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BRIEF 2

ENGAGING VOLUNTEER NETWORKS FOR FAMILY PLANNING:

Connecting Communities with Facilities

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INTRODUCTION **The Ministry of Health and Family Welfare in Bangladesh recruited 23,500 family welfare assistants (FWAs)—frontline staff of the Directorate General of Family Planning (DGFP)—between 1978 and 1990 to reach households with family planning services and to generate demand for family planning. Initially, the DGFP assigned each FWA to visit a family planning unit of approximately 600 households every two months. As the population of women of reproductive age increased from 28 million in 1990 to 45 million in 2015, the number of households requiring support from each FWA nearly doubled. With the increasing workload of FWAs, the number of home visits declined dramatically. In several locations, FWAs assumed responsibility for an additional family planning unit where the corresponding FWA position was vacant. The FWAs' workloads further increased in 2009 when they began to serve at community clinics three days per week in addition to continuing their household visits. Currently, FWAs visit 11% of married women of reproductive age.[1]**

To help close the gaps in household visits by fieldworkers, the DGFP encouraged nongovernmental organizations (NGOs) to engage volunteers to reach women with family planning information and to strengthen community-facility referral linkages. EngenderHealth, through the Mayer Hashi II (MH-II) project, funded by the United States Agency for International Development (USAID), provided technical assistance to select NGOs to engage volunteers to disseminate family planning information, generate demand for family planning services—especially long-acting reversible contraceptives (LARCs) and permanent methods (PMs)—and refer prospective clients to the appropriate service delivery facility.

IMPLEMENTATION MODALITY

MH-II engaged six local NGOs: BRAC, Mukti Nari-o-Shishu Unnayan Sangstha (Mukti), Population Services and Training Center (PSTC), Sushilan, the VPKA Foundation, and Young Power in Social Action (YPSA). With support from MH-II, these NGOs built the capacity of 4,135 volunteers and 325 supervisors to conduct family planning demand generation activities in their respective communities. These NGOs also organized family planning special days (locally known as "FP camps"), with support from local DGFP offices and MH-II. The volunteer strategy

[1] NIPORT, Mitra and Associates, and ICF International. 2016. *Bangladesh Demographic and Health Survey 2014*. Dhaka, Bangladesh and Rockville, MD, USA.

was implemented in 28 rural *upazilas* across 7 districts and 12 district towns. BRAC implemented interventions for 25 months, Sushilan implemented interventions for 28 months, and other NGOs implemented interventions for 18 to 21 months. MH-II did not provide remuneration to the volunteers. The project contributed transportation and phone communication costs for the volunteers to contact clients for interpersonal communication (IPC), courtyard sessions, and follow-up.

INTERVENTIONS

MH-II's volunteer strategy included outreach and referral elements. NGOs trained their respective volunteers and assigned them to: (1) conduct IPC and group education sessions through home visits and courtyard meetings, (2) identify prospective family planning clients and refer them to the nearest government or NGO facilities, and (3) mobilize clients for family planning special days.

Building the Capacity of Volunteers and Supervisors

BRAC deployed volunteers from their existing pool, two NGOs (Sushilan and VPKA) recruited new volunteers, and other three NGOs (Mukti, PSTC and YPSA) used volunteers from their existing pool and recruited new volunteers as needed. The recruited volunteers were required to meet a defined set of criteria: each volunteer must be a resident of the community, have completed grade 10 at a minimum, and be between the ages of 18 and 40 years. MH-II trained the NGOs' mid-level staff to supervise volunteers during a three-day training-of-trainers workshop in line with the DGFP's family planning manual. The trained NGO staff then conducted one-day trainings for their respective volunteers; six months after this basic training, the NGO staff conducted one-day refresher trainings. In addition, NGOs used monthly meetings to discuss volunteer performance and to provide further training to continuously improve volunteer performance. MH-II oriented the six NGOs on how to organize family planning special days.

