CMR), availability of GBV registers, CMR management kit, GBV referral pathway with at least one trained staff on CMR, and laboratory investigations, supported by comprehensive referral pathways and strong community outreach mechanisms. GBV case workers were found available in some of the PHCCs. The presence of robust support systems, such as well-documented referral processes and effective communication with Community Health Workers (CHWs), enhances the overall quality and accessibility of services at PHCCs.

Gender-based violence (GBV) management, with staff well-trained and supported by clear guidelines, was found to be present in more PHCs as compared to health posts.

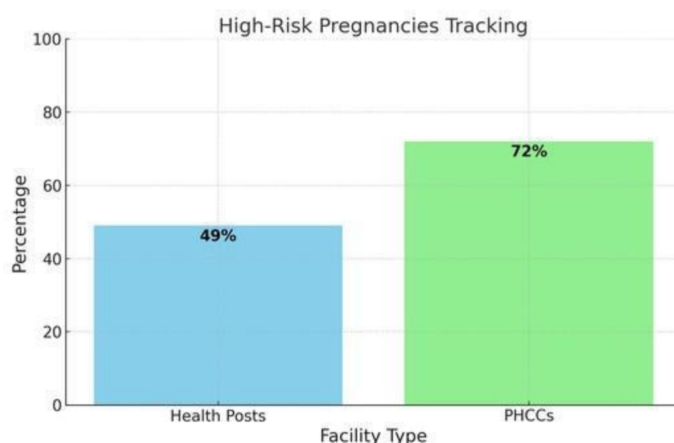
Health Posts struggle with integrating essential services like nutrition and mental health support, which are critical for comprehensive maternal and newborn care. There is a lack of effective coordination and referral systems in Health Posts, particularly in stabilizing patients before referral and ensuring seamless transitions between different levels of care. Improving these aspects is essential to provide holistic care and better health outcomes for mothers and newborns.

Detailed Findings

Antenatal Care (ANC)

Antenatal care (ANC) was generally available and accessible in all health facilities assessed, including Health Posts (HPs), Primary Health Care Centers (PHCCs), and field hospitals. Midwives provided ANC services in 81% of HPs and 90% of PHCCs, often with support from medical assistants and medical officers. The quality of ANC varied, with 77% of health workers at HPs and 82% at PHCCs greeting and introducing themselves to patients.

Only **25% of HPs had national guidelines for quality ANC**, and 49% had no guidelines at all. In contrast, 40% of PHCCs had both national and WHO guidelines available, while 34% had none. ANC registers for identifying high-risk pregnancies were present in 49% of HPs and 72% of PHCCs. Compliance with verifying client information was high, with 91% of health providers at HPs and 88% at PHCCs adhering to this practice. History-taking compliance was 88% at HPs and 82% at PHCCs, while compliance in examining vital signs was 70% and 68% respectively.



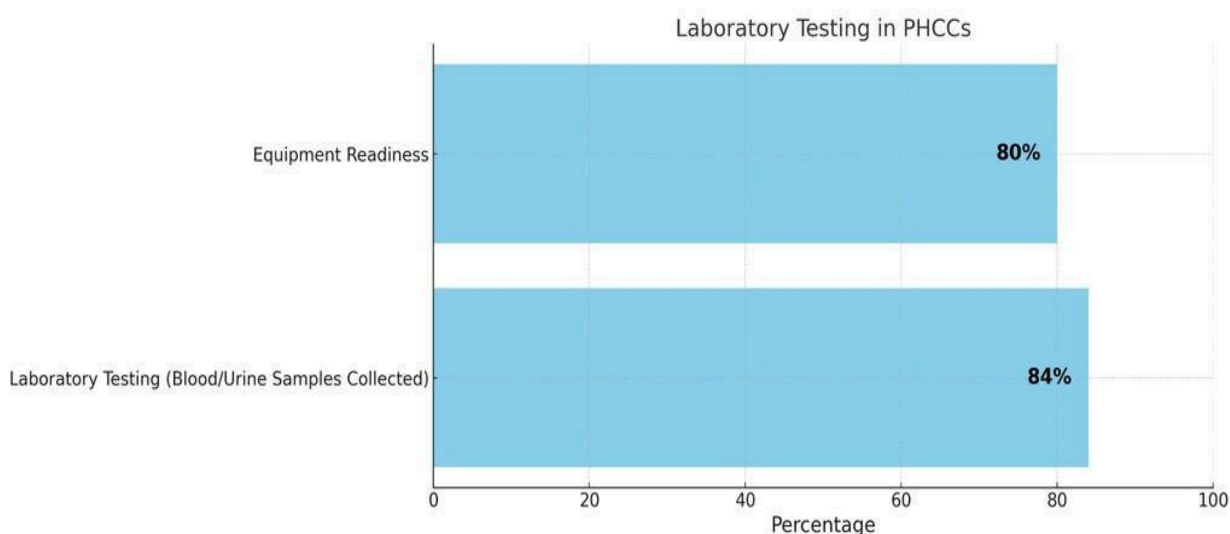
Infection prevention and control (IPC) practices, particularly hand hygiene before ANC examinations and in between patients, required improvement across both HPs and PHCCs. Compliance in counseling on maternal danger signs was 70% for HPs and 82% for PHCCs, and nutrition counseling was provided by 74% of HPs and 66% of PHCCs.

The use of standardized ANC cards was low, with only 2% of HPs and 14% of PHCCs utilizing them. Integration with nutrition services was present in 32% of HPs compared to 60% of PHCCs. Management of high-risk pregnancies showed that only 42% of HPs adhered to established guidelines, while PHCCs had a higher compliance rate of 78%.

Training on respectful maternity care was lacking for 47% of HP staff compared to 64% in PHCCs. Internal assessment mechanisms were present in 70% of HPs and 90% of PHCCs, reflecting disparities in quality assurance processes between the two types of facilities.

Normal Vaginal Delivery (NVD)

