MARCH 2020 | POLICY GUIDELINE

Costed Implementation Plan for National Family Planning Program in Bangladesh (2020-2022)

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USAID FROM THE AMERICAN PEOPLE
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Shukhi Jibon
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Pathfinder INTERNATIONAL Sexual and reproductive health without fear or boundary

Cover Image

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS

AHI	Assistant Health Inspector
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
AUFPO	Assistant Upazila Family Planning Officer
BBS	Bangladesh Bureau of Statistics
BDHS	Bangladesh Demographic and Health Survey
BDT	Bangladesh taka
CC	Community Clinic
CHCP	Community Health Care Provider
CIP	Costed Implementation Plan
CPR	Contraceptive Prevalence Rate
DD	Deputy Director
DG	Director General
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DH	District Hospital
DP	Development partner
ECP	Emergency Contraceptive Pill
FP	Family planning
FPI	Family Planning Inspector
FPSA	Family planning Spending Assessment
FWA	Family Welfare Assistant
FWC	Family welfare Center
FWV	Family Welfare Visitor
FYP	Five Year Plan
HA	Health Assistant
HI	Health Inspector
HIV	Human immunodeficiency virus
HPNSP	Health Population and Nutrition Sector Program
HR	Human Resource
HTR	Hard-to-reach
IEC	Information, Education and Communication
IUD	Intrauterine Device
LAPM	Long-Acting and Permanent Methods
LARC	Long-Acting Reversible Contraceptives
LARC&PM	Long-acting Reversible Contraceptives and Permanent Methods
LD	Line Director
M&E	Monitoring and Evaluation
MCH	Maternal and child health/ Medical College Hospital
mCPR	Modern Contraceptive Prevalence Rate
MCWC	Mother & Child Welfare Centre
MISP	Minimum Initial Service Package
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
MOLGRD	Ministry of Local Government, Rural Development and Co-operatives
MoU	Memorandum of Understanding
MR	Menstrual Regulation
MRM	Menstrual Regulation with Medication
MSR	Medical and Surgical Requisites
NGO	Non-Governmental Organization
OA	Office Assistant
OCC	One-stop Crisis Cell/ one-stop crisis center
OP	Operational Plan
PAC	Post abortion care
PMMU	Project management and monitoring unit
PNC	Postnatal Care
QIT	Quality Improvement Team
RMG	Readymade garment
SACMO	Sub-Assistant Community Medical Officer
SDG	Sustainable Development Goal
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
TOR	Terms of Reference
TOT	Training of Trainers
UFPA	Upazila Family Planning Assistant
UFPO	Upazila Family Planning Officer
UH&FWC	Union health and family welfare center
UHC	Upazila health complex
UHFPO	Upazila health and family planning officer
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USD	United States Dollar

Executive Summary

1. Background

Bangladesh has achieved notable progress in family planning even with its limited resources. The TFR declined from 3.0 in 2004 to 2.3 in 2017 and the Contraceptive Prevalence Rate (CPR) increased from 58 percent in 2004 to 62 percent in 2017. However, during the last decade, the CPR has been almost stagnant. In addition, widespread unmet need for modern methods of 12 percent among married couples and discontinuation of the methods by 37 percent of eligible coupes remain significant concerns. Moreover, the limited accessibility to the long-acting reversible contraceptives and permanent methods (LARC&PM) is also a challenge.

Bangladesh is committed to achieving Universal Health Coverage (UHC) by 2032. To achieve this goal the 4th sector plan, known as Health, Nutrition and Population Sector Program (HNPSP), has been developed by the Government of Bangladesh, and includes 32 operational plans (OPs) out of which seven OPs are for family planning aiming to achieve the FP2020 targets --most of which are strongly related to SDGs.

Realizing its importance, a Costed Implemented Plan (CIP) for family planning sector was developed in 2015 with support from UNFPA. The CIP is a critical tool that helps transform family planning goals into concrete programs and policies. The CIP process helps to prioritize appropriate interventions, allocate limited resources, unify stakeholders around one plan, and build the base for increased support. The main purpose of the 2015 CIP was to provide assistance in developing the 4th sector plan; however, the current situation of FP is different from the context when the first CIP was developed. New challenges have appeared and more convincing new evidence of high impact FP strategies especially targeting adolescents that deserve to be included in the HPNSP have also emerged. The HNPSP was initiated in 2017 and there is a provision for a midterm review, which is about to start in the first quarter of 2020. Given these contexts, it is imperative to undertake another CIP for reassessing the resource requirements and advocating changes in the strategies and activities of HPNSP in the upcoming mid-term review.

The overall objective of the current CIP is to assist the midterm review of the Fourth National Health Sector Plan to be undertaken by the Government. The specific objectives are as follows:

- Determine the strategies required to achieve both FP2020 and national level targets
- Estimate the budget required to implement the newly defined and high impact strategies.
- Estimate the resource-gap especially additional resources required to implement the newly defined and high impact strategies.

Given the known challenges in buy-in and acceptability of the former CIP, this CIP was developed in close collaboration with government stakeholders and in alignment with the DGFP seven operational plans. Extra effort has been made to avoid parallel strategies. Where gaps were evident, extensive dialogue with the DGFP and line directors were carried out to generate a consensus on key issues.

2. Major Challenges and Issues of Family Planning Program

The performance of the family planning sector in terms of trend of family planning indicators is uninspiring. In recent decades, FP has lost its impetus, in fact, in many cases indicators show a reverse trend. While some overarching and cross-cutting issues are present, some specific challenges deserve immediate attention.

- Child marriage is unfortunately showing no sign of waning and adolescent pregnancy is still a challenge. The higher prevalence of unmet need among adolescents aggravates the situation. Moreover, not having an effective strategy to take the FP message to male participants—who have a strong voice in decision making given gender norms in Bangladesh—remains an endless challenge.

- Although there is some increasing trend in the use of LARC&PM, thanks to the increased use of implant, the contribution of this method, however, still very small in the method-mix. Though use of implant is on the rise, the total proportion is still less impressive. The persistent lower proportion of IUD remains a significant challenge.
- The urban areas, especially slum areas are still under-served. Some pilot exercises are in place, for example, some activities targeting garment sectors in urban areas and covering slum population in Sylhet. However, the extent of these services' coverage is not on par with the burgeoning urban population. Lack of clarity concerning the purview for FP services between local government and DGFP still remains. In addition, people in urban areas seek health services mostly from private and NGO facilities; however, only the NGOs working under Urban Primary Health Care Services Delivery Project receive FP commodities from DGFP. Government's reach with FP commodities to other facilities (other than public facilities) are less inspiring.
- An effective collaboration between DGFP and DGHS is vital for a successful implementation of the FP program and this effective collaboration is even more important for PPFP. However, a lack of coordination between DGHS and DGFP is still extant with no convincing sign of waning. Unless availability of FP services is strengthened in the DGHS facilities, it would be challenging to improve the overall FP service coverage and thus to reduce unmet need. Unfortunately, very limited scale FP services are available in the DGHS facilities.
- Human resource crisis--partly resulting from the retirement of large volume of field level staff and delay in recruitment--is inhibiting continued and regular FP services in most places. Currently, about 29% posts of field level staff are vacant throughout the country; among which, about 35% are FWAs, 28.50% are SACMOs. These problems are severely hindering service in the hard-to-reach areas where the human resource crisis is more prevalent. The crisis will be more acute in the coming years when a large pool of FWAs and FWVs who were recruited in the 1980s will retire.
- The quality of services is an overarching issue be it for LARC&PM or short-acting methods. Lack of proper attention to management of side effects is constricting the adoption of LARC&PM; for instance, extremely low uptake of IUD compared to neighboring countries insinuates some serious lack in the service delivery for LARC&PM. Unavailability of services coupled with lack of proper counselling and side effect management has been plaguing the uptake of contraceptive and increasing the discontinuation rate. Moreover, since availability of doctors is required for most of the LARC&PM, the human resources crisis of this segment may severely affect the performance for LARC&PM.
- Targeting male clients remains a significant challenge in the family planning sector as it is women centric by design. In addition, gender norms and social structure is hurting the targeting of male clients in both rural and urban areas.
- Currently, only 26% facilities have LARC&PM services, and more than one third of the district hospitals do not provide LARC&PM services; the accessibility is even worse when it comes to private facilities. Therefore, facility readiness is one of bottlenecks in enhancing service coverage.
- Effective monitoring and supervision, and supportive mentorship are regarded as one of the key challenges in service provision. Moreover, human resource crisis further aggravates the problem.

3. Strategies for achieving FP2020 goals

Based on the stakeholders' consultation, review of international and national level evidences, and finally a consultative workshop with the policy makers of DGFP and other policy makers, the study identified some key strategies that are required for achieving FP2020 goals. These strategies are:

- Strengthening service delivery provision in existing facilities (service coverage, current and new FP commodities, HR)
- Increasing acceptability of LARC&PM through skilled HR and engaging male
- Promoting interval and post-partum contraception
- Giving special focus on hard to reach & urban areas and other low performing areas

- Increasing monitoring & evaluation (M&E) and research
- Targeting adolescent especially married adolescents
- Targeting male who are currently uncovered or unreachable

Under each strategy, several activities and sub-activities are identified and costed.

3.1 Key Strategies, Activities and Sub-activities

To achieve the FP2020 goals, several activities are recommended in this CIP and these are costed for the upcoming three years (remaining three years, 2020-2022, of current 4th HPNSP). Note that sub-activities here are actually the inputs used to cost the activities.

3.1.1 Strengthening service delivery provision in existing facilities (service coverage, current and new FP commodities, HR)

Currently around 4,000 health facilities are run by DGFP. Of these, only 74 are in upazila and above level. However, due to lack of proper knowledge about FP methods, side effect management, counseling, etc., they are failing to achieve the expected outcomes. Strengthening all health facilities (including personnel, MSR, contraceptives, IEC materials, etc.) is a must to achieve the goals of FP2020 and sector targets by 2022. With a view to ensuring service coverage and current FP commodities in existing facilities as well as introducing new methods, several activities and sub activities are recommended.

3.1.2 Increasing acceptability of LARC&PM through skilled HR and engaging male

Nine percent of currently married women use a long-acting or permanent method such as female or male sterilization, implant, or IUD. This is quite low compared to the government's target of 20% by 2021. There exists a huge shortage of skilled human resources (HR) as well as lack of male engagement in accepting LARC&PM. Conducting several trainings and workshops throughout the country for all level staff, proper monitoring of services may be important in this regard. Training to the LMAF of the Blue-Star (or similar) pharmacies regarding counseling to the male can be initiated.

3.1.3 Promoting interval and post-partum contraception

In the existing structure, most of the facility deliveries are happening at DGHS facilities where personnel from DGFP are providing FP services. There exists a gap in coordination between these two major wings of MOHFW. This hampers interval and post-partum contraception. Inclusion of private hospitals and clinics in developing PPFP services as well as initiating dedicated counselor for PPFP services in each facility where delivery occur may play a significant role.

3.1.4 Intra and inter sectoral collaboration and co-ordination including NGOs

Intra and inter sectoral collaboration and co-ordination is vital to achieve the FP2020 goals and government's target by 2021. Outsourcing to NGOs may be an interim solution to the shortage of skilled and/or retired human workforce. Coordination meeting on regular basis at all administrative levels is highly recommended. Especially, collaboration between DGFP and DHGS is a must to achieve the FP2020 goals.

3.1.5 Special focus on hard to reach & urban areas and other low performing areas

There are around 1,200 hard-to-reach (HTR) unions spread over 257 Upazilas and 50 districts in Bangladesh. These areas consist of mainly poor households which lack availability and accessibility to the contraceptive methods. Again, households from urban area, especially urban slums, have limited access to contraceptive methods. To achieve the FP2020 goals, HTR and urban households need to be considered with more priority. HTR allowances to the personnel may act as an incentive to regular provision of services in these areas. Outsourcing of NGOs in these areas, initiating mobile team may be noteworthy in this regard.

3.1.6 Monitoring & Evaluation (M&E) and Research

Timely monitoring & evaluation (M&E) and research is required in order to assess whether the family planning program is on track and to understand the root causes of some barriers. But in the existing set

up, M&E and research activities especially much needed research activities are very low in number. Therefore, the study recommends several activities to improve that situation.

3.1.7 Targeting adolescents

Role of adolescents cannot be ignored in achieving the FP2020 goals and government's target by 2021. If adolescents are not aware of contraceptive methods through proper counseling, achieving the goals may not be possible with the existing systems. With a view to targeting adolescents, national level study is required for assessing the need of adolescents. Again, privacy must be ensured while being examined or counseled in the health facilities.

3.1.8 Targeting adolescent with special focus on male

This strategy stresses on adolescents and male clients. Though LARC&PM are mainly used by the females, their male counterpart is the main decision maker, especially among the poor households and households from HTR, urban slums. Again, separate arrangements are required for differently abled adolescents. In our country, buying contraceptives (either male or female methods) before the marriage is considered as taboo, especially in the rural areas. Initiating one counseling session with delivery of male method before and after marriage registration can be crucial for achieving the FP2020 goals and targets. In addition, counseling the parents of adolescents is also needed to make the FP program acceptable to all. Only targeting adolescents may not be fruitful unless their parents are oriented/counseled. Again, religious leaders also play a significant role while making the FP contraceptives acceptable to all eligible couple. High school teachers can also play some role. Considering these, table 4.8 represents the activities and sub-activities required for targeting adolescents as well as engagement of several stakeholders mentioned above.

4. Cost summary of CIP

After all the strategies along with their activities and sub-activities were identified, they have been costed. While the full report covers the details of costing, some glimpse of those findings are presented here. The full cost also covers the costs of contraceptive commodities, costs for filling up the vacant posts, and other relevant costs.

The following table 1 summarizes the cost of CIP over three years (2020-2022). Total cost equals USD 718.51 million over three years. The year 2020 would require much more than the other two years, USD 270.70 million. This is because maximum activities of the strategies are to be ensued in the first year. The second and third years require USD 220.82 million and USD 227 million, respectively. This is due to the inflation rate and increased number of FP contraceptive users projected earlier. On the other hand, implementing the strategies recommended in this CIP will cost more than half (56.48%) of the total cost of CIP. The rest half is for timely and adequate procurement of contraceptive methods.