Demand Generation Activities

Each volunteer was responsible for visiting 100–150 households every two months to conduct IPC on family planning methods and to address myths and misconceptions surrounding LARCs and PMs. At the community level, volunteers—under the guidance of a supervisor—organized monthly one-hour courtyard education sessions for 10–15 women of reproductive age and men. In rural areas, volunteers coordinated with FWAs and invited them to the courtyard sessions in order to synchronize with the DGFP's outreach activities. At the IPC and courtyard sessions, volunteers distributed social and behavior change communication materials (e.g., leaflets and hand fans) to strengthen knowledge retention related to family planning. Volunteers worked approximately eight days per month with a flexible schedule. The supervisor monitored the courtyard sessions and visited households to observe the quality of IPC conducted by volunteers and provided on-site coaching to volunteers as needed.

Networking with Government Outreach Functionaries

In rural areas, NGO supervisors and volunteers attended monthly meetings at upazila health complexes and union health and family welfare centers. At the meetings, local DGFP managers reviewed the NGO work plans and the volunteers' activities and performance. These meetings improved the working relationships between NGOs and DGFP's mid-level service providers (known as family welfare visitors) and fieldworkers (i.e., FWAs) and their supervisors (known as family planning inspectors) and strengthened the referral linkages between NGO outreach workers and government facilities for family planning services.

Family Planning Special Service Days

MH-II's advocacy with government family planning offices at the national and district levels enabled the project-supported NGOs to organize family planning special days at government facilities. NGO volunteers conducted outreach activities to mobilize prospective clients for these special days. In rural areas, NGOs organized family planning special days at government facilities; in urban areas, they used government and non-government facilities, following an operating guideline developed by MH-II.

Referral Services

Volunteers maintained client registers, identified prospective clients during home visits, and screened clients for eligibility for specific methods. Then, volunteers linked pill

and condom clients with FWAs, family welfare visitors, or NGO providers. For LARCs and PMs, volunteers identified potential clients, informed FWAs and family welfare visitors, and accompanied these clients to the facilities. Volunteers primarily referred prospective clients to government facilities. MH-II's advocacy resulted in established referral linkages between intervention NGOs and local DGFP facilities. When volunteers referred family planning clients to government facilities, they received a fee to cover the transportation cost for each LARC or PM uptake as a result of their referral, as per government regulation.

Client Follow-Up

The volunteers followed up with each LARC or PM client within the first month of method adoption through household visits and determined whether the new adopters required further follow-up assistance from a provider. Volunteers referred clients experiencing side-effects to an appropriate facility for treatment. In addition, when volunteers conducted routine IPC or courtyard sessions, they followed up with new LARC and PM adopters to ensure that they were pleased with their method of choice. The supervisors visited households within three months of a volunteer visit to follow up and provide additional information, as appropriate.

ACHIEVEMENTS

Between February 2015 and June 2017, the volunteers (under the guidance of their supervisors) organized 34,108 courtyard education sessions with married women of reproductive age. Volunteers visited 710,237 women at home and identified, informed, and referred 242,278 women for injectables, LARCs, or PMs. Referrals by NGO volunteers were effective: 83% of referred clients (201,917 of 242,278) adopted a family planning method (Table 1). Of the women who adopted a method, 74% chose an injectable while the remaining 26% chose a LARC or PM (20% implant, 3% intrauterine device, and 3% sterilization).

Performance varied across the NGOs. Those with a small volunteer network were most successful at reaching clients with family planning information who then chose to adopt an injectable, LARC, or PM. The family planning performance of the four small NGOs—Mukti, Sushilan, VPKA, and YPSA—exceeded their corresponding share in engaging volunteers (Figure 1). For example, Mukti provided 5% of all project-supported volunteers, but their volunteers supported 12% of all family planning adoption. Process monitoring revealed that NGOs with small numbers of volunteers had strong internal supervision and monitoring, held monthly review meetings, and routinely collaborated with the DGFP's local managers to ensure smooth implementation of activities. It is worth noting that large NGOs primarily used their existing volunteers and tasked these volunteers with the project activities in addition to their regular responsibilities.