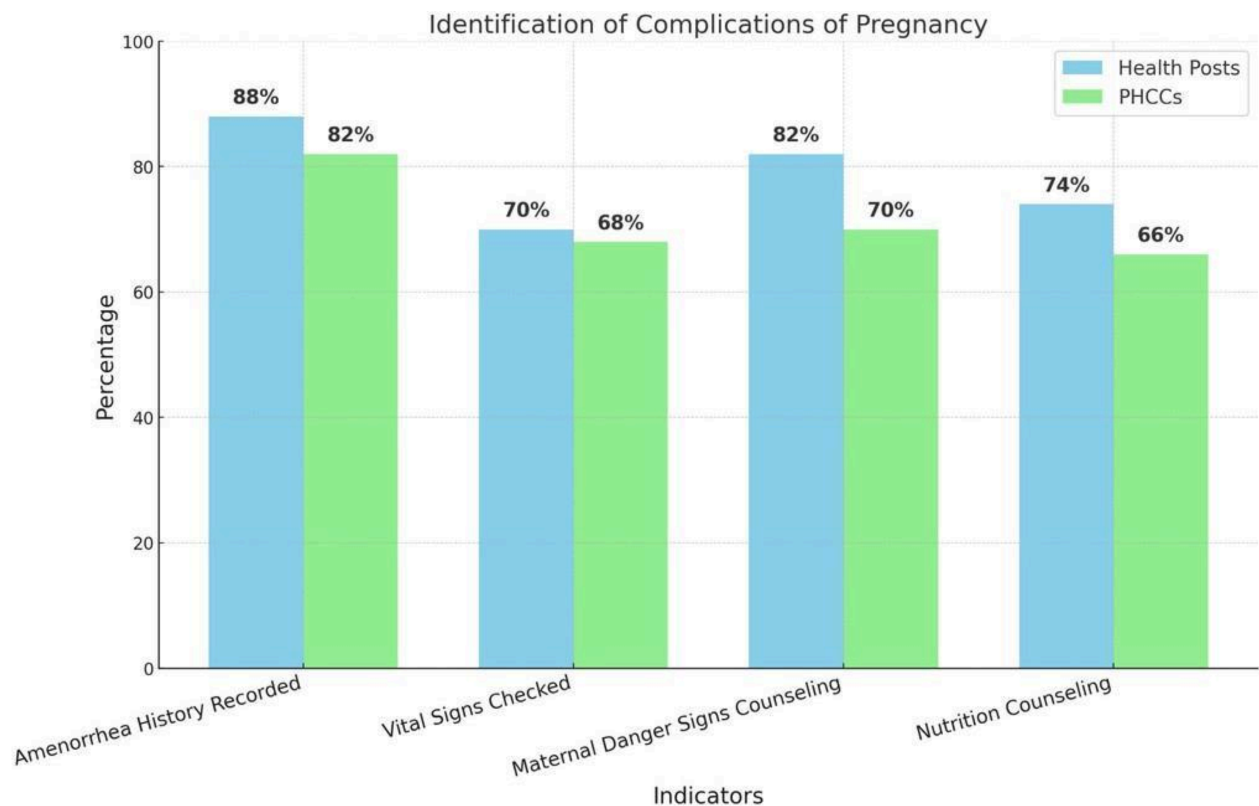
Facility-based delivery was available in all the PHCCs. At Primary Healthcare Centers (PHCCs), midwives are responsible for normal vaginal delivery (NVD) services in 88% of Primary Health Care Centers, showcasing their significant role in maternal care. While other healthcare providers such as nurses, medical assistants, and medical officers provided NVDs in 12% of PHCCs. Respectful maternity care by health workers and patients is crucial. At PHCCs, 70% of health workers greeted women and their companions, introduced, and communicated clearly, creating a positive environment for care. However, this practice is not observed in 30% of the PHCCS, indicating inconsistencies in patient engagement. Furthermore, 84% of facilities report that health workers explain procedures to the patients before examinations, but there is variability in how effectively this is implemented.



In terms of privacy, 78% of facilities ensure private examination conditions, while 22% do not fully adhere to this standard. Comprehensive assessments, including evaluations of gestational age and expected delivery dates, are conducted in 82% of facilities, with a similar level of thoroughness reported in 70% of general health assessments. However, abdominal examinations are only conducted by 78% of facilities, indicating some inconsistencies.

Laboratory investigation practices show that 84% of facilities conduct the minimum investigation such as collecting blood and urine samples for investigations. Partograph adherence/correct partograph use was observed in 74% of facilities. High-risk pregnancies were identified in 80% of facilities. Regarding equipment readiness/preparedness, 80% of PHCCs have essential tools available. Patient-centered care is supported by 80% of facilities allowing women to choose their birthing positions, although this choice is limited to a few options in only one-fifth of PHCCs.

Documentation of NVD and partograph sheets is maintained in 84% of facilities, and 76% of midwives are trained in emergency obstetric management.



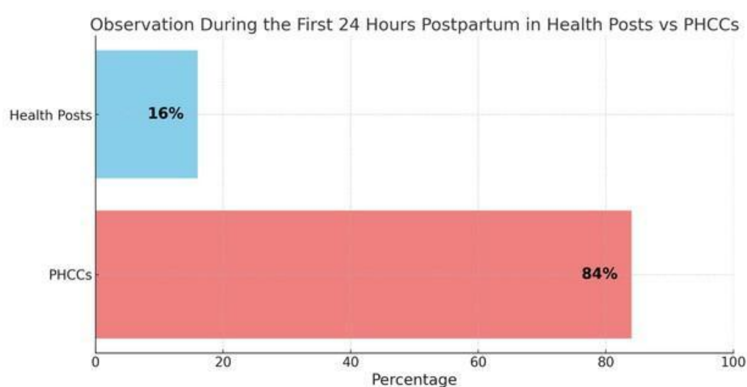
Postnatal Care (PNC) Services

Postnatal care (PNC) services were generally available and accessible in all health facilities assessed, including Health Posts (HPs) and Primary Health Care Centers (PHCCs). Midwives were the primary providers of PNC services, covering 81% of all services at HPs and 92% at PHCCs. In HPs, the remaining PNC services were delivered by medical officers, nurses, medical assistants, and other healthcare workers.

Postpartum care monitoring is carried out in 76% of facilities., Health workers in 84% of PHCCs and 81% of HPs ensured that the next PNC visit was scheduled according to guidelines, promoting continuity of care. Privacy during examinations was maintained in 84% of PHCCs using screens or curtains, while 77% of HPs provided similar privacy measures. Companions were allowed to stay with the woman during consultations in 78% of PHCCs and 82% of HPs, offering emotional support. However, only 16% of HPs ensured observation during the first 24 hours postpartum, compared to 84% of PHCCs.