Table 1: Cost summary of CIP

Method	2020 (USD)	2021 (USD)	2022 (USD)	Total	
				USD	Local Currency
Strategies Total	167,682,808	115,868,914	122,241,704	**405,793,426**	**34,451,861,867**
Contraception Total	61,974,329	63,908,231	63,714,974	**189,597,534**	**16,096,830,604**
Filling up vacant HRs	41,039,310	41,039,310	41,039,310	**123,117,930**	**10,452,712,257**
Total CIP expenditure	**270,696,447**	**220,816,455**	**226,995,988**	**718,508,890**	**61,001,404,728**

Note: Exchange rate is USD 1= BDT 84.90

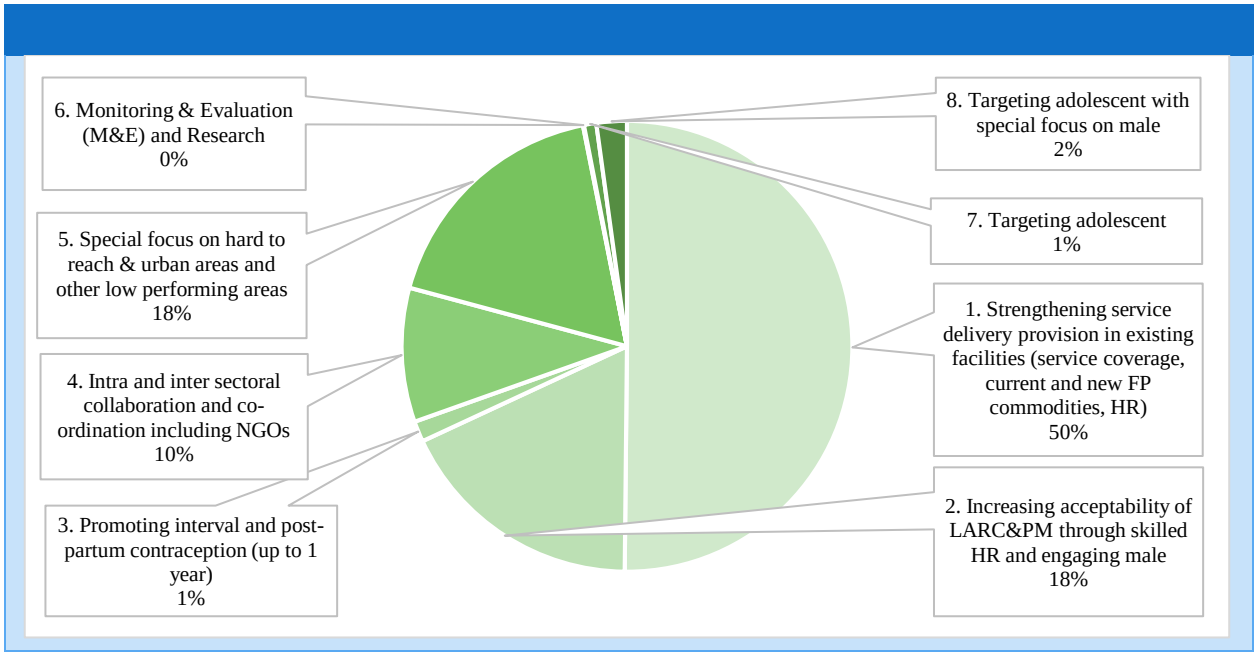
The following table 2 summarizes the cost of the proposed strategies by administrative levels. Around 70% of the total cost will be spent at the upazila level. 17.32% and 7.37% of the total cost will be spent at the union and national level. Ward/ community level and district level requires around 3% each.

Table 2: Cost of proposed strategies by administrative level

	Cost (USD)			Total Cost	
Level	**2020**	**2021**	**2022**	**USD**	**Local Currency**
Ward/Community	4,055,152	4,278,185	4,513,485	**12,846,823**	**1,090,695,250**
Union	22,183,749	23,403,855	24,691,067	**70,278,672**	**5,966,659,235**
Upazila	119,326,348	78,326,960	82,634,942	**280,288,250**	**23,796,472,388**
District	3,990,747	4,128,453	4,355,518	**12,474,717**	**1,059,103,485**
National	18,126,812	5,731,461	6,046,691	**29,904,964**	**2,538,931,447**
Total	**167,682,808**	**115,868,914**	**122,241,704**	**405,793,425**	**34,451,861,806**

The following figure 1 depicts the share of the cost of strategies.

Figure 1: Percentage share of the strategies



Strengthening service delivery provision in existing facilities (service coverage, current and new FP commodities, HR) will cost half of the total cost. Another three of the eight strategies: increasing acceptability of LARC&PM through skilled HR and engaging male; special focus on hard to reach & urban areas and other low performing areas; and intra and inter sectoral collaboration and co-ordination including NGOs will cost about 46% of the total cost of strategies. The remaining five strategies will require around 4% of the total cost.

Some of the activities costed in this CIP are already costed in several OPs of HNPSP. In most of the cases, to achieve FP2020 goals DGFP will need to spend much higher than current budget of OPs. Table 3 compares the costing of CIP with those costed in several OPs of HNPSP. About USD 180.1 million is required more for training, workshop, study and consultancy purpose. USD 158.4 million more is needed for adequate procurement of contraceptives, purchase of consumable stores; and vaccines & other drugs. However, the current budget of OPs exceeds the costs allocated for advertising and similar activities.

Table 3: Comparison of cost in CIP and OPs for matched inputs

Inputs	Projected cost of CIP (USD)	Source of Funds (USD)			
		GOB	GoB through RPA	DPs	Total (USD)
Training, workshop, consultancy and study	180,061,869	8,653,110	8,341,060	4,670,742	21,664,911
Advertisement	776,334	3,320,024	7,265,017	283,863	10,868,904
Contraception methods	198,541,271	14,618,516	137,106,125	3,914,299	155,638,940

Note: Exchange rate is USD 1= BDT 84.90

Adjusting for the costs already included in OPs, the additional costs required to carry out all the strategies suggested is presented Table 4. To conduct all the strategies suggested in this study, additional funding required is USD 373.26 million while this amount will turn into USD 530.34 million if the cost of contraceptives and human resource (filling up the vacant posts) are included.

Table 4: Additional cost required for strategies and CIP

Cost of strategies excluding contraceptives (USD)		Cost of CIP including contraceptives (USD)	
Strategies costed in CIP	405,793,426	Cost of CIP	718,508,890
Strategies costed in OP	32,533,815	Costed in OP	188,172,755
Additional requirement	373,259,611	Additional requirement	530,336,135

5. Possible challenges in implementation

Although the current CIP exercise has identified few areas of intervention to achieve FP2020 and HNPSP 2017-2022 goals some implementation changes remain which may impede or slow down the implementation.

1. Even though both health and family planning sectors are committed to achieving SDG and HNPSP 2017-2022 goals, the bifurcated service system—both at central and field level—pose a serious threat to the implementation. There is an evident and stark lack of coordination between these two divisions of MOHFW may limit the possibility of increased service coverage and quality service provision. For instance, improving PPFP services and increasing service coverage in DGHS facilities require coordinated efforts.
2. A significant number of field level staff are going to retire soon which will linger human resource crisis since hiring new staff involves lengthy bureaucratic procedures. Alternative suggestions--hiring volunteers, hiring retirees in contract basis, and outsourcing services to NGOs--will require some changes in policy. To do so, inter-ministerial coordination will be immensely important, and a lack of effective collaboration can pose a threat.
3. Policy changes will also be needed for making attending compulsory counselling sessions with marriage registration, providing training to traditional providers and pharmacy shopkeepers, increasing the contents of FP in the medical curriculum. All of these actions will necessitate a common understanding on the importance of FP for achieving overall health sector goals which might be challenging.
4. There is a persistent lack of motivation in the FP service providers, managers and field level staff. To achieve FP2020 goals requires not only an effective participation and strong strides in the activities suggested but also strong enthusiasm to do so. The current promotional structure — where it is difficult to motive the staff—may works as a barrier in improving service. Although some motivational interventions are suggested, increasing motivation would be extremely challenging without an overhaul of family planning organogram.
5. Currently, DGFP cannot fully utilize the allocated development budget, and hence, it can be challenging to persuade finance division for the allocation of additional funds.
6. Carrying out all activities suggested would require facility readiness of both DGFP and DGHS facilities. Timely facility readiness can be challenging which can jeopardize a successful implementation.

Detailed Report

1. BACKGROUND

Bangladesh has achieved remarkable progress in family planning (FP) even with its limited resources. The total fertility rate (TFR) declined from 3.0 in 2004 to 2.3 in 2017. The Modern Contraceptive Prevalence Rate (mCPR) increased from 47.3% in 2004 to 52% in 2017. Timely adoption of government policies and effective roles of NGOs and Development Partners (DPs) are the main drivers of this success. However, during the last decade, the CPR has not increased in a significant way. In fact, in 2017 the TFR and CPR remained constant compared to 2011 and 2014 (National Institute of Population Research and Training, 2018). Widespread unmet[1] need for modern methods among 12% of married couples, along with rates of discontinuation of the methods by 37% among eligible coupes, are also of concern. The limited accessibility to contraceptives, especially the long-acting and permanent methods (LAPM) is also a challenge. For adolescents (ages 15 to 19), the situation is even worse as the fertility rate is unusually high (108 live births per 1000 of women) for this age group. Moreover, the unmet need is higher (156 %) and CPR is lower (56%) compared to the national rate (National Institute of Population Research and Training, 2018). This calls for identifying the bottlenecks and outlining required strategies so that access to quality FP services, contraceptive acceptability, and CPR can be improved towards achieving the national targets and commitments.

Bangladesh has made several national commitments to achieve Universal Health Coverage (UHC) by 2032. To achieve this goal the, 4th sector plan, known as Health Population and Nutrition Sector Program (HPNSP), has been developed by the Government of Bangladesh, which includes 32 operational plans (OPs). The seven FP related OPs aim to achieve specific targets by 2022, which are aligned with the FP2020 targets[2]. Moreover, these FP targets related activities also align with the Sustainable Development Goals (SDGs) since family planning is directly and indirectly related to almost all Sustainable Development Goals, especially Goals 3 and 5[3].

Realizing its importance, a Costed Implementation Plan (CIP) for family planning sector was developed in 2015 with support from UNFPA (Ahmed & Islam, 2015). The CIP is a critical tool that helps transform family planning goals into concrete programs and policies. This is designed under the FP2020 initiative. The CIP process helps to prioritize appropriate interventions, allocate limited resources, unify stakeholders around one plan and build the base for increased support. It is worth mentioning that the Ministry of Health and Family Welfare (MOHFW) is the main government authority responsible for providing health care to the entire population and also for policy, planning, and decision making at the macro level. Under the MOHFW, there are two major implementation wings, the Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP). The family planning activities are mainly undertaken by DGFP.

The purpose of developing the previous CIP was to provide assistance in developing the HPNSP. However, the CIP failed to attain its main purpose, as its recommendations were not fully reflected in

[1] Unmet need for family planning refers to the portion of women who are not using any modern method but want to postpone the next pregnancy or stop childbearing.

[2] FP2020 is a global partnership to empower women and girls by investing in rights-based family planning. At the London Summit of FP2020, Bangladesh made a number of commitments. For instance, reducing TFR to 2.0, unmet need of modern FP methods to 10%, etc. (for detail please see the Table 1).

[3] under Goal- 3 of SDG namely, 'Ensure Healthy Lives and promote well-being for all at all ages' there is a sub-indicator, which is by 2030 to ensure universal access to sexual and reproductive health-care services including family planning, information and education, and the integration of reproductive health into the national strategies and programs. Also, another sub-indicator (3.8) is to achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. Again, under the Goal-5 which is to 'achieve gender equality and empower all women and girls' there are several sub-indicators related to family planning; for example, to end all forms of discrimination against all women and girls everywhere (5.1), to eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploration (5.2), to eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation (5.3) etc. In addition, the sub-indicator goal to ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the program of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences (5.6) is also highlighting the importance of family planning.

the HPNSP, in part because there was a lack of policymakers' buy-in. Moreover, it did not include the cost of some essential inputs (Ahmed & Islam, 2015) , which resulted in the underestimation of the resource gap and costing of FP services. In addition, the current environment of FP is likely to be different from the context when the 2015 CIP was developed. New challenges have emerged and more convincing evidence of high impact FP strategies, especially targeting adolescents, that deserve to be included in the HPNSP, are also available. Though the HPNSP was initiated in 2017, there has been a provision for a midterm review, which is about to start in February of 2020. Given these contexts, it became imperative to undertake another CIP for reassessing the resource requirement and advocating changes in the strategies and activities of HPNSP in the upcoming mid-term review.

The overall objective of the current CIP is to assist the midterm review of the 4th National Health Sector Plan to be undertaken by the Government. The specific objectives are as follows:

I. Determining the strategies required to achieve both FP2020 and national level goals
II. Estimating the budget required to implement the newly defined and high impact strategies
III. Estimating the resource-gap, especially additional resources required to implement the newly defined and high impact strategies

Given the known challenges in obtaining the buy-in and acceptability of the former CIP, this CIP was developed in close collaboration with government stakeholders, ensuring alignment with the DGFP's seven operational plans. Extra effort was made to avoid parallel strategies. Where gaps were found (for example, on adolescent programming – see below), extensive dialogue with the DGFP and line directors (LD) were conducted to generate consensus.

2. CURRENT SITUATION AND TRENDS OF FAMILY PLANNING PROGRAM

For the situational analysis, the study relies heavily on data from the Bangladesh Health and Demographic Survey, 2017-18. Before identifying key strategies, it is essential to assess the current state of FP programming and to find the key issues and main areas of underperformance. The strategies are identified based on this analysis.

2.1 National FP Goals, Commitments

Bangladesh is a country with a population of 164.6 million (of which 82.4 million are male and 82.2 million are female) in an area of 147,570 square kilometers with a population density of 1,116 persons per square kilometer (Bangladesh Bureau of Statistics, BBS, 2019). It has 32.1 million households with an average household size of 4.2. The life expectancy at birth for males and females is 70.8 and 73.8 years, respectively. The annual population growth rate is 1.33 percent. The mean age at first marriage is 24.4 years for males and 16.3 years for females. The crude death rate is 5.0 per 1000 population. The infant mortality rate and maternal mortality rate are respectively 22/1000 live birth and 169/100,000 live births (Bangladesh Bureau of Statistics, BBS, 2019).