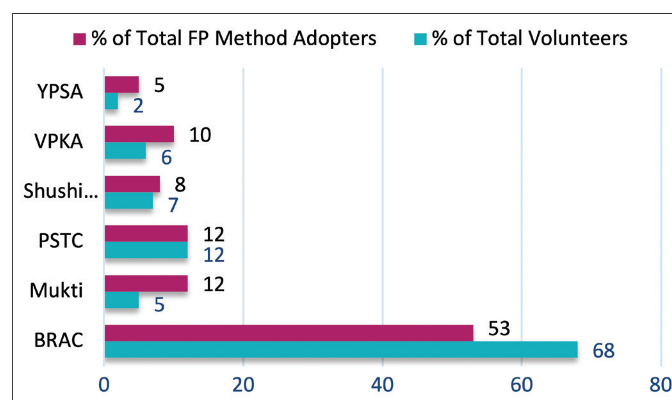

Figure 1: Percent Distribution of Volunteers and of Family Planning Performance, by NGO

Table 1: Number of Volunteers Trained, Clients Visited, Clients Referred, and Methods Adopted

NGO	Volunteers Trained	Clients Visited	Clients Referred	FP Methods Adopted
BRAC (Feb. 2015–Feb. 2017)	2,813	279,875	112,943	107,393
Mukti (Nov. 2015–Jun. 2017)	200	50,542	30,378	23,208
PSTC (Jan. 2016–Jun. 2017)	510	258,377	40,488	24,762
Sushilan (Mar. 2015–Jun. 2017)	275	63,751	24,482	16,323
VPKA (Jan. 2016–Jun. 2017)	240	49,561	22,557	20,437
YPSA (Oct. 2015–Jun. 2017)	97	8,131	11,430	9,794
Total	**4,135**	**710,237**	**242,278**	**201,917**

Source: MH-II database

CHALLENGES

- NGO volunteers are not permitted to distribute pills and condoms during the household visits. The DGFP needs to formulate a policy that will allow NGO volunteers to distribute pills and condoms.
- Because NGO volunteers and their supervisors were not affiliated with local DGFP facilities, they did not always update union- and upazila-level government providers and managers about specific demands for contraception and client concerns in their assigned catchment areas. The government service providers, primarily family welfare visitors, often lacked the information on actual demand for family planning in the communities where volunteers were assigned and remained unaware of the clients in the locality who had complications after receiving a method.

SUSTAINABILITY

The DGFP included a provision for recruiting volunteers for community outreach activities in its Operational Plan under the Health, Population, and Nutrition Sector Development Program 2017–2022. The DGFP also planned to recruit volunteers in 90 upazilas by 2022. As of June 2018, the DGFP had recruited 1,670 volunteers and deployed them to 30 upazilas across 20 districts. These volunteers completed a five-day basic training followed by two-day refresher training. These government volunteers work five days a week and are assigned to visit 200 to 350 young married couples. They receive a daily compensation for their services; this compensation is higher for volunteers working in hard-to-reach areas.

CONCLUSION

MH-II's volunteer strategy, which used simple program inputs (e.g., basic training, refresher training, and onsite mentoring, combined with job aids and communication materials) resulted in effective IPC activities at the community level and successfully linked potential clients with facilities. The biggest achievement of the MH-II project is that the DGFP has, as a result of the project's success, initiated a five-year program to deploy volunteers in hard-to-reach and underserved areas, including those where gaps in community outreach efforts exist due to the increased workload of its FWAs or FWA vacancies. The DGFP-recruited volunteers perform specific community-based activities. Volunteers are responsible for conducting IPC through household counseling and courtyard meetings and for providing referrals and follow-up support—under the supervision of the DGFP's family planning inspectors.

In Bangladesh, many NGOs have a large network of volunteers who provide health and nutrition services. The government can engage those NGOs to implement DGFP's volunteer strategy in areas where FWA positions are vacant or the number of eligible clients is disproportionately high. The DGFP should exercise caution in assessing the workload of existing volunteers prior to engaging them to address gaps in community outreach efforts for the national family planning program.

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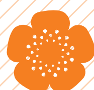

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