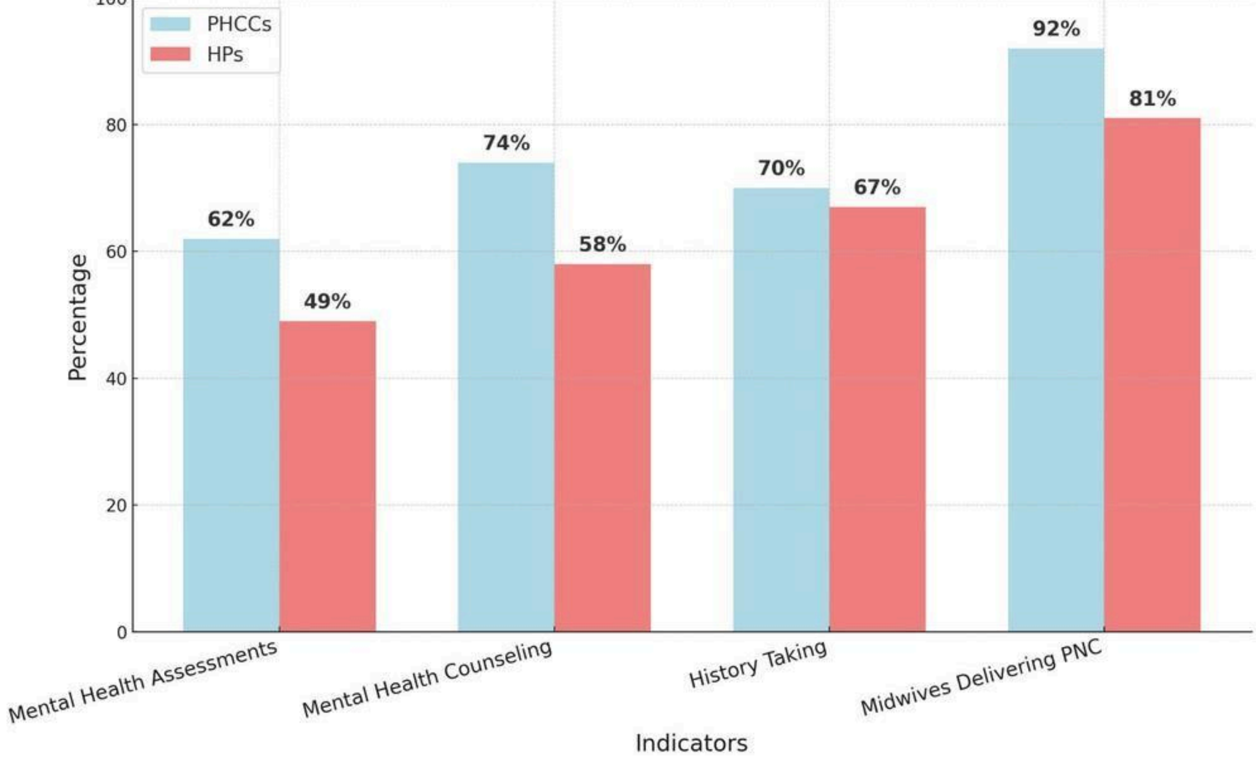
with 68% providing education on breastfeeding techniques.

Counseling on the importance of breastfeeding and immunization was provided in 82% of PHCCs and 81% of HPs. Health workers in 78% of PHCCs and 74% of HPs counseled women on the importance of attending four postnatal visits, while 78% of PHCCs and 75% of HPs provided information on recognizing maternal and newborn danger signs. EPI immunization services or referrals were offered in 90% of PHCCs, compared to 68% of HPs. Furthermore, 92% of PHCCs had an internal mechanism for facility assessment, whereas only 67% of HPs had similar systems in place.

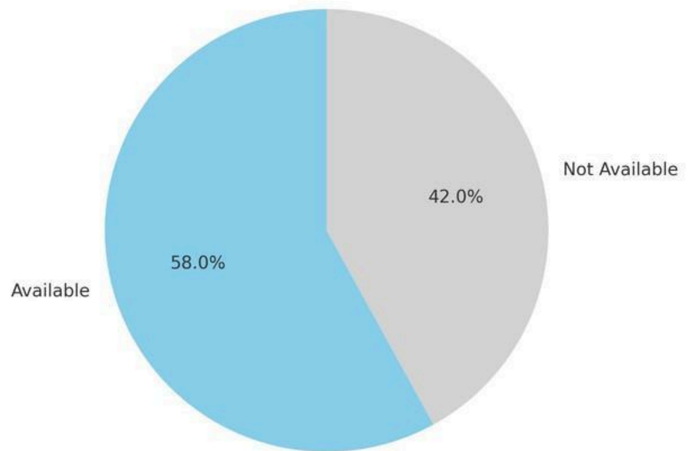


The quality of PNC services varied across facilities. Health workers greeted and introduced themselves to patients in 74% of PHCCs and 75% of HPs, fostering a welcoming environment. General health assessments, including checks of height, weight, temperature, and blood pressure, were performed in 70% of PHCCs and 65% of HPs. Abdominal and breast examinations were conducted in 78% of PHCCs and 70% of HPs, while perineal and pelvic examinations to check lochia discharge were done in 74% of PHCCs and only 58% of HPs. Newborn vital signs, such as heart rate, respiratory rate, and temperature, were measured in 82% of PHCCs, compared to 70% of HPs. The availability of IEC materials, such as posters and flip charts, was higher in PHCCs (64%) compared to HPs (37%).

Health workers in 62% of PHCCs and 49% of HPs conducted assessments for postpartum mental health, including mood swings and anxiety. Postpartum mental health counseling was provided in 74% of PHCCs, while only 58% of HPs offered this service. History taking regarding past illnesses, such as diabetes, hypertension, and asthma, was recorded in 70% of PHCCs and 67% of HPs. Midwives were responsible for delivering 92% of PNC services at PHCCs, while in HPs, they delivered 81% of services, supported by other healthcare providers. This distribution reflects the varying capacity of service providers to deliver comprehensive postnatal care.



Family Planning (FP), Menstrual Regulation (MR), and Post-Abortion Care (PAC) Services

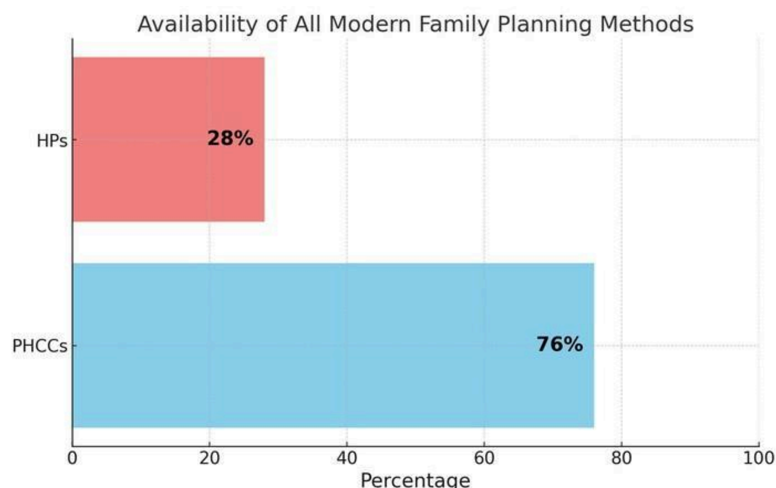


Family Planning (FP), Menstrual Regulation (MR), and Post-Abortion Care (PAC) services were generally available in both Health Posts (HPs) and Primary Health Care Centers (PHCCs). Midwives were the primary providers of these services, accounting for 79% of the total service delivery in HPs and 74% in PHCCs, supported by medical officers, nurses, and other healthcare workers.

Family planning services were available all seven days of the week in 80% of all PHCCs, compared to only 7% of all HPs, indicating limited accessibility in HPs. Confidential and non-judgmental environments were maintained in 92% of all PHCCs, whereas 84% of all HPs ensured the same level of service. Separate counseling and service areas for maintaining privacy and confidentiality were available in 84% of all PHCCs, compared to 65% of all HPs. Additionally, 58% of all PHCCs provided 24/7 PAC services, while only 2% of all HPs offered round-the-clock PAC support.

Modern family planning methods were offered in 76% of all PHCCs, whereas only 28% of all HPs provided comprehensive family planning options. FP counseling charts and the WHO wheel of family planning were available in 70% of all PHCCs and 46% of all HPs. Adolescents seeking family planning services were accepted in 92% of all PHCCs and 81% of all HPs, demonstrating broad coverage for youth. FP services inclusive of all genders of reproductive age were available in 92% of all PHCCs and 88% of all HPs. The provision of MR services throughout the week was available in 38% of all PHCCs and only 7% of all HPs.