The Government of Bangladesh initiated FP services in 1965, though civil society efforts had started from the early 1950s. Since then, the FP program underwent several reforms and revaluations before it reached the current state. At present, the DGFP, a separate department under MOHFW, monitors and supervises the FP activities, including those undertaken by other government agencies. To reform the Health and Population Sector and overcome the challenges the Government of Bangladesh launched the first HNP SWAp- the 'Health and Population Sector Programme (HPSP)' during 1998-2003, replacing 128 discrete projects in the MOHFW. The sector program contains the provision of policy packages and operational plans (OPs) towards attaining national targets. Recently, the HPNSP is being implemented from January 2017 to June 2022 and is linked to the 7th Five Year Plan (FYP) of the Government.

The National FP goals and commitments as per the OPs of fourth sector plan are to: reduce TFR to 2.0; reduce unmet need for FP methods to 10%; reduce discontinuation rates of modern FP methods to 20 %; increase CPR to 75 %; and increase long-acting permanent method (LAPM) as a percentage of method mix to 20 %. The available data shows that the current scenarios of these indicators are 2.3 %, 12 %, 37 %, 62 %, and 9 %, respectively (BDHS, 2017). Table 5 represents a comparison of the current state of FP indicators and the desired national FP goals. This is helpful to understand the magnitude of gap the GOB seeks to address.

Table 5: National Targets and Bangladesh current scenarios

Indicators	Committed targets by 2021	Actuals as of 2017	Required annual estimated growth percentage points	Historical trends (annual growth between 2014 and 2017) percentage points
TFR	2.0	2.3%	-0.1	0
CPR	75%	62%	4.33	0
LAPM	20%	9%	3.66	.33
Unmet need of modern FP methods	10%	12%	-0.67	0
Discontinuation rate of FP methods	20%	37%	-5.66	2.33

Source: Bangladesh Announcement at the London Summit of FP2020; BDHS 2017-18

Furthermore, Table 5 indicates that in recent years the performance of Bangladesh was far from optimal in terms of reaching national targets and international commitments (the FP2020 commitment is aligned with the 2021 targets). It is evident that the FP services are not having the desired impact, and therefore new approaches are needed.

2.2 Stakeholders in Family Planning

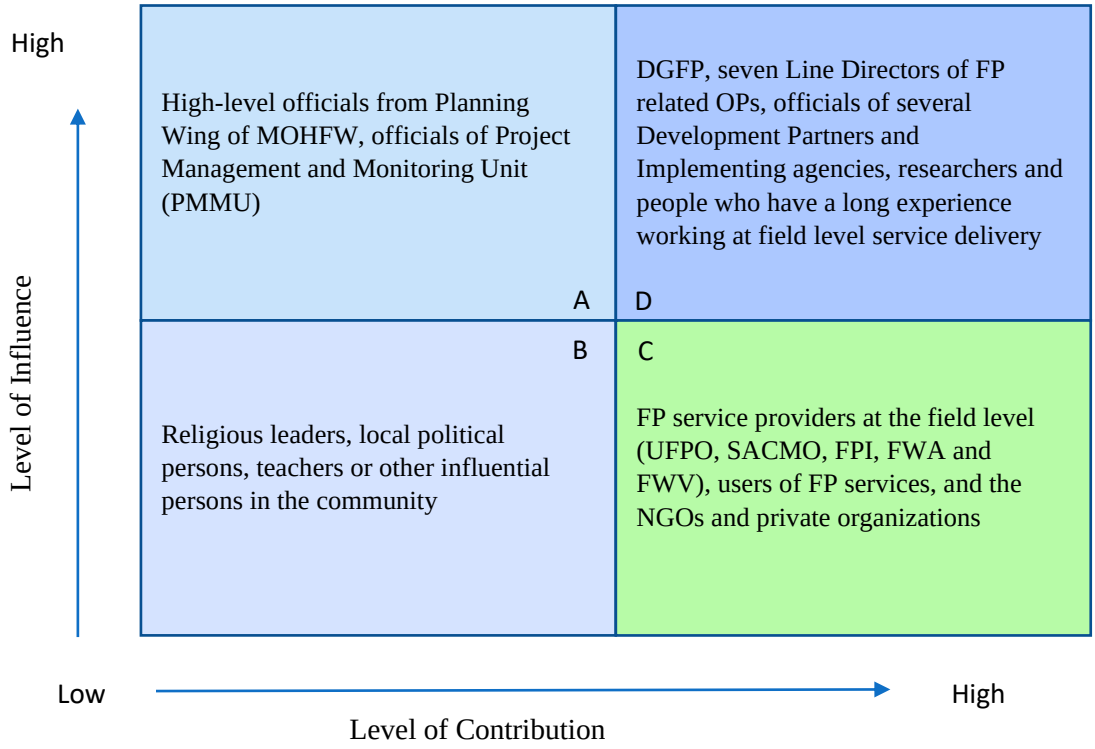
In the context of a CIP for the family planning (FP) program, any person, organization or institution with some level of involvement in the FP program are considered stakeholders. This includes beneficiaries and providers of FP services, the experts with in-depth knowledge on family planning, government officials, and other staff from development partners and international organizations who have direct/indirect influence over the national FP program. In addition, stakeholders can be staff of non-governmental organizations (NGOs), for-profit companies, research and training institutions, and regulatory agencies that work on FP service provision. It is also crucial to include community representatives such as religious leaders, political representatives and leaders, teachers and other influential persons. Several consultation meetings were organized to gain buy-in from the stakeholders for the current CIP development[4]. For the current CIP the selected stakeholders were as follows:

- Directors, Line Directors, Deputy Director, Program Managers of related Operational Plans of DGFP
- High-level officials from Planning Wing of MoHFW
- Officials of Project Management and Monitoring Unit (PMMU)
- Officials of several Development Partners and Implementing agencies
- FP service providers at the field level
- Users of FP services[5]
- NGOs and private organizations (both non-profit and for-profit) that work in family planning areas.
- Religious leaders, local political persons, teachers or other influencing persons in the community

[4] The criteria for selecting stakeholders is part of the guideline of CIP resource kit
[5] Interview with ten short and long acting users at the field level

The following figure 2 stakeholder map was useful in analyzing the types of stakeholders engaged for the current CIP, where the stakeholders are categorized into four groups represented by quadrants labeled A, B, C and D. Quadrant A represents the group which has high influence but less contribution. Similarly, quadrant B, C, and D represent groups with a low influence-low contribution, low influence-high contribution, and high influence-high contribution.

Figure 2: Stakeholders' Map



The CIP research team held consultative meetings with DPs and implementing agencies such as DFID, USAID, Pathfinder, UNFPA, and FP2020, where we discussed the process of CIP development and collected opinions on issues and bottlenecks in the FP program. We also consulted with the Director General of Family Planning and several Line Directors of the family planning program to obtain insights into the status of the FP program and their priorities. We met with Deputy Secretary of Planning-wing of MOHFW to seek support so that the CIP would be considered in the midterm review of the HPNSP. We also visited two upazilas[6], where we talked with several field-level officers (e.g., UFPO, SACMO, FWV, FPI, FWA, and users of FP methods) on the challenges of delivering FP services at the field level and also on the constraining factors of FP services expansion especially the LARC methods. We have consulted with NGOs, private institutions, research organizations to get useful information on family planning which was very helpful for developing effective strategies for the current CIP. We have attempted to seek the support of the PMMU for effective implementation and monitoring.

2.3 Demographic Profiles and FP Indicators of Bangladesh

Table 6 shows the age-specific fertility rates, measured by the number of births per 1000 women. This measure is different than the TFR, which is expressed as the number of births per woman. It can be said that the fertility rate is considerably higher for adolescents (age category 15-19). It is also found that the fertility rate is higher in rural areas in almost all age categories.

[6] We visited two upazilas: Srimangal and Bahubal under Hobiganj district on October 13-14, 2019.

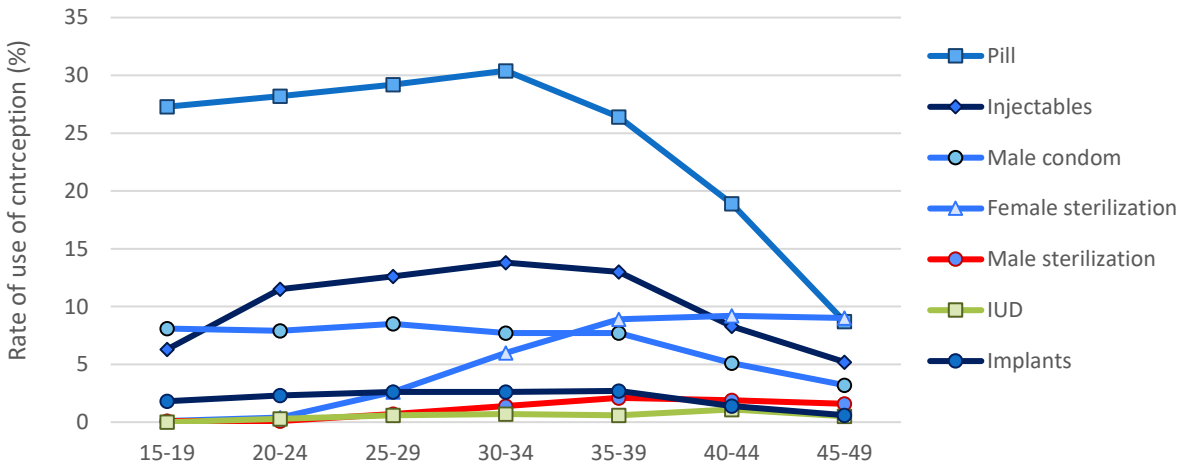
Table 6: Age-specific and total fertility rate

Age group	Residence		
	Urban	Rural	Total
10-14	3	5	5
15-19	93	114	108
20-24	125	151	143
25-29	100	120	114
30-34	59	62	61
35-39	20	18	18
40-44	7	4	5
45-49	3	0	1
TFR (15-49)	2	2.3	2.3

Source: BDHS Survey Report, 2017-18
Note: Age-specific fertility rates are per 1,000 women while TFR is expressed per woman.

As per the Bangladesh Demographic and Health Survey (2017-2018), 52% of women use modern contraceptive methods. Amongst the modern methods, the pill is the most popular method (25.4%), followed by injectables (10.7%), the male condom (7.2%), female sterilization (4.8%), male sterilization (1.1%), IUD (0.6%), and implants (2.1%). According to NIPORT, the use rate of Long-Acting Reversible Contraceptive and Permanent Methods (LARC&PM) is 9% (National Institute of Population Research and Training 2018).

Figure 3: Current Use of Contraception (Modern Methods) by Age Categories



Source: BDHS, 2017-18

Figure 3 provides the rate of use of different contraceptives by age categories. Almost 63 % of modern FP method users are in the age range of 30-34, followed by women aged 35-39. Oral pill is the most popular in all age categories including adolescents. The male condom is the second most popular contraceptive method for the adolescent. The injectable is comparatively more popular in the middle age groups.

The use rate of LARCs (i.e., IUDs and Implants) is very low in all age categories. As expected, women aged 30–49 are more likely to be sterilized than women at a younger age (National Institute of Population Research and Training 2018).

Considering only modern methods, CPR is relatively low among adolescents and older age categories, which are 43.7 % and 28.7 % respectively (Table 7).

Table 7: CPR by Age Categories

Age categories	Any method	Any modern method	Any traditional method
15-19	48.9	43.7	5.2
20-24	55.6	50.9	4.7
25-29	63.5	56.8	6.7
30-34	71	62.7	8.3
35-39	75.4	61.4	13.9
40-44	66.2	45.9	20.3
45-49	44.6	28.7	15.9

Source: BDHS, 2017-18

Nearly 20.8 % of users of modern methods have no living children. Given prevailing social norms that dictate that once married, women should bear children if they can, this implies that they are using these methods to delay pregnancy. More than half (56.7%) of the modern method users have 3-4 living children. A large proportion of modern contraceptive users (54.9%) live in urban areas. Among the divisions, modern method use is highest in the Rangpur division (59%) and lowest in Chattogram and Sylhet divisions (45%). Also, LARC&PM is the highest in the Rajshahi division and the lowest in the Sylhet division.

CPR is 54.7 % for those who have completed primary education. Whereas, those who have completed secondary and above, the CPR is 49.5 %. At the lowest wealth quintile, the use of modern contraceptives (57.2%) is highest, followed by second wealth quintile (52.6%) and fourth wealth quintile (51.3%). The highest wealth quintile people are the lowest users of the modern FP method. For long-acting or permanent methods, the CPR is highest in the lowest income quintile and lowest in the highest income quintile (National Institute of Population Research and Training 2018).

The private sector serves almost half (49.3%) of the users of modern FP methods. On the other hand, 44% of modern contraceptive users obtain FP commodities from the public sector and government field staff; family welfare assistants (FWAs) are the most important provider at the community level, serving 16% of users. NGOs supply contraceptives to 5% of users of which major portion is coming from Government. The private sector mainly supplies short term methods - i.e., pills (55.5%) and condoms (78.2%). The public sector is the main provider of long-acting and permanent methods - i.e., implants (87.8%), and IUD (78.8%), female sterilization (63.1%), and male sterilization (87.5%) (National Institute of Population Research and Training 2018).

2.4 Teenage/adolescent Pregnancies

The use of modern contraceptives is much lower for adolescents (43.7%) compared to the national average (51.9%) as per the BDHS, 2017. Moreover, regional disparity also exits in many indicators. Table 8 presents the socio-economic profile of adolescent pregnancy. It is found that adolescent pregnancy is much higher in rural areas compared to urban areas. Amongst the divisions, adolescent pregnancy is highest in Rajshahi followed by Rangpur and lowest in Sylhet. It seems that with higher education adolescent pregnancy rates decline, as the percentage of adolescent married women with live birth or pregnancy with the first child is lowest in the category of secondary education completed and higher. Also, adolescent pregnancy is highest in the lowest wealth quintile and lowest at the highest wealth quintile.

Table 8: Socio-economic profile of adolescent pregnancy

Background characteristics	% of women with live birth or are pregnant with 1st child
Residence	
Urban	23.4
Rural	29.3
Dhaka	25.9
Khulna	30.4
Mymensingh	30.6
Rajshahi	32.7
Rangpur	32
Sylhet	14.1
Education	
No education	38.2
Primary incomplete	47.8
Primary completed1	46.7
Secondary incomplete	26
Secondary completed and higher	18.5
Wealth quintile	
Lowest	36.5
Second	30.3
Middle	28.3
Fourth	26.7
Highest	17.7

Source: BDHS, 2017-18

2.5 Contraceptive use and its trends

From Figure 4, it is clear that during 1993 and 2017 mCPR growth was very insignificant. Between 2011 and 2017 the growth of mCPR was zero and forecasted to remain the same for several more years. If we consider use rate of all the modern methods separately a stagnant trend is observed (Figure 5) except implants, which shows a clear upward trend (Figure 6). However, the proportion of implants in total method mix is still minuscule. This trend is also influencing an upward trend for LAPM methods though the total number is much less than the target.