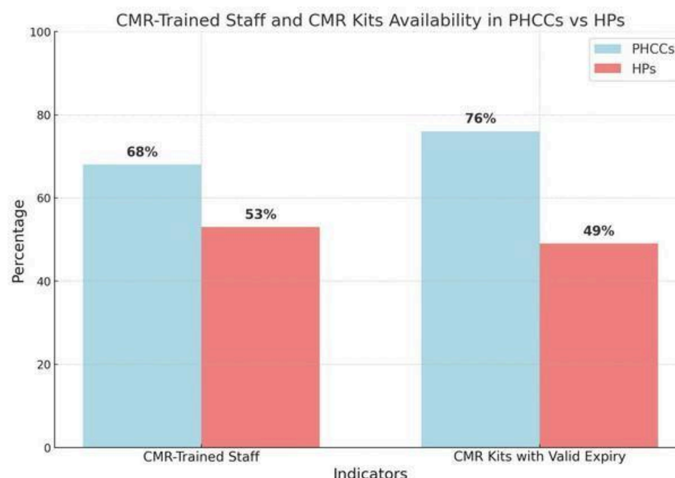
The quality of service delivery varied across the facilities. Health workers greeted clients with respect and dignity in 92% of all PHCCs and 86% of all HPs, promoting a welcoming environment. Vitals and physical examinations, including checks for anemia, jaundice, edema, and dehydration, were conducted in 88% of all PHCCs and 70% of all HPs. Health workers provided accurate information about family planning methods and allowed clients to choose their preferred method in 96% of all PHCCs and 84% of all HPs. Informed consent for long-acting reversible contraception (LARC) was obtained in 78% of all PHCCs, while only 35% of all HPs ensured this practice.



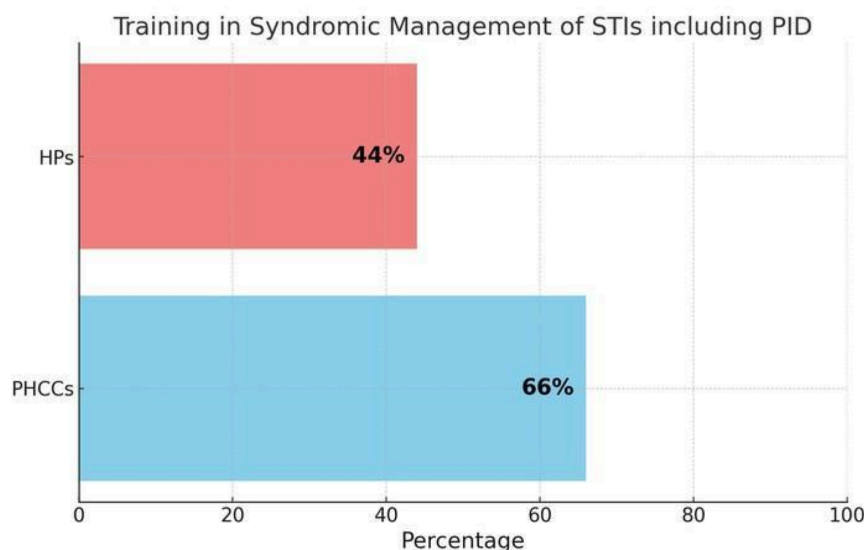
Stockouts of family planning commodities were reported in 16% of HPs and 36% of PHCCs over the past month, signaling a need for improved supply stability in PHCCs. Staff training on family planning service provision was completed in 72% of all PHCCs and 58% of all HPs. Service providers knowledgeable about using the FP wheel were present in 70% of all PHCCs and 44% of all HPs. The capacity to counsel clients on different family planning methods, emphasizing their rights and choices, was ensured by 94% of all PHCCs and 86% of all HPs. Health workers asked clients about their obstetric history and past medical history in 94% of all PHCCs, compared to 82% of all HPs. Internal mechanisms for facility assessment were in place in 92% of all PHCCs and 72% of all HPs, reflecting the ability to maintain and monitor service quality.

Health sector response to GBV, STI, RTI, HIV Services

Gender-based violence (GBV), Sexually Transmitted Infections (STI), Reproductive Tract Infections (RTI), and HIV services were generally available in both Health Posts (HPs) and Primary Health Care Centers (PHCCs). Medical officers were the primary providers of these services in 40% of HPs and 42% of PHCCs, with midwives covering 32% of the total service delivery in HPs and 40% in PHCCs. The involvement of other healthcare workers, such as medical assistants, nurses, and paramedics, supported the overall service provision.

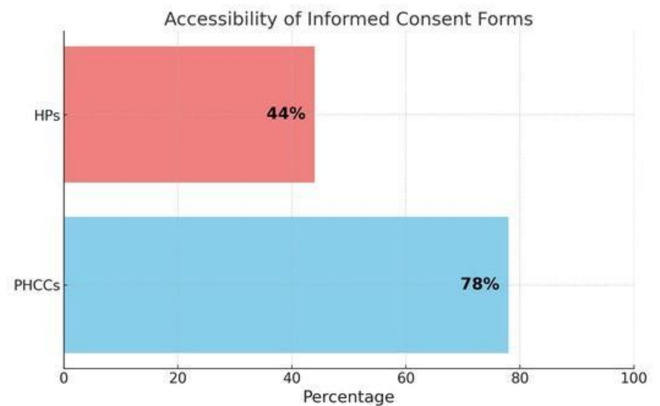


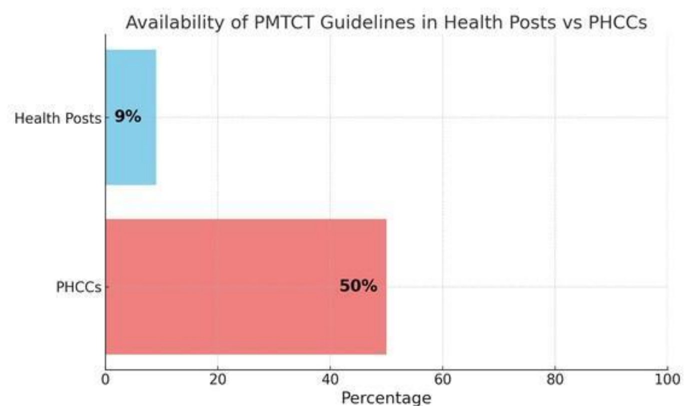
Clinical Management of Rape (CMR) guidelines were available in 68% of all PHCCs, compared to 47% of all HPs. Informed consent forms were present in 78% of all PHCCs, whereas only 44% of all HPs had them available. A visible and updated GBV referral pathway was established in 74% of all PHCCs and 46% of all HPs, ensuring that survivors could access appropriate care. Psychosocial and mental health support for survivors was provided in 92% of all PHCCs and 47% of all HPs, highlighting a gap in accessible support services in HPs. For HIV services, only 26% of all HPs had HIV counseling and testing guidelines available, compared to 62% of all PHCCs. PMTCT (Prevention of Mother-to-Child Transmission) guidelines were in place in 50% of all PHCCs, while only 9% of all HPs had these guidelines available.