Figure 4: Actual and Forecasted Rates for mCPR

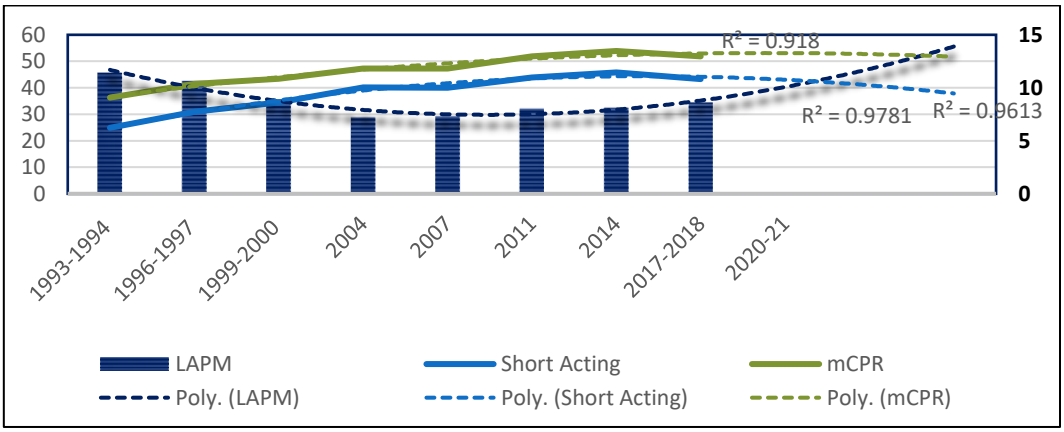


Figure 5: Actual and Forecasted Rates for Short-Acting Methods

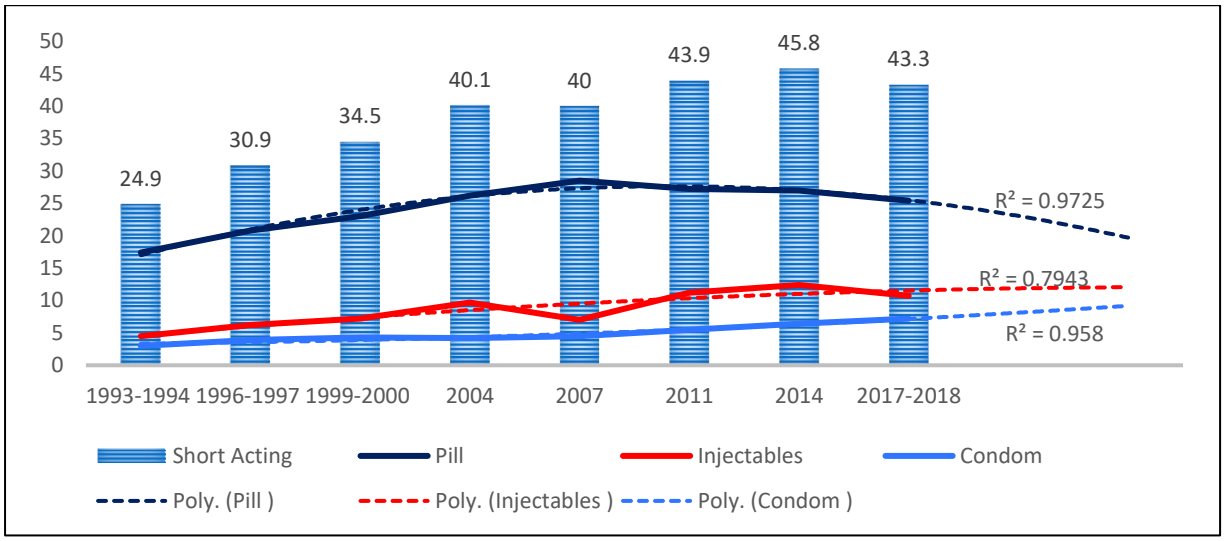
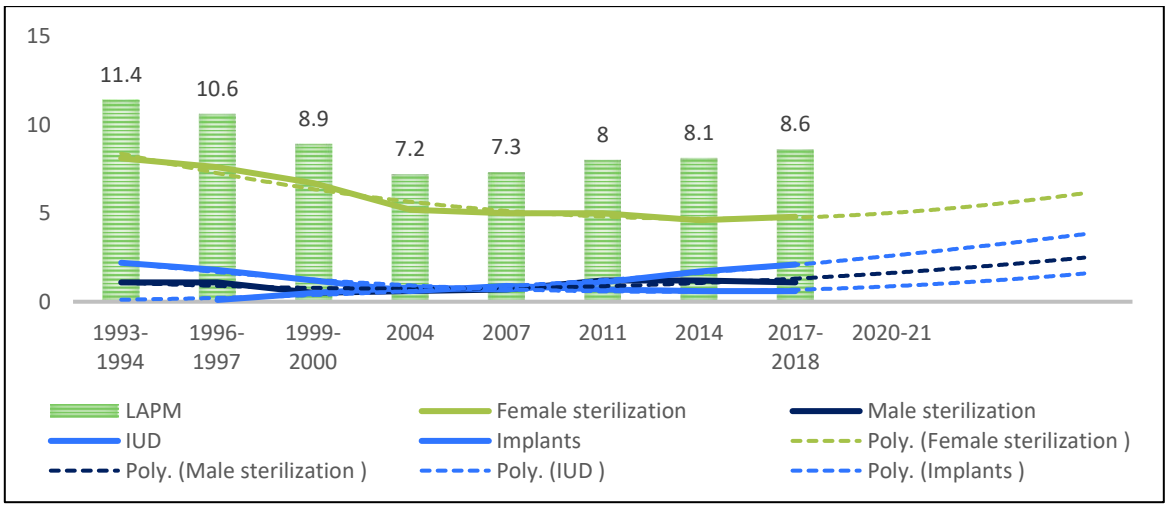


Figure 6: Actual and Forecasted Rates LAPM Methods



Polynomial functions are used to forecast, and the explanatory power of the models is very high (more than 90%), and therefore the forecasted trends are very reliable. The current trends clearly demonstrate that the FP2020 goal is not achievable unless something significant changes are brought into the sector.

2.6 Unmet Need for Contraception

The overall unmet need for FP is 12 % in 2017, which did not change from 2014. However, the unmet need among adolescents has decreased from 17% to 15.5 %, yet higher than the overall unmet need, furthermore the unmet need is higher in rural areas compared to urban areas. Among the divisions, unmet need is highest in Chattogram (18%) and lowest in Rangpur (8.1%). It also shows that unmet need is lower with education and with no education the unmet need is lowest (7.1%). If we compare the wealth quintiles, unmet need increases with higher wealth; it increases with every higher quintile except the highest quintile.

Table 9:Unmet need and background characteristics

	Unmet Need	Total demand for FP
Age		
15-19	15.5	64.4
20-24	15.7	71.3
25-29	13.3	76.8
30-34	12.9	83.9
35-39	10.3	85.7
40-44	7.9	74.1
45-49	4.8	49.4
Residence		
Urban	9.2	74.6
Rural	13.1	73.5
Division		
Barishal	13.9	75.6
Chattogram	18	71.8
Dhaka	12.3	74.5
Khulna	8.5	73.2
Mymensingh	9.5	72.9
Rajshahi	9.6	74.2
Rangpur	8.1	77.9
Sylhet	13.8	69.1
Education		
No education	7.1	69.5
Primary incomplete	11.1	75.6
Primary complete	12	77.1
Secondary incomplete	14.3	74.7
Secondary complete or higher	12.6	71.8
Wealth quintile		
Lowest	9.9	76.2
Second	11.5	75
Middle	12.8	72
Fourth	13.3	74.4
Highest	12.1	71.9

Source: BDHS, 2017-18

2.7 Socioeconomic and cultural Norms, Practices and Barriers to FP Uptake

The government has a strong political commitment to achieve its FP2020 goals. However, that has not necessarily translated to budget allocation or priority settings. Furthermore, there has been little to no progress on key indicators; and the government's strong political support, especially in terms of financing and human resource support, appear to be weakening. The waning interest and commitment of the government is indicated by high vacancy rates of FP workers, inadequate numbers of trained

staff, and a high percentage of Ministry of Health and Family Welfare (MOHFW) facilities not equipped to provide LAPM options (USAID, 2016) without which it is difficult to achieve the mCPR target. Bangladesh government's financial strength resulting from sustained economic growth has not increased the allocation for the FP sector proportionately even though the private sector has been contributing more to the FP sector in recent years.

Moreover, social norms are also affecting performance. For instance, misconceptions about FP methods resulting from lack of proper education about FP methods, acts as obstacles in popularizing the FP program. In some regions, religious norms/stigma are hurdles to FP method expansion. Along with knowledge gaps of users, there exists some knowledge gaps among health providers with regard to side effects of LAPMs, especially female and male sterilization Study also found that providers have misconceptions regarding the effectiveness and convenience of LAPMs, especially IUD and implants compared to the short-acting contraceptive methods (Ugaza, Kathryn, Stephen, Wahidizzaman, & Julie, 2016). Moreover, during the field visit, the team found that the majority of providers believe that husbands prefer short-acting methods to LAPMs and so women should have to comply with what their spouses' preferences.

3. MAJOR CHALLENGES AND ISSUES OF FAMILY PLANNING PROGRAM

The performance of the family planning sector in terms of trends of family planning indicators is clearly lackluster. In the recent decades FP has lost its momentum, in fact, in many cases indicators exhibited reverse trend. While some overarching and cross-cutting issues are prevalent, some specific challenges deserve immediate attention.

- Child marriage[7] is unfortunately showing no sign of significant decline and adolescent pregnancy is still a challenge. The higher prevalence of unmet need among adolescents compared to adults exacerbates the situation. Moreover, not having a clear and effective strategy to take the FP message to men—who have a strong voice in decision making given the gender norms in Bangladesh—remains an unending challenge.
- Although there is some increasing trend in the use of LARC&PM, thanks to the increased use of implant, the contribution of this method, however, still very small in the method-mix. Though use of implant is on rise, the total proportion is still less impressive. The persistent lower proportion of IUD—very small compared to other South Asian countries—remains to be a significant challenge.
- The urban slum areas are still under-served as per the findings of the discussion with DGFP officials. Some pilot exercises are in place, for example, some activities targeting garment sectors in urban areas, covering slum population in Sylhet; however, the extent of these services coverage is much less than what is required for burgeoning urban population. This is partly due to the limited capacity of local governments to provide primary health care which is part of their mandate. In addition, people in urban areas seek health services mostly from the private and NGO facilities; however, NGOs working under Urban Primary Health Care Services Delivery Project and other GOB programs receive FP commodities from DGFP. Government's reach with FP commodities to other facilities i.e. private clinic, hospitals etc. is absent.
- An effective collaboration between DGFP and DGHS is imperative for a successful implementation of FP program and the necessity of this effective collaboration is more important for PPFP. However, a lack of coordination between DGHS and DGFP is still extant with no convincing sign of waning. Moreover, currently, very limited scale FP services are available in the DGHS facilities. Unless availability of FP services is strengthened in the DGHS facilities, it would be challenging to improve the overall FP service coverage and thus to reduce unmet need.

7 Among women age 20–49, 71% married by age 18, and 85% married by age 20. Nearly one-third (31%) of women age 20–49 reported that they had married at age 15 (BDHS 2017-2018)

- Human resource[8] crisis--partly resulting from the retirement of a large number of field level staff and delays in recruitment--is inhibiting continued and regular FP services in most places. Currently, about 29% posts of field level positions are vacant throughout the country; among which, about 35% are of FWAs, 28.50% are of SACMOs (see Table 10 and Figure 7). These problems are severely impeding service in the hard-to-reach areas since the human resource crisis is more pervasive in those areas. The crises will be more acute in the coming years when a large pool of FWAs and FWVs will retire at the same time – mostly those who were recruited in 1980s. The hard-to-reach areas (hilly and haor areas) may be affected more due to human resource crises because as like in case of the plain land the remaining stuffs could not be able to cover the other areas where relevant stuff positions are vacant. Some upazila manager positions are filled up by the low cadre officer who does not have managerial capacity which have greater impact on program. The quality of services is an overarching issue as far as LARC&PM or short-acting methods are concerned. Lack of proper attention to the management of side-effects is constricting the adoption of LARC&PM; for instance, extremely low uptake of IUD compared to neighboring countries insinuates some serious lack in the service delivery for LARC&PM. Unavailability of services coupled with lack of proper counselling, screening and side effect management has been plaguing the uptake of contraceptive and increasing the discontinuation rate. Currently there are a mechanism in the system to deal with clients with side-effect but during our field visit we found that both clients and service providers face difficulties to get support in this regard. Moreover, since availability of doctors are required for most of the LARC&PM, human resource crisis of this segment may severely affect the performance for LARC&PM.
- Targeting the male clients still remains to be a significant challenge in the FP sector as it is women centric by design. In addition, gender norms and social structure is hurting the targeting of male clients in both rural and urban areas.
- Currently, only 26% facilities have LARC&PM services, and more than one third of the district hospitals do not provide LARC&PM services; the accessibility is even worse when it comes to private facilities, though two third of the facility delivery are conducted at private facilities. Therefore, facility readiness is one of bottlenecks in enhancing service coverage.
- Effective monitoring and mentorship, and supportive supervision are regarded as one of the key challenges in service provision. Moreover, human resource crisis further aggravates the problem.

Table 10: Number of posts (sanctioned, filled, and vacant)

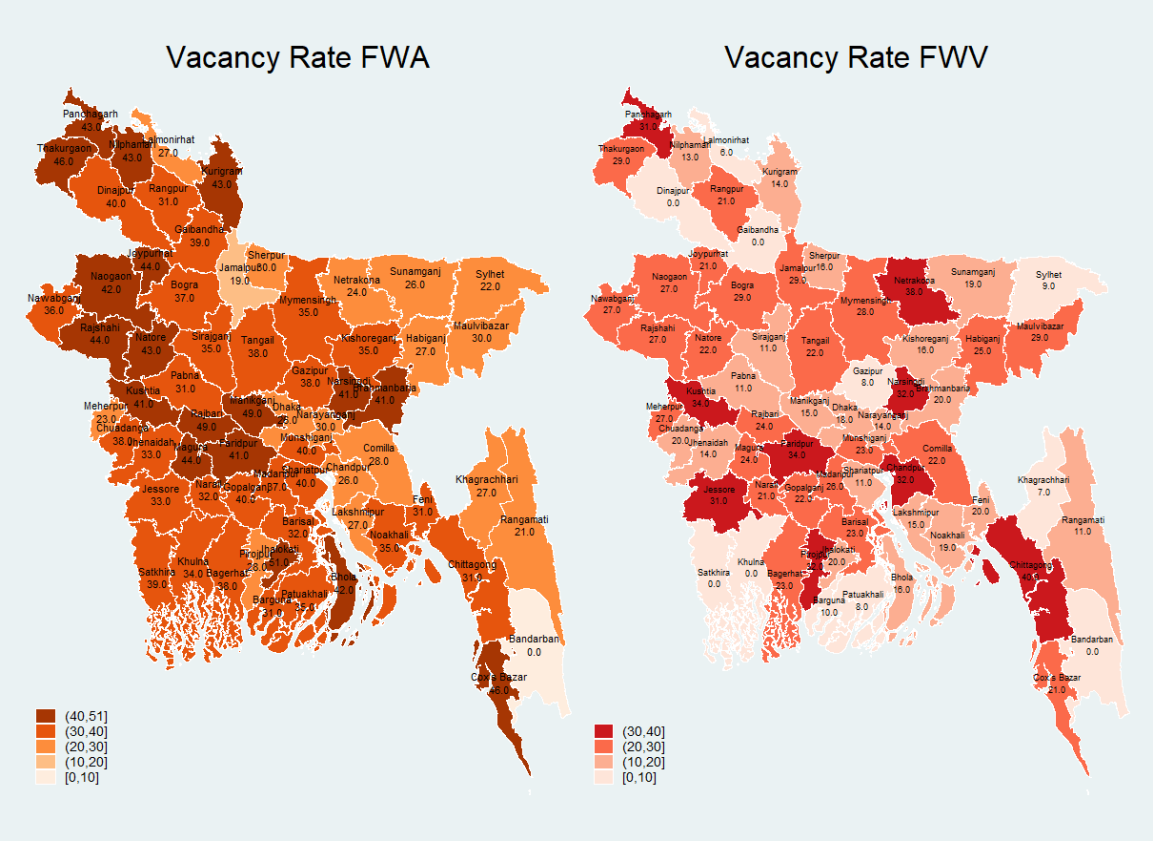
Division	Posts	TFPA	O/A	SACMO	FWV	FPIx	FWA	Total
Barishal	Sanctioned	119	38	218	417	339	1,821	2,952
	Filled	117	37	157	340	275	1,175	2,101
	Vacant (%)	**1.68**	**2.63**	**27.98**	**18.47**	**18.88**	**35.48**	**28.83**
Chottogram	Sanctioned	306	88	613	1,157	940	4,782	7,886
	Filled	267	79	372	876	732	3,304	5,630
	Vacant (%)	**12.75**	**10.23**	**39.31**	**24.29**	**22.13**	**30.91**	**28.61**
Dhaka	Sanctioned	267	87	559	1,170	981	4,859	7,923
	Filled	245	84	436	930	786	3,029	5,510
	Vacant (%)	**8.24**	**3.45**	**22**	**20.51**	**19.88**	**37.66**	**30.46**
Khulna	Sanctioned	180	58	403	660	596	3,053	4,950
	Filled	168	66	302	573	508	1,954	3,571
	Vacant (%)	**6.67**	**-13.79**	**25.06**	**13.18**	**14.77**	**36**	**27.86**
Maymansingh	Sanctioned	102	34	232	426	348	1,984	3,126
	Filled	93	34	168	300	317	1,415	2,327
	Vacant (%)	**8.82**	**0**	**27.59**	**29.58**	**8.91**	**28.68**	**25.56**
Rajshahi	Sanctioned	201	65	371	692	570	3,186	5,085
	Filled	192	66	315	539	447	1,958	3,517
	Vacant (%)	**4.48**	**-1.54**	**15.09**	**22.11**	**21.58**	**38.54**	**30.84**
Rangpur	Sanctioned	174	58	243	433	541	2,845	4,294

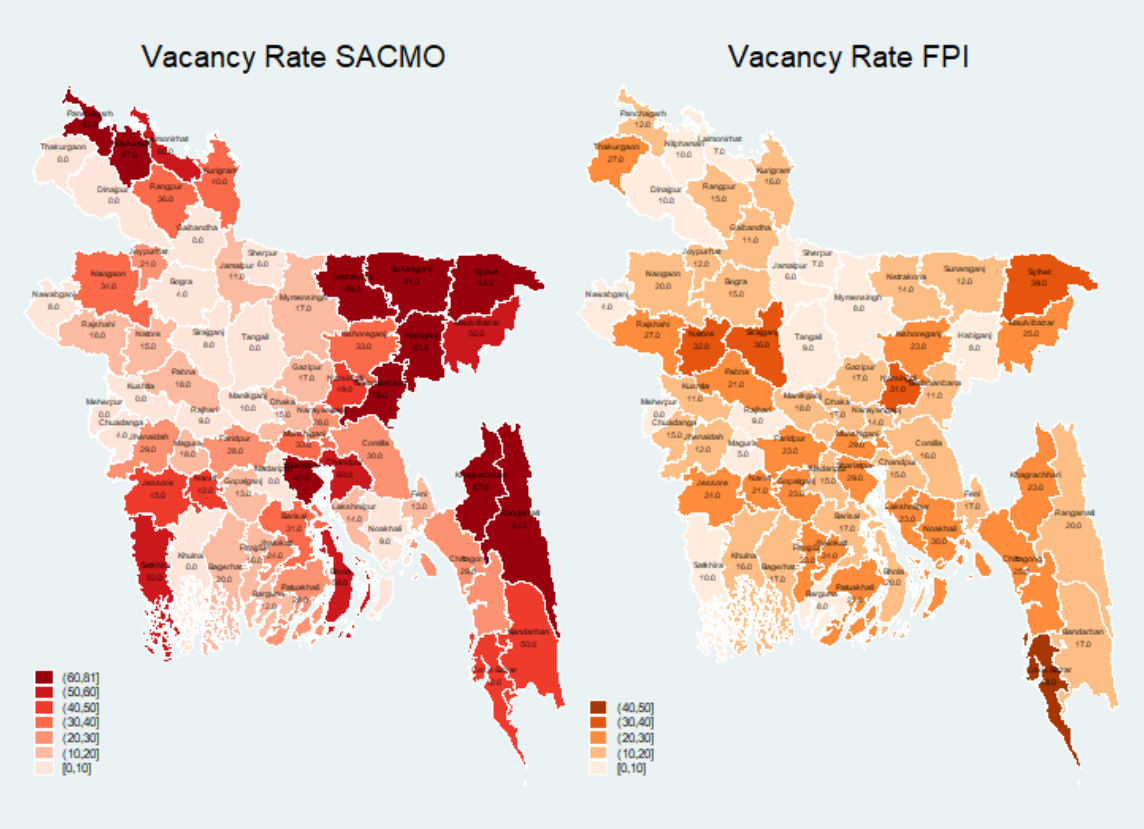
[8] While FWAs are frontline/field workers who usually are available for domiciliary services along with limited short acting services, FWVs provide all short acting methods and IUDs. Medical officers provide other LARC&PM services.

Division	Posts	TFPA	O/A	SACMO	FWV	FPIx	FWA	Total
	Filled	164	57	212	472	469	1,741	3,115
	Vacant (%)	**5.75**	**1.72**	**12.76**	**-9.01**	**13.31**	**38.8**	**27.46**
Sylhet	Sanctioned	114	34	197	386	329	1,659	2,719
	Filled	95	23	66	310	257	1,229	1,980
	Vacant (%)	**16.67**	**32.35**	**66.5**	**19.69**	**21.88**	**25.92**	**27.18**
Overall	**Sanctioned**	**1,463**	**462**	**2,836**	**5,341**	**4,644**	**24,189**	**38,935**
	Filled	**1,341**	**446**	**2,028**	**4,340**	**3,791**	**15,805**	**27,751**
	Vacant (%)	**8.34**	**3.46**	**28.49**	**18.74**	**18.37**	**34.66**	**28.72**

Note: TFPA-Thana Family Planning Assistant, OA- Office Assistant, SACMO- Sub-Assistant Community Medical Officer, FWV-Family Welfare Visitor, FPI-Family Planning Inspector, FWA-Family Welfare Assistant. The vacant posts are given as percentage of the sanctioned posts.

Figure 7: Human resource shortage (vacancy by districts and types of providers)





Source: Authors' compilation

At the risk of repetition, all the challenges already identified, and few more challenges, can be classified as CIP standard theme as follows:

Commodity security

Table 11: Commodity Security

Key issue	Details
Private sector involvement	• Private sector data is not properly included in the forecasting and supply planning processes
Budgetary allocation for commodities	• Dependence on development budgets for many FP commodities even though commodities are recurring and essential part of family planning services.

Financing

Table 12: Financing

Key issue	Details
Budgetary allocation	• OPs have budget for trainings and counselling for FP service providers on the provision of LAPM which are not properly planned and monitored. Some trainings are as usual, not effective and not necessary too. Line Directors should prioritize the training or orientation and allocate budget accordingly
Diversity and amount of FP funding	• Private sector role in FP service delivery and financing not clearly defined

Stewardship, Governance and Partnerships

Table 13: Stewardship, Governance and Partnerships

Key issue	Details
Political good-will	• Clear lack of political goodwill is observed which is substantiated by lower attention in observing national population and other related days
Weak supportive supervision mechanisms and structures	• Serious lack in supervision and monitoring, and accountability are evident
Inadequacy of FP coordination and governance mechanisms	• Lack of coordination with NGOs, private providers, even with DGHS providers
Lengthy and complicated bureaucratic process	• Not filling the vacant posts within minimum time possible

Research, Monitoring and Evaluation

Table 14: Research, Monitoring and Evaluation

Key issue	Details
Research on FP	• DGFP spends extremely small amounts in research purpose which bars evidence-based program designing
Weak M&E system	• Limited systematic use of data in formulation and implementation of national FP program. Availability and quality of necessary data is another issue

Demand Creation

Table 15: Demand Creation

Key issue	Details
Weak FP services seeking behavior among adolescents	• Both higher unmet need and lower total demand for FP services
Lack of accurate and consistence information among adolescents	• There are adolescent targeted interventions i.e. establishment of adolescent corners, counselling. However, those are not effective as par the opinion of field and central level stuff. Lack of proper information to gatekeepers of adolescents (parents, teachers, religious bodies and incorrect information from peers) is also an issue, which could be highly effective.
Myths and misconceptions on side effects	• Cultural and/religious beliefs fuel myths and misconceptions

Service Delivery

Table 16: Service Delivery

Key issue	Details
Lack of motivation among the field staff	Inadequate health care workers compromises access to and quality of FP services provided by the existing personnel
Quality of services is significant barriers	Quality services are not available in many facilities
Lack of services in under-served areas especially in monsoon	• Though separate package and mechanism for hard-to-reach areas are in the narrative part of FP related OPs, the

	effort made is not enough to address the problem observed in those areas • No strategy to provide FP services during natural disaster/calamity, particularly during flood and waterlogging • Services for marginalized community (tea garden workers, Shaontal, Bede, urban slum, etc.) and displaced population are lack/absent
Insufficient strategies for provision of high-quality youth friendly services (YFS)	• Support by critical stakeholders (parents, health care workers, religious leaders) and a multi sectoral approach is not consolidated • Biases exist among health care providers and workers • Inadequate youth friendly service delivery points
Cultural factors	• Low male involvement in FP and RH services • Religious leaders and community support are not at the optimum level
Low male targeting	Males are not targeted well since FP is women-centric by design

4. PRIORITY AREAS

Based on the stakeholder consultation, review of international and national level evidences, and finally a consultative workshop with the policy makers of DGFP and other policy makers, the study identified key strategies and activities that are required for achieving FP2020 goals. These strategies are:

- Strengthening service delivery provision in existing facilities (service coverage, current and new FP commodities, HR)
- Increasing acceptability of LARC&PM through skilled HR and engaging men
- Promoting interval and post-partum contraception
- Giving special focus on hard to reach & urban areas and other low performing areas
- Increasing monitoring & evaluation (M&E) and research
- Targeting adolescent and youth
- Targeting men

It is worth mentioning that for costing purpose, splitting of the above-mentioned strategies has been done to make the costing tool (CIP costing tool) to work and make the calculation clear. The following section summarizes the key strategies along with their activities and sub-activities.

4.1 Key Strategies, Activities and Sub-activities

To achieve the FP2020 goals, several activities are recommended in this CIP and these are costed as well for the upcoming three years (remaining three years, 2020-2022, of current 4th HPNSP). The following sub sections describe the strategies required to achieve the objectives and the activities and sub-activities required. Sub-activities are the inputs used to cost the activities. Some sub activities do not require to be costed and these are marked as 'No additional cost required' in the 'Sub-activity (Inputs)' column.

4.1.1 Strengthening service delivery provision in existing facilities (service coverage, current and new FP commodities, HR)

Currently around 4,000 health facilities are run by DGFP (Bangladesh Health Facility Survey 2014, 2016). Of these, only 74 are in upazila and above levels. However, shortage of skilled provider, lack of proper knowledge about FP methods, management of side effects, counseling, etc., is contributing to the failing to achieve the expected outcomes. Strengthening all health facilities (including personnel, medical surgical requisites (MSR), contraceptives, IEC materials, etc.) is a must to achieve the FP2020 goals and targets by 2022. With a view to ensuring service coverage and availability of FP commodities in existing facilities as well as introducing new methods, the activities and sub-activities are recommended in table 17.