GBV registers for recording cases were available in 80% of all PHCCs and 60% of all HPs. At least one CMR-trained staff member was available in 68% of all PHCCs and 53% of all HPs. **Facilities with adequate CMR kits with valid expiry dates were 76% of all PHCCs and 49% of all HPs**. Syndromic management guidelines for STIs were present in 80% of all PHCCs, compared to 53% of all HPs. Similarly, guidelines for syndromic management of RTIs were available in 74% of all PHCCs and 46% of all HPs. Screening services for opportunistic infections for individuals with weakened immune systems due to HIV were provided in 52% of all PHCCs and only 23% of all HPs, reflecting limited coverage in HPs.

The quality of GBV, STI, RTI, and HIV services varied across facilities. Privacy and confidentiality, including the use of lockable cabinets for secure storage of patient files, were ensured in 80% of all PHCCs, compared to 58% of all HPs. Visual privacy during examinations, such as the use of doors, curtains, or screens, was available in 90% of all PHCCs and 75% of all HPs. Adequate lighting in examination rooms was reported in 88% of all PHCCs and 72% of all HPs. Angle lamps for pelvic examinations were available in 78% of all PHCCs and 44% of all HPs, indicating a disparity in examination equipment quality. Health workers maintained privacy and confidentiality in 96% of all PHCCs and 81% of all HPs. Furthermore, 90% of all PHCCs and 67% of all HPs ensured that health workers conducted both general and systemic examinations of mothers.





The capacity of service providers to deliver quality care was highlighted by the presence of CMR- trained staff in 68% of all PHCCs and 53% of all HPs. Training on the syndromic management of STIs, including pelvic inflammatory disease (PID), was completed by health workers in 66% of all PHCCs and 44% of all HPs. Health workers in 92% of all PHCCs and 70% of all HPs took detailed medical and obstetric histories from clients, while 86% of all PHCCs and 70% of all HPs provided counseling on personal hygiene, safe sex practices, and follow-up care. The availability of drugs for the syndromic management of STIs was reported in 86% of all PHCCs and 77% of all HPs. Oral antibiotics, antiretroviral therapy (ART), and post-exposure prophylaxis (PEP) were available in 66% of all PHCCs, compared to 23% of all HPs.

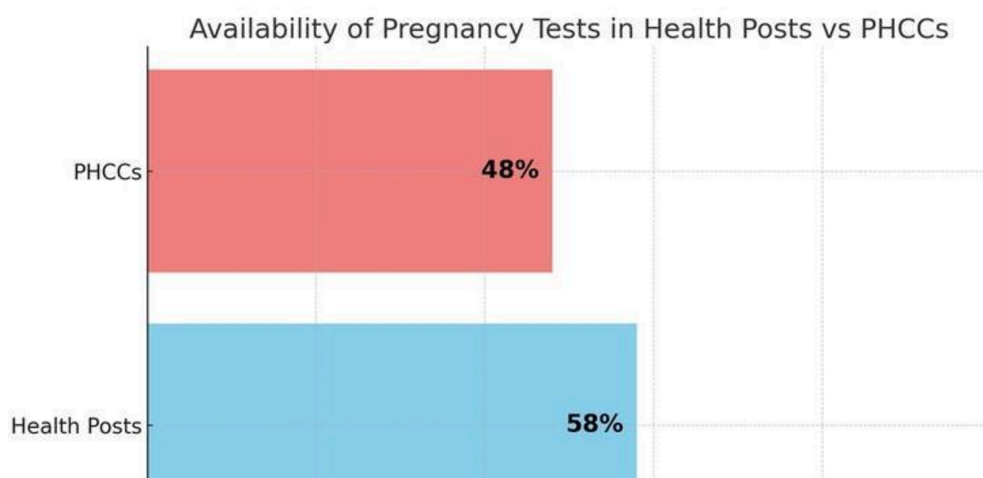
Laboratory Investigation Services

Laboratory investigation services were generally available in both Health Posts (HPs) and Primary Health Care Centers (PHCCs). Laboratory technologists were primarily responsible for conducting investigations, accounting for 49% of the total laboratory service delivery in HPs and 92% in PHCCs. The remaining investigations were managed by other healthcare workers, covering 51% of laboratory services in HPs and 8% in PHCCs.

The availability of essential laboratory investigations varied across facilities. Hemoglobin (Hb%) testing was available in 50% of all PHCCs, while 47 of the 57 HPs offered this test, indicating a wider availability in HPs. Random Blood Sugar (RBS) testing was available in 49 of the 50 PHCCs, whereas 53 of the 57 HPs offered this service, showing good accessibility in both facility types. Blood grouping and RH typing were available in 48 of the 50 PHCCs and in 27 of the 57 HPs, highlighting a gap in service provision at HPs.

Testing for Hepatitis B Surface Antigen (HbsAg) and Hepatitis C Virus (HCV) was available in 96% of PHCCs and 84% of HPs, demonstrating broad coverage within each facility type. The Venereal Disease Research Laboratory (VDRL) test for syphilis was accessible in 94% of PHCCs and 51% of HPs, indicating stronger availability in PHCCs. HIV testing or referral mechanisms were established in 90% of PHCCs and 51% of HPs, highlighting the need for expanded coverage in HPs. Urine tests for protein and sugar were available in 98% of PHCCs and 74% of HPs. Ultrasound (USG) services for pregnancy profiles were offered in 72% of PHCCs but were available in only 25% of HPs, reflecting limited access in HPs. Malaria and dengue testing were available in 94% of PHCCs and 75% of HPs, showing comprehensive coverage across both types of facilities.

The quality of laboratory services was influenced by the availability of essential tests. All but one PHCC offered pregnancy tests, while all HPs provided this service, reflecting strong quality standards for basic pregnancy detection across both facility types. However, the availability of more specialized tests such as USG for pregnancy profiles and comprehensive HIV testing services were significantly higher in PHCCs, highlighting disparities in service quality between PHCCs and HPs.



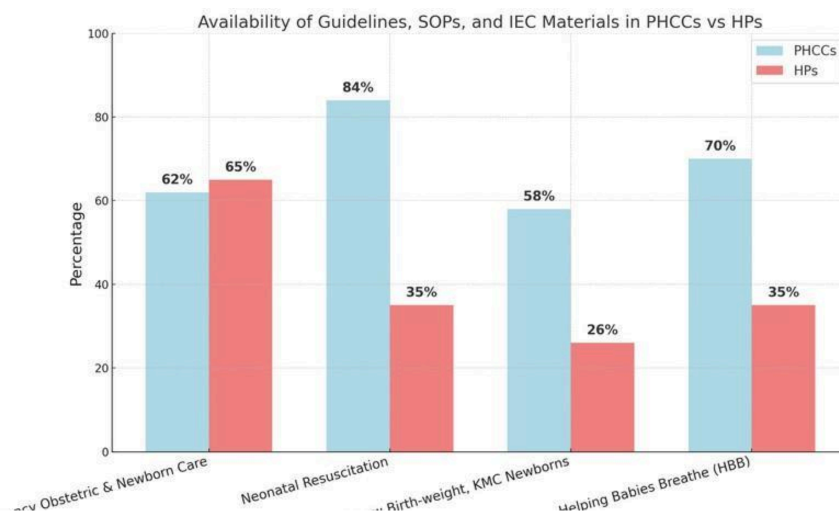
The capacity to conduct laboratory investigations was higher in PHCCs, with 92% of all investigations performed by trained laboratory technologists, compared to 49% in HPs. This reflects a stronger capacity in PHCCs to deliver accurate and reliable laboratory results. In HPs, 51% of laboratory services were managed by other healthcare workers, indicating a need for increased training and recruitment of lab technologists to enhance service capacity.