Table 17: Strategy 1- Strengthening service delivery provision in existing facilities (service coverage, current and new FP commodities, HR)

Strategy	Focusing/ Priority area	Activity	Sub-activity (Inputs)	Related OPs
1. Strengthening service delivery in existing facilities (service coverage, current and new FP	Overall+ SA+ LARC&PM	1.1 Strengthen satellite clinics and Community Clinics through: ○ Capacity development on FP-MCH activities for DGFP and DGHS frontline workers	1.1.1 Train FWVs, FWAs, FPIs CHCP and HA, AHI and HI- all unions, 2 days training in the first year at upazila level	FSD, CCSDP, PSSM
			1.1.2 One-day refresher training for remaining years	
			1.1.3 Curtains, banner for satellites (1 curtain and banner for each union)	
			1.1.4 Ensure sufficient IEC materials for counseling (No additional cost required)	

Strategy	Focusing/ Priority area	Activity	Sub-activity (Inputs)	Related OPs
commodities, HR)		○ Training on counseling and referral to access LARC&PM at higher level, side effects management ○ Increasing privacy in the satellite clinics ○ Organization and implementation of courtyard meeting	1.1.5 Introduce referral slip (cost of printing referral slip); 10,000 piece per union per year	
			1.1.6 Prepare guideline and fund allocation for courtyard meeting (quarterly meetings by each FWA, BDT 300 budget per meeting); once a month by each FWA	
			1.1.7 Orient Upazila FP committee, UH&FWC and satellite clinic management committee members (20 participants per upazila, 1 in a year)	
	LARC&PM	1.2 Strengthen UH&FWCs by: ○ Ensuring required equipment/MSR, etc. ○ training staff members on forecasting and prevention of stock-outs ○ Training on IUD insertion ○ Formation of a master training team for every district for LARC	1.2.1 Two days refresher training on IUD insertion each year for FWVs and female SACMOs (all FWVs 2 day training, 1 training per year) at each upazila, with the MO clinic or some other resource person conducting the training.	FSSM, CCSDP
			1.2.2 Two days training on forecasting and prevention of stock-outs for all FPIs, FWVs, FWAs, SACMOs and Pharmacists (1 training for each year at upazila level (can be TOT)	
	Overall + LARC&PM	1.3 Develop all MCWCs with increased LARC&PM services	1.3.1 Train on LARC&PM (FWVs, MOs from each selected MCWC, 5 days training in first year and 1-day refresher training for last two years)	CCSDP
		1.4 Ensure supply of MSR	No additional cost required	PSSM
		1.5 Post creation and recruitment of doctor, pharmacists and FWVs for effective functioning (initiation of process)	No additional cost required	DGFP
	Overall (motivation)	1.6 Increase motivation of the service providers	1.6.1 Yearly award to best performer in each of the 491 upazilas (crest for FWAs, FWVs and FPIs) (BDT 1,000 for each)	PME
		1.7 Strengthen sadar/upazila head quarter clinic at all upazila for LARC&PM	1.7.1 Development of tool for performance evaluation: Hire a consultant for one month	FSD, CCSDP
			1.7.2 Monthly video conference (maybe with skype) meeting between DGFP & DDs, UFPOs, MO-MCH (No additional cost required)	

Strategy	Focusing/ Priority area	Activity	Sub-activity (Inputs)	Related OPs
		1.8 Ensure monitoring and performance review of field level service providers by central officials, local level managers and supervisor	1.8.1 Develop a functional joint monitoring cell at the DGFP. No additional cost required	PME
	Overall (improving management capacity and leadership)	1.9 Increase management capacity of the managers and providers in terms of planning, monitoring and reporting	1.9.1. One training workshop at central level (at least 1 person from each upazila, 5 day training); 10 TOT; 50 participants each; first year only	PME, MIS
			1.9.2 One training at each upazila (all AUFPOs, AUFPOs (MCH) FPIs in respective upazila, 3-day training); first year only	
			1.9.3 Hire consultant for leadership training/selection of institute for conducting 10 TOTs (120 days)	
			1.9.4 Print training module (for each upazila)	
	Overall (Policy issue) + LARC&PM	1.10 Strengthen all DH, Medical Colleges and other govt. hospitals by providing necessary equipment, MSR, FP commodities, and other medical supplies for LARC&PM	1.10.1 Assign a full FP team (1 MO, 1 Nurse/FWV, 1 Support Staff/FWA)	FSD, CCSDP
			1.10.2 Ensure supply of FP contraceptives including MSR (No additional cost required)	
		1.11 Select and train 2 persons from each DH on FP methods with special focus on LARC&PM at DH	1.11.1 Training on FP methods, including LARC&PM (2 for each DH, MCs, other government hospitals, 5-day training, 1 training per year)	CCSDP, FSD
		1.12 Expand FP-MCH and SRHR services among the RMG workers	1.12.1 Train service providers and mid-level managers of RMG factories (200 factories-2 from each factory) 8 trainings with 50 participants each; 1-day training	CCSDP, MCRAH, FSD
		1.13 Expansion of FP services through traditional healers (village doctors and medicine shopkeepers)	1.13.1 Orientation program for traditional healers and medicine shopkeepers (at least one from each union at upazila level, once in a year)	FSD
	Overall (Planning)	1.14 Developing procurement plan that comprises proper need assessment and projection	1.14.1 Training on need assessment (UFPO of each upazila at central level); 10 trainings with 50 participants each; 1-day; first year only	PME, MIS
			1.14.2 Operationalize the Logistic Coordination Forum for contraceptive forecasting and	

Strategy	Focusing/ Priority area	Activity	Sub-activity (Inputs)	Related OPs
			tracking distribution at the SDP level (No additional cost required)	
	Overall (procurement)	1.15 Timely procurement FP commodities	No additional cost required	PSSM, MIS
	Overall (logistics)	1.16 Improve the storage quality in the upazila and union level	1.16.1 Purchasing AC in each upazila (BDT 70,000 for each; 2 ACs); first year only	PSSM
			1.16.2 Maintenance and renovation each upazila store (BDT 500,000 for each upazila per year)	
	Overall (logistics)	1.17 Improve transportation and communication activities	1.17.1 *21 vehicles* (outsourcing) for 4 times a year for 7 days (No additional cost required- just outsource as per requirement)	PSSM
	Overall (logistics)	1.18 Ensure adequate ICT materials for reporting availability of FP drugs	No additional cost required	IEC
	GBV	1.19 Ensure emergency contraceptives in one stop crisis cell (OCC) (67) and centers (9)	1.19.1 *500* ECP for each of the 76 (67+9) OCCs	PSSM, FSD
	SA + LARC & PM	1.20 Understand the preference for contraceptive varieties	1.20.1 Conduct a study based on nationally representative sample; first year only	PME,
		1.21 Introduce self-administering FP method (pilot)	1.21.1 Lump-sum amount for self-administering FP method (pilot) (BDT 2 crore) in every year	CCSDP, FSD
	Overall (policy issue)	1.22 Contract out to NGOs especially in HTR areas	No additional cost required	DGFP
		1.23 Hire retired and skilled staff (of NGO) in contract basis to fill the gap of lead time between retirement to recruitment	1.23.1 Average salary FWVs for 20 staff in each upazila	DGFP
		1.24 Reorient domiciliary services	1.24.1 National consultative study for reorientation of DGFP's domiciliary service-lump sum 2 crore	FSD, CCSDP
			1.24.2 Provide supportive logistics (e.g., bag, umbrella etc.) to all 23,500 FWAs- BDT 5,000 lump sum in first year	

4.1.2 Increasing acceptability of LARC&PM through skilled HR and male engagement

Nine percent of currently married women use a LARC or PM (Bangladesh Demographic and Health Survey 2017-2018: Key Indicators, 2019). This is quite low compared to the government's target of 20% by 2021. There exists a huge shortage of skilled human resources (HR) as well as lack of male engagement in accepting LARC&PM. Conducting several trainings and workshops throughout the

country for all level staff, proper monitoring of services may be important in this regard. Further, training to the service providers of the Blue-Star (or similar) pharmacies on male counseling can be initiated. In order to increase the acceptability, table 18 presents the recommended activities and sub-activities.

Table 18: Strategy 2- Increasing acceptability of LARC&PM through skilled HR and engaging male

Strategy	Focusing/ Priority area	Activity	Sub-activity (Inputs)	Relevant OPs
2. Increasing acceptability of LARC&PM through skilled HR and engaging male	Overall + LARC&PM	2.1 Ensure the quality of services: improving management activities, improving providers' attitude by introducing QIT (Quality Improvement Team) consultant for improving quality of services	2.1.1 Five-day national level TOT for QIT for participants from all districts; first year only; 2 TOTs; 32 participants each	PME
			2.1.2 One Training workshop on attitude/use of quality assurance tool at district level (1 person from each upazila, 3-day training); (10 TOTs; 50 participants each); first year only	
			2.1.3. One training at each upazila (all FWVS, SACMOs and FPIs in respective upazilas, 3-day training); first year only	
		2.2 Ensure proper training of QIT	No additional cost required	PME
		2.3 Ensure regular monitoring and super vision by QIT as per guideline	No additional cost required	PME
	LARC&PM	2.4 Ensure counseling on advantages and side effects of LARC&PM at all level facilities targeting the young and newly married couples	2.4.1 One training or workshop/year at central level - 1 person from each upazila, 2-day training (10 TOTs; 50 participants each)	FSD, CCSDP
			2.4.2 One training/year at each upazila (all FPIs, FWAs, SACMOs, FWVs in respective upazila, 2-day training)	
	LARC&PM	2.5 Use satisfied clients/champions for the promotion of LARC&PM in the community	2.5.1 Promotional workshop (2 workshop/year at each Upazila level/UH&FWC, participants may be 50 clients, cost would be BDT 30,000/workshop)	CCSDP, FSD
			2.5.2 Ensure proper monitoring and supervision for effective implementation of the promotional workshop (No additional cost required)	
	LARC&PM	2.6 Systematic collection of client feedback on service quality to assess client satisfaction level through exit interview	2.6.1 Develop a check list/tool for getting feedback: If needed (No additional cost now)	MIS, FSD, CCSDP
			2.6.2 Orientation workshop (can be TOT) at central level (1 person from each upazila, 1 day); (10 TOTs; 50 participants each); first year only	
			2.6.3 Orientation workshop at each upazila (all FPIs, FWAs, FWVs, and SACMOs in respective upazila, 1-day; first year only	

Strategy	Focusing/ Priority area	Activity	Sub-activity (Inputs)	Relevant OPs
	LARC&PM	2.7 Use religious leader for the promotion of LARC&PM: Extensive workshops to sensitize religious leaders (Note: even though these strategies are in place as stated in FP OPs, field observation suggested that they were not effectively implemented)	2.7.1 Improve the quality of manuals/booklets for sensitizing religious leaders: Involving religious leaders through Islamic Foundation (No additional cost required)	CCSDP
			2.7.2 Update and Print training module (for each upazila)	
			2.7.3 One Training workshop at central level (1 person from each upazila, 2-day training) (10 TOT; 50 participants each); every year	
			2.7.4 One cascade meeting/orientation at each upazila (participants will be 50 Religious Leaders per upazila, 1 day training)	
	Overall (Policy issue)	2.8 Integrate FP services with existing Child Health/ANC/PNC/ Immunization/ HIV/STI, fistula, cervical and breast cancer prevention programs	2.8.1 Collaborative meeting at central level with DGHS (50 participants, 1-day workshop, 1 workshop); first year only	CCSDP, MCRAH, FSD
			2.8.2 Orientation workshop of field staff (DGHS+DGFP) at upazila level (1-day; 30 participants one/year)	
			2.8.3 Developing and printing brochures/IEC materials: Hire a consultant for one month	
	LARC&PM	2.9 Follow up services for LARC&PM via mobile technology by FWAs for better and continuous service	2.9.1 Mobile allowance (BDT 300 for FWAs and FWAs at each union)	CCSDP, FSD
			2.9.2 Monitoring from DD office (random check) and upazila office (No additional cost required)	
		2.10 Giving contact number of FWVs and FWAs to the clients in case of support	No additional cost required	CCSDP, FSD
	Overall	2.11 Promotion of call centers through enhancing the quality of services and increasing social marketing (Adding the option of choosing gender of representatives)	2.11.1 One comprehensive training for call centers staffs on FP (10 persons, 5 days)	FSD, CCSDP, IEC
			2.11.2 Continuous refreshers training/year 10 participants 3 days	
			2.11.3 Method specific and or client specific advertisement on TV, Radio (daily one 30 sec add on TV, daily 2 add on radio), social media (Facebook, YouTube)	
		2.12 Increase targeted marketing	2.12.1 Advertise in social media (Facebook, Instagram, etc.)	IEC
	LARC&PM	2.13 Technical training on FP methods specially	2.13.1 Training workshop (TOT): for service provider -1 Training/year workshop at central level (1 person from each upazila, 5-	FSD

Strategy	Focusing/ Priority area	Activity	Sub-activity (Inputs)	Relevant OPs
		LARC&PM on regular basis	day long training) (10 TOTs; 50 participants each); first year only	
			2.13.2 One training at 12 training facilities (all FPIs, FWAs, FWVs in respective upazila, 3-day training); once in 3 years	
	Overall (motivation)	2.14 Train on motivation, counseling, and referrals, for midwives, FWVs, FWAs, FPIs, SACMOs	2.14.1 One training/year at each upazila (all midwives, FPIs, FWAs, FWVs, HIs, AHIs, CHCPs in respective upazila, 3-day training); once in 3 years	FSD, CCSDP, IEC
			2.14.2 Developing training module: Hiring consultant (if needed) (assuming no additional cost required)	
	LARC&PM	2.15 Special training on side effects management for LARC&PM: ○ Train on gender responsive FP for FP workers ○ Audio-visual training ○ Train on serving the challenged or disabled people - all training curriculum should also include one chapter on this	2.15.1 One Training/workshop at central level (1 person from each upazila, 5-day training); 10 TOTs; 50 participants; once in 3 years	FSD, CCSDP, IEC
			2.15.2 One training/ year at each upazila (all FPIs, FWAs, and FWVs in respective upazila, 3-day training)	
			2.15.3 Design and material development for training purpose: Hiring 1 consultant (if needed) (assuming no additional cost required)	
	Overall (communication)	2.16 Train on communication skills	2.16.1 One Training/ workshop at central level (1 person from each upazila, 5-day training); 10 TOTs; 50 participants; once in 3 years	IEC, FSD, CCSDP
			2.16.2 One training at each upazila (all midwives, FPIs, FWAs, and FWVs in respective upazila, 3-day training); first year only	
			2.16.3 Design and material development for training purpose: Hiring consultant (if needed) (assuming no additional cost required)	
	HTR + overall	2.17 Include a service provider with reproductive health skills within its rapid	2.17.1 Build a rapid response team (RRT) for low lying and coastal areas (one team in each division) (some budget for travel; 50 thousand per year per district)	MCARH, FSD, CCSDP, IEC

Strategy	Focusing/ Priority area	Activity	Sub-activity (Inputs)	Relevant OPs
		response teams and mainstream the minimum initial service package (MISP) for reproductive health in crisis into its emergency response	2.17.2 Allocate separate fund for RRTs (No additional cost required as costed in above 2.17.1)	
		2.18 Include a service provider with reproductive health skills within its rapid response teams and mainstream the minimum initial service package (MISP) for reproductive health in each of the 373 haor areas during monsoon	2.18.1 Allocate separate fund for transportation (lump sum- BDT 120,000 per year for 6 months of monsoon in each of the 373 labor unions)	FSD
	Overall (policy issue)	2.19 Strengthen FP contents in the course curriculum for different healthcare providers	2.19.1 Develop contents to be included in the curriculum: Hiring 1 consultant for two months	FSD, CCSDP, IEC
			2.19.2 Training workshop with relevant stakeholders for buy-in at central level yearly (half-day, 3 workshops, no of participants: 15)	
	Overall	2.20 Provide capacity building training at district and sub-district levels on using data to set goals, plan and monitor activities	2.20.1 Training workshops -1 Training/ workshop at central level (1 person from each upazila, 3-day training); 10 TOTs; 50 participants; first year only	IEC, CCSDP, FSD
	Overall +SA (targeting male)	2.21 Train the Blue Star service providers of the Blue-Star (or similar) pharmacies regarding counseling to the male	2.21.1 Pilot in 2 districts (one hard to reach and one normal district (1 workshop/year 50 participants in each upazila; 1 day)	FSD, CCSDP

4.1.3 Promoting interval and post-partum contraception (up to 1 year)

In the existing structure, most of the facility deliveries are happening at the DGHS facilities whereas personnel from DGFP is providing FP services. There exists a gap in coordination between these two major wings of MOHFW. This hampers the interval and post-partum contraception. Inclusion of private hospitals and clinics in developing PPFP services as well as initiating dedicated counselor for PPFP services in each facility where deliveries occur may play a significant role. Table 19 shows the activities and sub-activities needed for promoting interval and post-partum contraception (up to 1 year).

Table 19: Strategy 3- Promoting interval and post-partum contraception (up to 1 year)

Strategy	Focusing/ Priority area	Activity	Sub-activity (Inputs)	Relevant OPs
3. Promoting interval and post-partum contraception (up to 1 year)	PPFP	3.1 Make PPFP (all FP) services available in the existing EOC centers and extend to centers both in DGFP and DGHS where those services are still unavailable - i.e., providing essential logistics, human resources equipment and financial support	3.1.1 Ensure supply of all FP materials including LARC&PM (No additional cost required)	FSD, CCSDP
			3.1.2 Ensure MSR (No additional cost required)	
			3.1.3 SBCC materials (2-page 300 piece for each union)	
			3.1.4 Printing materials (e.g., register books, cards)	
			3.1.5 Training for service providers of DGHS and DGFP providing ANC and PNC -1 Training/year on interval and post-partum FP (both technical and counseling) at district level (1 person from each UHC, MCWC and DH; 5-day training)	
		3.2 Provision of dedicated counselor for PPFP services in each facility where delivery occur. Afghanistan model can be followed (Tawfik, Rahimzai, Ahmadzai, Clark, & Kamgange, 2014)	3.2.1 Piloting for dedicated counselor (FWV pay-scale) for PPFP services in five districts including Medical Colleges, DH, MCWC, UHC, Private clinics/hospital providing delivery services (training at least on 1 FWVs from each upazila 2-day at central level)	DGFP
		3.3 Extend model FP clinic in all Public Medical College Hospitals and FP Corners in all District/Sadar/General Hospital under administrative control of DGFP	Costed in activity 1.10; no additional cost required	CCSDP, FSD
		3.4 Enable clinical staff to provide counselling services to the mother during post-partum period and to the husband and close relatives such as mother/father in law, sister in law etc.	3.4.1 One training; one from each upazila; 10 TOTs; 2-day training at central level; 50 participants each; first year only	FSD, CCSDP
			3.4.2 One training at upazila level; one day; 20 participants from UHC, FWC; first year only	
		3.5 Orientation/Training/ workshops for the DGFP and DGHS officials to initiate PPFP methods,	3.5.1 One training/year workshop at central (40 participants basically managers from DGHS and DGFP: all important person from both departments; 2-day long workshop)	FSD, CCSDP
			3.5.2 District level workshop 1-day 1/year (30 participants from Medical	

Strategy	Focusing/ Priority area	Activity	Sub-activity (Inputs)	Relevant OPs
		imprest fund, record keeping and reporting	college, District Hospital, MCWC, NGOs)	
			3.5.3 Upazila level workshop 1-day 1/year (30 participants managers and service provider at UHC and bellow including NGOs	
		3.6 Post MR, post abortion care (PAC) FP services, MR with medication (MRM)	3.6.1 Technical training on post MR, post abortion care (PAC) FP services, MR with medication (MRM) at places where delivery takes place -2 TOTs training at central level; 32 participants each (total 64); 3 days long; first year only	FSD, CCSDP
			3.6.2 Training at upazila level (492); 9 FWVs; 1 day; first year only	
		3.7 Inclusion of private hospitals and clinics in developing PPFP services	3.7.1 Co-ordination workshop with wings of MoHFW (1-day workshop, 60 participants)	FSD, CCSDP, PME
			3.7.2 MoU between director hospital and DGFP to ensure designated FP corners/services in private facilities providing delivery services (No additional cost required)	
			3.7.3 Tripartite MoU/ co-ordination workshop between private hospital associations, DGFP and Director Hospital (No additional cost required)	
			3.7.4 Orientation workshop with private clinics'/hospitals' staff to ensure delivery of FP services (20 participants in each meeting, 10 meeting in Dhaka, 5 meeting in other divisions)	
			3.7.5 Ensure FP commodities with MSR in private clinic/ hospital (No additional cost required)	

4.1.4 Intra and inter sectoral collaboration and co-ordination including NGOs

Intra and inter sectoral collaboration and co-ordination is vital to achieve the FP2020 goals and government's target by 2021. Especially, collaboration with NGOs is needed in this regard. Outsourcing of NGOs may be an interim solution to the shortage of skilled and/or retired human workforce. Coordination meeting on regular basis at all administrative level is highly recommended. Especially collaboration of DGFP with DHGS is a must to achieve the FP2020 goals. Strategy 4 in table 20 shows the activities which will attempt to increase the intra and inter sectoral collaboration and co-ordination including NGOs.

Table 20: Strategy 4- Intra and inter sectoral collaboration and co-ordination including NGOs

Strategy	Focusing/ Priority area	Activity	Sub-activity (Inputs)	Relevant OPs
4. Intra and inter sectoral collaboration and co-	Overall + LARC&PM	4.1 Use of field staff of DG Health for counseling of FP methods	4.1.1 Training for CHCP (training at upazila level, all CHCP, 3 days training, 2/year)	FSD, CCSDP

Strategy	Focusing/ Priority area	Activity	Sub-activity (Inputs)	Relevant OPs
ordination including NGOs	Overall	4.2 Strengthen LARC&PM referral via better collaboration between Health and Family Planning department	4.2.1 Coordination meeting on regular basis at upazila level (once in a month; 15 participants from government and non-government providers) only food and refreshment cost (NB: cost for training of these activities are already included in the activities of strengthening CCs)	FSD, CCSDP
		4.3 Increase coordination with other local government authority i.e., union, upazila and district, municipality and city corporation	4.3.1 Meeting / workshops (1 workshop at upazila level, 50 participants, 1-day workshop, 1/year on FP methods and importance their participation	FSD, CCSDP, PME
		4.4 Training for doctors, midwives, nurses, other DGHS officials on FP methods	4.4.1 Training workshops (3 days training, 20 participants, 3/year)	FSD, CCSDP, IEC
		4.5 Jointly work with DGHS officials and MoLGRD for undertaking awareness building programs	4.5.1 Coordination meetings at all administrative level (once in a month; 15 participants) only food and refreshment cost	DGFP
		4.6 Orientation workshop for civil society i.e., journalists, teachers, religious and political leaders, social welfare officers etc.	4.6.1 One day workshops (once in a year) at upazila level 1/year, may be 20 participants	FSD, CCSDP, IEC
	Overall + HTR+ Urban	4.7 Increase collaboration and co-ordination with NGO	4.7.1 Developing clinical guideline, training package, decision making tool on for private and NGOs: Hiring 1 consultant for 2 months	DGFP
			4.7.2 Organizing promotional and sensitizing workshop with representatives of NGOs and private sectors at each district (1-day workshop, 1/year, 30 participants)	
			4.7.3 Collaboration meetings at upazila level (four in a year; 10-15 participants) only food and refreshment	
	LARC&PM	4.8 Use of NGO volunteers in the community level for promoting and improving	4.8.1 Training for community volunteers of NGO (2 days training at Upazila level in each year with 20 participants)	FSD, CCSDP, PME

Strategy	Focusing/ Priority area	Activity	Sub-activity (Inputs)	Relevant OPs
		the referrals for LARC & PM methods		

4.1.5 Special focus on hard to reach & urban areas and other low performing areas

There are around 1,200 hard-to-reach (HTR) unions spread over 257 upazilas and 50 districts in Bangladesh (Ahmed & Hassan, 2012). These areas consist of mainly poor households that lack accessibility to the contraceptive methods. Again, households from urban areas, especially urban slums, lack access to contraceptive methods to a large extent. To achieve the FP2020 goals, HTR and urban households need to be considered with more priority. HTR allowances to the personnel may act as an incentive to regular provision of services in these areas. Outsourcing of NGOs in these areas, initiating mobile team may be noteworthy in this regard. The following table 21 shows the activities and sub-activities targeted to urban and HTR area households.

Table 21: Strategy 5- Special focus on hard to reach & urban areas and other low performing areas

Strategy	Focusing/ Priority area	Activity	Sub-activity (Inputs)	Relevant OPs
5. Special focus on hard to reach & urban areas and other low performing areas	Urban+ HTR	5.1 Developing comprehensive Regional Service Packages (RSPs) for hard-to-reach areas	5.1.1 HTR working allowance for FP service providers (to all HR- 1FPI, 1 FWV, 9 FWA of HTR 1,200 unions)	IEC
			5.1.2 Mobile satellite clinic session, mobile clinic in vessels, etc., could be initiated in HTR unions (1,200 quarterly sessions)	
		5.2 Outsourcing of NGO for FP-MCH activity	No additional cost required	FSD, CCSDP
		5.3 Recruitment and training for volunteers until permanent HR are available including UH&FWC and field level	5.3.1 Allowances and conveyances: BDT 9,500 per month (How many?)- 20 in each 491 upazila	DGFP
		5.4 Outsourcing services to the NGO to target HTR and underserved areas	5.4.1 MoU with NGO to operate in a specific (HTR) areas (No additional cost required)	FSD, CCSDP
			5.4.2 MOU with urban LGIs (No additional cost required)	
			5.4.3 Orientation (Pilot in 25 of 257 upazila) of the NGO workers about DGFP strategies (How many participants?)- 100 workers in each of 25 of 257 HTR upazila	
	HTR	5.5 Providing service through mobile team on	5.5.1 Travel allowance & Accommodation (No additional cost required as costed in 2.17.1)	FSD, CCSDP

Strategy	Focusing/ Priority area	Activity	Sub-activity (Inputs)	Relevant OPs
		regular basis for hard-to-reach areas (373 haor unions) and other areas that suffer from lack of skill providers, which has already been done as piloting in some areas with collaboration to DPs and NGOs, but need to scale up	5.5.2 Local transport allowance (No additional cost required as costed in 2.17.1)	
			5.5.3 Ensure supply of FP related materials including MSR (No additional cost required)	
	Urban	5.6 Taking initiative to register all slum and non-slum couples via GO-NGO collab-oration and co-ordination	5.6.1 Initiation and collaboration meeting with MoLGRD and NGOs (No additional cost required)	FSD, CCSDP
			5.6.2 One-day workshop for planning data collection process and technique (15 participants in each HTR upazila)	
			5.6.3 Buying register book for all wards	
	Overall+ Urban	5.7 Following Sylhet model[9], replicating and scaling in other urban areas Note: 6.5 crore for 5 years for 25,000 eligible couples in Sylhet	5.7.1 Piloting in Mymensingh, Gazipur, Narayanganj (assuming 50,000 eligible couples in each) every year	FSD

4.1.6 Monitoring & Evaluation (M&E) and Research

Timely monitoring & evaluation (M&E) and research is required in order to assess whether the family planning program is on track and to understand the root causes of some barriers. But in the existing set up, M&E and research activities especially much needed research activities are very low in number. Table 22 offers the activities and sub-activities to address the concerns.

[9] Sylhet model: as claimed in the Endling project document the pilot project for Family Planning in the slums of Sylhet City Corporation was aimed at providing quality family planning services to people living in the slum areas of Sylhet City Corporation. The mode of service delivery was: doorstep service, evening satellite clinics, and the regular static clinic-based services. The duration of the project was three years from June 2014 to May 2017. *Shimantik* has established doorstep service delivery approach for the slum dwellers while DGFP provided technical assistance for BCC, quality of care, facilitative supervision and monitoring, training, research and evaluation. All the slums selected for this intervention were within the Sylhet City Corporation area, and total target population of the project area was 25067 eligible couples. The project was implemented with German technical and financial assistance through KfW Development Bank. (Ref. Hossain et al 2017. Endline Survey Report on Family Planning Pilot Project in the Slum of Sylhet City Corporation. Draft Report)

Table 22: Strategy 6- Monitoring & Evaluation (M&E) and Research

Strategy	Focusing/ Priority area	Activity	Sub-activity (Inputs)	Relevant OPs
6. Monitoring & Evaluation (M&E) and Research	Overall	6.1 Establish a central monitoring team	6.1.1 Development of routine monitoring plan (hiring consultant for four months)	PME
		6.2 Preparation of M&E framework	6.2.1 Action oriented follow up progress monitoring activities (No additional cost required)	PME, MIS
		6.3 Establish a research team at DGFP headquarter/ strengthen the research activities	6.3.1 Periodic research on FP-MCH program (Allocate 60 lacs each for research activities)	DGFP

4.1.7 Targeting adolescents and youth

Role of adolescents cannot be ignored while achieving the FP2020 goals and government's target by 2021. If adolescents are not aware of contraceptive methods through proper counseling, achieving the goals may not be possible with the existing set up. With a view to targeting adolescents, national level study is required for assessing the need of adolescents. Again, privacy must be ensured while being examined or counseled in the health facilities. The following table 23 recommends the required activities and sub-activities targeting adolescents.