Guidelines, Standard Operating Procedures (SOP) , and Referral Services

Guidelines, SOP, and referral services were followed by various healthcare providers across Health Posts (HPs) and Primary Health Care Centers (PHCCs). Facility supervisors were primarily responsible for overseeing these processes, accounting for 47% of all responsibilities in HPs and 48% in PHCCs. Medical officers played a significant role, covering 40% of guideline responsibilities in both HPs and PHCCs. Midwives contributed 9% of total responsibilities in HPs and 10% in PHCCs.

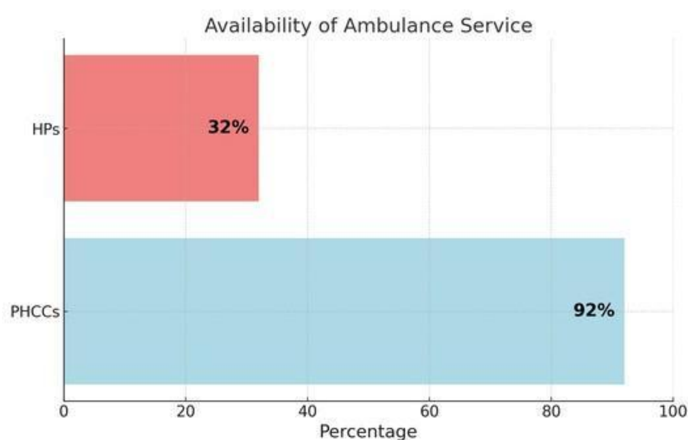
Emergency obstetric and newborn care guidelines were available in 82% of PHCCs and 65% of HPs. Neonatal resuscitation guidelines were in place in 84% of PHCCs and 35% of HPs. Guidelines for the care of pre-term or low birth-weight infants, including Kangaroo Mother Care (KMC), were present in 58% of PHCCs and only 26% of all HPs. "Helping Babies Breathe" (HBB) guidelines were available in 70% of all PHCCs and 35% of all HPs, reflecting limited access to standardized neonatal care practices in HPs. An updated Obstetric referral pathway was in place in 88% of all PHCCs, compared to 63% of all HPs, ensuring better coordination and referral processes in PHCCs.

Stabilization of obstetric referred cases before transfer was achieved in 92% of all PHCCs, while only 75% of all HPs ensured this critical step, indicating a gap in emergency care readiness at HPs. Documentation of referred cases was thorough in 92% of all PHCCs and 79% of all HPs, reflecting stronger coverage in record-keeping in PHCCs. Communication between referral and receiving facilities prior to sending patients was ensured in 98% of all PHCCs, compared to 81% of all HPs, showcasing a need for improved inter-facility communication in HPs. Referral facilities ensured escort documentation with partographs in 90% of all PHCCs, whereas only 23% of all HPs provided this support, indicating significant gaps in comprehensive referral processes in HPs.



Ambulance services were available in 92% of all PHCCs, compared to only 32% of all HPs, highlighting disparities in transportation support for emergency referrals. The quality of referral documentation and communication was high in PHCCs, with 92% of facilities receiving and recording referrals from Community Health Workers (CHWs), compared to 68% of HPs. This reflects better integration and quality in managing referral networks in PHCCs. Additionally, PHCCs provided more comprehensive care, with 58% offering pre-term and low birth-weight care, compared to 26% of HPs, and 70% implementing "Helping Babies Breathe" protocols, compared to 35% of HPs.

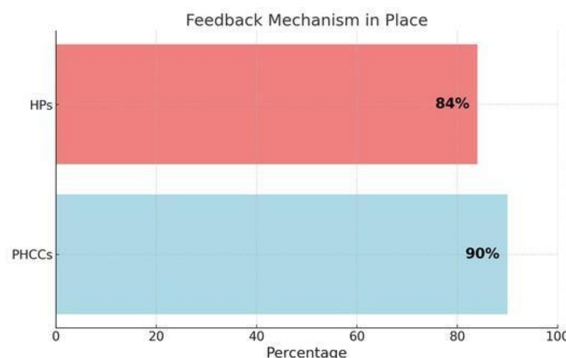
Facility supervisors and medical officers were the primary personnel responsible for guidelines and SOP observation, with supervisors covering 47% of HPs and 48% of PHCCs, and medical officers covering 40% in both facility types. Midwives contributed to 9% of responsibilities in HPs and 10% in PHCCs. The availability of CMR-trained staff and comprehensive SOPs reflects the capacity to manage emergency and referral services more effectively in PHCCs. The lower percentage of HPs with documented referral escorts and ambulance services indicates a need for capacity building in these areas.



Structure and Mechanism

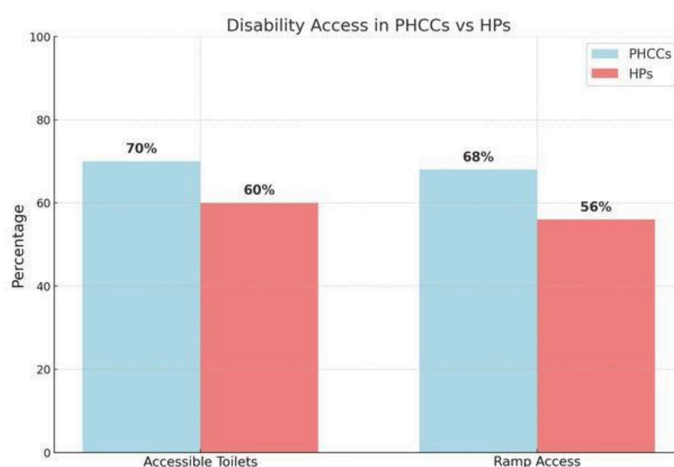
Structure and mechanism oversight in health facilities is crucial for ensuring effective service delivery and operational efficiency. In health posts, 65% have facility supervisors responsible for observing structural mechanisms. Additionally, 32% of health posts have medical officers managing these responsibilities, while 2% of health posts rely on midwives and 2% on other staff for this oversight. In comparison, 64% of PHCCs have facility supervisors overseeing structure and mechanisms, 28% of PHCCs have medical officers in charge, 2% of PHCCs have midwives, 2% have MIS officers, and 2% have other staff contributing to these roles.

Feedback mechanisms were in place in 90% of all PHCCs, compared to 84% of all HPs, ensuring clients had a platform to provide input on services received. Privacy and confidentiality with separate waiting areas for males and females were ensured in 84% of all PHCCs, whereas 72% of all HPs had this arrangement, highlighting a gap in maintaining patient privacy.



Power supply with backup was available in 98% of all PHCCs, compared to 84% of all HPs, ensuring uninterrupted service delivery. Accessible toilets for persons with disabilities were available in 70% of all PHCCs and 60% of all HPs, indicating room for improvement in accessibility infrastructure.

Functional waste disposal systems were in place in 96% of all PHCCs, compared to 84% of all HPs, ensuring proper waste management practices. Similarly, functional wash facilities with running water were present in 96% of all PHCCs and 93% of all HPs, indicating broad coverage in providing basic hygiene facilities. Community outreach mechanisms were available in 92% of all PHCCs and 67% of all HPs, reflecting broader outreach coverage in PHCCs. A structured inventory mechanism for expired drugs, autoclaves, etc., was established in 90% of all PHCCs, compared to 72% of all HPs, demonstrating stronger inventory control in PHCCs.



Maternal Mortality Surveillance Mechanisms for timely reporting within 72 hours of death were in place in 94% of all PHCCs, while only 40% of all HPs had such systems, indicating a significant quality gap in mortality reporting at HPs. Perinatal Mortality Surveillance Mechanisms were established in 92% of all PHCCs and only 39% of all HPs, further emphasizing the need for improved quality in death reporting in HPs. Coordination meetings with Traditional Birth Attendants (TBAs), Community Health Workers (CHWs), and other stakeholders were regularly held in 92% of all PHCCs, compared to 74% of all HPs, showcasing stronger internal coordination in PHCCs.

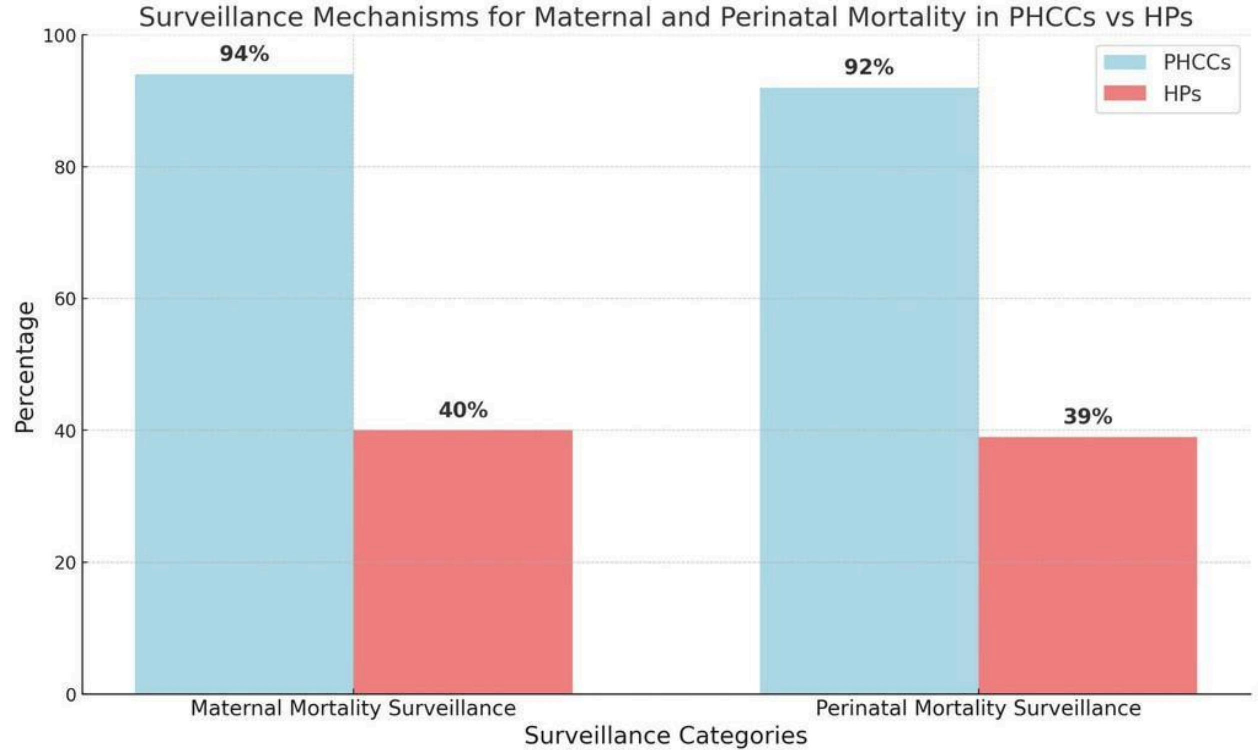
The capacity to manage effective structural and mechanism processes varied between HPs and PHCCs. Only 7% of all HPs had at least six midwives in place, compared to 54% of all PHCCs, reflecting the limited capacity of HPs to handle a high volume of maternal and newborn care. Effective CHW mechanisms were established in 92% of all PHCCs, while only 61% of all HPs had these mechanisms, indicating a need for enhanced community health worker integration in HPs. Additionally, facilities ensuring that 40% of home trials reached their Estimated Delivery Date (EDD) were 92% of all PHCCs, compared to just 37% of all HPs, highlighting a capacity gap in-home visit follow-ups.

Challenges in Conducting the Health Facility Assessment

The assessment of over 100 health facilities posed several logistical and operational challenges for the joint team members. One of the primary difficulties was coordinating mutual availability among team members for field visits, as conflicting schedules often made it challenging to plan visits effectively. Additionally, mobilizing resources such as vehicles for field visits, especially to remote and camp settings, proved difficult at times, causing delays and disruptions to the planned schedule.

This was the first comprehensive assessment of its kind, and there was no prior baseline to guide the process. As a result, establishing a standard methodology and adapting to the diverse conditions across facilities required significant time and effort. The absence of a previous baseline also made it challenging to measure progress or identify trends over time.

A key limitation encountered during the assessment was the inability to directly observe some procedures. In such cases, the team had to rely on interviews and self-reported data from facility staff. While these interviews provided valuable insights, they may not fully capture the nuances and quality of service delivery as direct observation would. Despite this limitation, the data collected through questioning were instrumental in filling the gaps and ensuring a comprehensive assessment of the services provided. A few facilities were found to be not operational/closed and so assessment of the facilities was not done.



Recommendations

1. Enhance Policy Frameworks for Midwifery-Led Care

The shortage of midwives and lack of supportive policies hinder access to quality maternal and newborn care in underserved areas. Advocacy should focus on recruiting, deploying, and training midwives in PHCCs and Health Posts, ensuring skilled care for women in remote regions. Efforts should begin within three months, targeting policy inclusion within a year.

2. Enforce the Implementation of Standard Clinical Practices

Inconsistent adherence to national and WHO-endorsed SRH guidelines impacts care quality for women and newborns. All facilities should adopt these guidelines, with regular audits ensuring compliance. Efforts should begin within three months and achieve full implementation within six months, led by the SRH Working Group and Health Sector.

3. Secure Sustainable Funding for Maternal Health

Limited resources for midwifery services, infrastructure, and supplies in Health Posts and as well in the PHCs heighten maternal and neonatal mortality risks. Engaging governments and donors to enhance funding and developing a resource mobilization strategy will strengthen SRH service delivery and health system resilience. Efforts should start within six months, with funding secured within a year, led by UN agencies, the SRH Working Group, and the Health Sector.

4. Implement Comprehensive Training Programs

Insufficient skills among healthcare providers affect SRH service quality and women's care experiences. Training on Respectful Maternity Care, Values Clarification and Attitude Transformation (VCAT), nutrition, consent, privacy, KMC, and breastfeeding should be prioritized, with routine refresher programs included. Efforts, led by the SRH Working Group and Health Sector Training Units, should begin within three months to achieve 80% coverage in a year.

5. Expand HIV/STI/RTI Care and Management Services

Limited HIV/STI/RTI services and provider knowledge lead to underdiagnosis and inadequate treatment. Advocacy to expand service availability and enhance provider skills in diagnosis and management is essential to prevent infections and improve health outcomes. Efforts should begin within three months, with expanded services in nine months, led by the SRH Working Group and HIV/STI Program Coordinators.

6. Expand Access to Diagnostic Services

Limited diagnostic tools and trained personnel in Health Posts delay accurate treatment, impacting patient outcomes. Investing in diagnostic tools and training lab technologists will enable early detection and timely interventions. Procurement and training should be completed within six months, with full implementation in a year by all the stakeholders according to the essential service package, led by the Health Sector, SRH Working Group, and all the partner organizations.

7. Strengthen Initial Stabilization and Referral Systems

Limited knowledge of stabilization and weak referral systems delay emergency care, raising maternal and neonatal mortality risks. Mentorship, training, updated CEmONC referral pathways, and ambulance availability will ensure timely, life-saving care. Training and review should be completed within three months, with full implementation in six months, led by the SRH Working Group and Referral technical team of Health Sector.

8. Improve Privacy and Dignity in Healthcare Settings

Lack of privacy and sex-segregated facilities affect patient dignity and discourage women from seeking care. Ensuring privacy during consultations and creating sex-disaggregated spaces will build trust and encourage timely care. Facility assessments should be completed within two months, with improvements implemented in six months, led by Facility Managers and the SRH Working Group.

9. Ensure Continuous Supply of Essential Medicines and Equipment

Frequent stock-outs of essential medicines disrupt SRH services and delay care. Strengthening logistics, updating inventory records, and accurate forecasting will ensure a consistent supply chain, reducing service disruptions. System improvements should begin within three months and be fully implemented in nine months, led by Facility Managers, Supply Chain Units, and the SRH Working Group

Conclusion

In conclusion, the joint supportive supervision of sexual and reproductive health (SRH) services reveals significant insights into the current status of access, quality, and availability of these essential services. While notable progress has been made in extending SRH services to all that need them, challenges remain in ensuring that services are consistently accessible, high-quality, and adequately resourced to meet diverse needs. Gaps in infrastructure, staffing, and availability of certain services impact both the quality and reach of care, underscoring the need for continued investment and strategic planning.

Key recommendations include enhancing training for healthcare providers, improving the supply chain for essential SRH commodities, and implementing more robust community engagement strategies to increase awareness and uptake of services. By addressing these areas, we can ensure that SRH services are more inclusive, responsive, and effective in promoting the health and well-being of all individuals. Continued support and conducting of more regular assessments at SRH WG as well as agency/partner levels will be vital in maintaining progress and adapting services to the evolving needs of the population.

Recognitions and Contributions:

Technical lead: Dr. A. A. Shafaatullah, Program Analyst, UNFPA

Monitoring and Technical Team: Kaylene Tomkins (Médecins Sans Frontières - MSF), Dr. Tanveer Ahamed Sujan (Research, Training and Management International - RTMI), Dr. Fatiha Ferdous Simika (Bangladesh Association for Prevention of Septic Abortion - BAPSA), Dr. Tasnuva Sadneen (World Health Organization - WHO), Dr. Nazia Sultana (Food for the Hungry - FH), Dr. Ruamana Jahan (International Rescue Committee - IRC), Dr. Md. Saifuddin Akthar (United Nations Children's Fund - UNICEF), Dr. S M Golam Sarwar (FRIENDSHIP), Dr. Antara Humaira (RTMI), Dr. Tanjina Yeasmin Tamanna (International Organization for Migration - IOM), Dr. Tanjida Basanti (Save the Children), Dr. Tasznuva Tonni (United Nations High Commissioner for Refugees - UNHCR), Dr. Touhida Bulbul (Ipas), Chaity Rahman (Partners in Health and Development - PHD), Saiduzzaman Asif (PHD), Susmita Das (UNFPA), Dr. Sadiya Afroz (Handicap International - HI), Dr. Nargis Sultana (RTMI), Dr. Mushfi (Gonosasthyo Kendra), Dr. Tasnuba Nourin (UNFPA), Dr. Lamia Ibtesham Osman (FRIENDSHIP), Dr. Mahfuza Mousumi (UNFPA)

Contributors: Saiful Islam MPMSR officer - RTMI, Nafiul Azim IM Analyst - UNFPA,

Reviewers: Roselidah Raphael, Head of Sub-Office, UNFPA, Dr. Orwa Al Abdulla, Health Sector Coordinator, Dr. Caroline Nalugwa, SRH Working Group Coordinator

Acknowledgements:
This assessment report recognizes the invaluable support and leadership of the Government of Bangladesh, the Health Sector, and the SRH Working Group. Special appreciation is extended to Dr. Orwa Al Abdulla and Dr. Caroline Nalugwa for their guidance throughout the process.

Dr. A. A. Shafaatullah led the assessment process as the author, overseeing the development of tools, facilitation of workshops, and coordination with partners to ensure seamless implementation in collaboration with the RRRC office.

The monitoring and technical team, composed of experts from diverse organizations, played a crucial role in data collection, analysis, and stakeholder engagement, ensuring the high-quality execution of the assessment.

Participating Organizations: This initiative was made possible through the collaboration of the United Nations Population Fund (UNFPA), World Health Organization (WHO), United Nations Children's Fund (UNICEF), International Organization for Migration (IOM), United Nations High Commissioner for Refugees (UNHCR), Médecins Sans Frontières (MSF), Save the Children, International Rescue Committee (IRC), Ipas, Handicap International (HI), BRAC, FRIENDSHIP, Research, Training and Management International (RTMI), Bangladesh Association for Prevention of Septic Abortion (BAPSA), Partners in Health and Development (PHD), Gonosasthyo Kendra, and Nari Moitri. Their collective expertise and commitment were instrumental to the success of the assessment.

Special Thanks is extended to GoB, RRRC Health Coordinator Dr. Abu Toha Md. Rizuanul Haque Bhuiyan, Assistant Health Coordinator Dr. MD Sarwar Jahan, and all health facilities in Teknaf and Ukhiya supported by SRH Working Group partners for their cooperation during the assessment.

Appendices

Find the below links for the presentation that shows the summary of the initiative and Pictures during workshops to develop the tool, kick off the assessment, and pictures during the assessment.

Presentation presented in Sector

Pictures during the assessment

SRH Working group Joint Assessment 2024,