Table 23: Strategy 7- Targeting adolescent

Strategy	Focusing/ Priority area	Activity	Sub-activity (Inputs)	Relevant OPs
7. Targeting adolescent	Adolescents	7.1 One need assessment of family planning services (with requirement of dissemination in TOR) to realize the current scenario and which will guide for future programming not only for government but also for NGOs/CSOs , nationwide but with more emphasis on the hard-to-reach and low-performing areas as well as reasons for low performance	7.1.1 National level study	FSD, CCSDP
		7.2 Training of providers on adolescent friendly services (AFS[10]) with privacy and confidentiality —FWVs and SACMOs focusing on	7.2.1 One 1-day training for each upazila (all SACMOs, FPIs, FWVs, FWAs, FPIs and paid volunteers)	FSD, CCSDP, IEC

[10] AFS does not have strong evidence of working in all setting (Chandra-Mouli, Lane, & Wong, 2015). However, the expert panel still believe it can be useful in Bangladesh and hence the report considers this option.

Strategy	Focusing/ Priority area	Activity	Sub-activity (Inputs)	Relevant OPs
		providing non-judgmental services, accurate information on medical eligibility, communication strategy for adolescents		
		7.3 Ensuring private and confidential counselling room with doors and window curtains, partitioning the waiting areas so that adolescents' clients do not have to mix adult clients, not conducting history taking and screening in public	7.3.1 Sound proof partition wall for each upazila	PSSM
		7.4 Developing adolescent friendly communication materials and digital health services	7.4.1 One consultant for one month for developing communication materials	IEC, MCARH
			7.4.2 Effective communication materials (for all adolescent—high school going children) printing	
			7.4.3 Android App development with FP contents	
			7.4.4 Ensure availability of the logistics at all level (No additional cost required)	
		7.5 Making all services (both short and LARC) available for the adolescents in the facilities Phasing of adolescent friendly contraceptive services	7.5.1 Ensure availability of the logistics at all level (No additional cost required)	IEC
	Overall + Adolescents (policy issue)	7.6 Policy formation (making mandatory counselling requirement for marriage registration)	7.6.1 Hiring a consultant for four months	IEC
		7.7 Integration with web	7.7.1 Hiring a consultant for integration with web for four months	IEC

4.1.8 Targeting adolescent with special focus on males

This strategy focuses on serving adolescents, particularly men and boys. Though LARC&PM are mainly used by the females, their male counterpart is the main decision maker, especially among the poor households and households from HTR, urban slums. Again, separate arrangements are required for differently abled adolescents. In Bangladesh, buying contraceptives (either male or female methods) before the marriage is considered taboo, especially in the rural areas. Initiating one counseling session with delivery of male method before and after marriage registration can be crucial for achieving the FP2020 goals and targets. In addition, counseling the parents of adolescents is also needed to make the

FP program acceptable to all. Only targeting adolescents may not be fruitful unless their parents are oriented/counseled. Again, religious leaders also play a significant role while making the FP contraceptives acceptable to all eligible couple. High school teachers can also play some role. With these considerations in mind, table 24 describes the activities and sub-activities required for targeting adolescents as well as engagement of stakeholders mentioned above.

Table 24: Strategy 8- Targeting adolescent with special focus on males

Strategy	Focusing/ Priority area	Activity	Sub-activity (Inputs)	Relevant OPs
8. Targeting adolescents with special focus on males	Adolescents & Targeting men	8.1 Counsel adolescent, newly married couple, in-laws, public representatives, and local elites to improve gender norms	8.1.1 Can be merged with activity 9.1 (No additional cost required)	FSD, CCSDP
		8.2 Train to serve differently abled adolescents	8.2.1 Train FPIs, FWVs, FWAs, volunteers (upazila level, 1 day, 50 participants)	IEC
	Adolescents & targeting men (policy issue)	8.3 Scale up counseling requirement for marriage registration, especially for the bridegroom/bride: one before marriage and one after marriage	8.3.1 ToT for marriage registrar 1 counseling session with delivery of male method before marriage -2 TOTs at central level, 1 from each district, 32 participants in each TOT (64 total)	FSD, CCSDP, IEC
		8.4 Make family planning commodities available to the bridegroom/bride	No additional cost required	PSSM
	Adolescents	8.5 Counsel and meetings for parents, providers, religious leaders, and other influential adults (public representatives and local elites etc.) who can foster a supportive environment in health facilities, schools, places of worship, and in homes	8.5.1 Yard meeting with parents; no. of wards in Bangladesh	FSD, CCSDP
			8.5.2 Upazila level one-day workshop/ orientation with religious leaders (30 participants)	
			8.5.3 Workshop with teachers of the schools (1 school in each union; only refreshment)	

Strategy	Focusing/ Priority area	Activity	Sub-activity (Inputs)	Relevant OPs
		8.6 Develop effective sexual education guidelines	8.6.1 Ten-page sexuality guideline (5,000*500 piece)	IEC
	Adolescents (policy issue)	8.7 Incorporate adolescent health program in school curriculum	8.7.1 Monitor the adolescent health program (No additional cost required)	MCRAH, IEC

4.2 Costing of Strategies by Strategies and Activities

Costing of strategies by activity and sub-activity are presented in this section. Here, costing is done for this CIP period (2020-2022). Table 25 shows costing by each strategy. Total cost of the strategies is USD 405.79 million over the three years. Year 2020 requires highest investment at USD 167.68 million and the remaining two years require USD 115.87 million and USD 122.24 million, respectively. The first year requires more than the other two years because maximum activities of the strategies are to be conducted in the first year, especially the training/workshop activities. This is to be noted that, only those activities and sub-activities are costed and presented here which require additional cost in the existing setting. Those activities and sub-activities that do not require additional cost are not considered while costing. The unit cost of each input is taken from the Family Planning Spending Assessment (FPSA) 2018-2019 and for some inputs, practicing rate and researchers' experience is used (attached in the annex).

The largest portion of total cost over the three years accounts for four strategies, namely: strengthening service delivery provision in existing facilities (service coverage, current and new FP commodities, HR) - USD 203.55 million; increasing acceptability of LARC&PM through skilled HR and engaging male- USD 72.73 million; special focus on hard to reach & urban areas and other low performing areas- USD 71.75 million; and intra and inter sectoral collaboration and co-ordination including NGOs- USD 39.03 million. Monitoring & Evaluation (M&E) and Research possesses the least at USD 0.28 million over the three years.

4.2.1 Costing of strengthening service delivery provision in existing facilities (service coverage, current and new FP commodities, HR)

This sub-section provides detailed cost of the strategy 1: strengthening service delivery provision in existing facilities (service coverage, current and new FP commodities, HR) (see table 26). The maximum cost is due to strengthening satellite clinics and CCs (USD 35.78 million) and strengthening UH&FWCs (USD 34.56 million). Other costs are for training/workshops mainly. The three years cost is USD 201.93 million and each year's cost ranges from USD 64 million to USD 71 million. Strengthening service delivery provision in existing facilities costs about 50% of the total strategies cost.

4.2.2 Costing of increasing acceptability of LARC&PM through skilled HR and male engagement

Increasing acceptability of LARC&PM through skilled HR and engaging male costs a significant (18.03%) portion of the total cost of the strategies. This strategy costs USD 72.73 million throughout the CIP period (see table 27). Ensuring counseling on the advantages and side effects of LARC&PM at all level facilities targeting the young and newly married couples (USD 16.24 million); training on motivation, counselling, referrals and client segments for FWVs, FWAs, FPIs, SACMOs (USD 14.27 million); and technical training on FP methods specially LARC&PM on regular basis (USD 10.75 million) are the major activities for higher costing requirement of this strategy.

4.2.3 Costing of promoting interval and post-partum contraception (up to 1 year)

Promoting interval and post-partum contraception (up to 1 year) will cost USD 6.02 million over the three years (see table 28). Orientation and Training workshops for DGFP and DGHS officials to initiate post-partum contraception (USD 2.60 million) and make PPFP (all FP) services available in the existing EOC centers and extend to centers both in DGFP and DGHS where those services are still unavailable (USD 2.38 million) are the main costs under this strategy.

4.2.4 Costing of intra and inter sectoral collaboration and co-ordination including NGOs

For better intra and inter sectoral collaboration and co-ordination including NGOs, it will cost USD 39.03 million over the three years. Use of field staff of DG Health for counseling of FP methods (USD 16.24 million) and their training on FP methods (USD 13.29 million) accelerates the cost of this strategy. The other costs are mainly for regular and routine coordination and collaboration meeting at all administrative levels. Activity wise cost is presented in table 29.

4.2.5 Costing of special focus on hard to reach & urban areas and other low performing areas

Special focus on hard to reach and urban areas as well as other low performing areas will cost USD 71.75 million throughout the CIP period (see table 30). Since a huge bulk of personnel are retiring in recent years and new recruitment is a lengthy process, recruiting and training of volunteers may be an interim solution. Recruitment and training for volunteers until permanent HR are available including UH&FWC and field level expedites the cost of this strategy (USD 41.77 million). Developing comprehensive Regional Service Packages (RSPs) for hard-to-reach areas also increases the cost (USD 25.96 million).

4.2.6 Costing of monitoring & Evaluation (M&E) and Research

Monitoring & Evaluation (M&E) and Research will cost only USD 0.28 million over the three years. It is quite low compared to the other strategies. This cost is mainly due to establish a research team at DGFP headquarter (USD 0.22 million). Year wise cost is shown in table 31.

4.2.7 Costing of targeting adolescent

With a view to targeting adolescents, it will cost USD 3.57 million during the CIP period. Developing adolescent friendly communication materials and digital health services (USD 1.70 million) and training for the providers on adolescent friendly services with privacy and confidentiality (USD 1.40 million) accelerates the cost of this strategy. Table 32 shows the activity and year wise cost.

4.2.8 Costing of targeting adolescent with special focus on male

Targeting adolescent with special focus on male will require a cost of USD 8.85 million during 2020-2022 (see table 33). The main costs for this strategy are for counselling and meetings for parents, providers, religious leaders, and other influential adults (USD 4.74 million) and providing training for serving differently abled adolescents to DGFP personnel from different levels (USD 4.06 million). This cost sanctions only the refreshment costs for these meeting/counselling.

4.3 FP Commodity Projection (Method-mix)

The 'Reality Check' tool[11] was used for FP commodity projection from 2020 to 2022 (EngenderHealth , 2019). The results are shown in table 34. Government's target is to increase the CPR to 75%, use of LAPMs to 20% by 2021, reduce unmet need to 10% by 2021. While projecting the method-mix, all these goals were considered simultaneously. To achieve all the three goals mentioned above, the method-mix in each year should be as projected in the Table 34. Here, 2019 is considered as the year prior to start the CIP and 2022 as the end year of CIP.

[11] Reality Check" is an Excel Workbook based tool used for projection. It helps to assess past trends in the contraceptive prevalence rate (CPR) and predict country specific future scenarios based on the local context.

4.3.1 Cost of Contraception

The cost of contraception calculated based upon the method-mix projection mentioned in the earlier sub-section. The unit cost of each method is taken from the Family Planning Spending Assessment (FPSA) 2018-2019. Other traditional methods do not need any cost as they are natural process. The core purpose of this CIP was policy makers' buy-in, hence in the text, government portion of commodity expenses are included. This cost of contraception is based upon the share of government (mentioned in the table 35, sourced from BDHS 2017) in total contraception. This is to be noted that, government provides imprest[12] fund to the private sector for LARC&PM. This is also included in this document. Inclusion of private sector cost will increase the total budget required for commodity.

[12] I An imprest fund is a small amount of cash that is given for incidental expenses. In the current context, imprest fund refers to the travel allowances, wage compensation, etc., provided to the clients and providers.

Table 25: Costing of the strategies of CIP 2020

Strategy	2020 (USD)	2021 (USD)	2022 (USD)	Total	
				USD	Local Currency
1. Strengthening service delivery provision in existing facilities (service coverage, current and new FP commodities, HR)	71,454,785	64,280,249	67,815,663	203,550,696	**17,281,454,130**
2. Increasing acceptability of LARC&PM through skilled HR and engaging male	53,417,050	9,397,977	9,914,865	72,729,892	**6,174,767,809**
3. Promoting interval and post-partum contraception (up to 1 year)	2,452,465	1,737,327	1,832,880	6,022,672	**511,324,871**
4. Intra and inter sectoral collaboration and co-ordination including NGOs	12,341,506	12,988,639	13,703,014	39,033,160	**3,313,915,310**
5. Special focus on hard to reach & urban areas and other low performing areas	22,648,149	23,893,797	25,207,956	71,749,902	**6,091,566,699**
6. Monitoring & Evaluation (M&E) and Research	130,671	74,558	78,659	283,889	**24,102,150**
7. Targeting adolescent	2,424,680	559,187	589,943	3,573,809	**303,416,425**
8. Targeting adolescent with special focus on male	2,813,502	2,937,179	3,098,723	8,849,404	**751,314,411**
Strategies Total	167,682,808	115,868,914	122,241,704	405,793,426	**34,451,861,806**

Note: Exchange rate is USD 1= BDT 84.90

Table 26: Costing of Strategy 1- Strengthening service delivery provision in existing facilities (service coverage, current and new FP commodities, HR)

Activity	Priority area	2020 (USD)	2021 (USD)	2022 (USD)	Total	
					USD	Local Currency
1.1 **Strengthen satellite clinics and CCs** ○Capacity development on FP ○MCH activities for DGFP and DGHS frontline workers ○Train on counseling and referral to access LARC&PM at higher level, side effects management ○Increase privacy in satellite clinics ○Organize and implement courtyard meetings	Overall+ SA+ LARC PM	15,959,940	9,645,952	10,176,480	35,782,372	**3,037,923,403**
1.2 **Strengthen UH&FWCs** ○Ensure required equipment/MSR	LARC&PM	10,907,487	11,507,399	12,140,306	34,555,191	**2,933,735,739**

Activity	Priority area	2020 (USD)	2021 (USD)	2022 (USD)	Total USD	Total Local Currency
○train staff members on forecasting and prevention of stock-outs ○Train on IUD insertion ○Form a master training team for every district for LARC						
1.3 Develop all MCWCs with increased LARC&PM services	Overall + LARC PM	114,431	24,145	25,473	164,049	**13,927,759**
1.6 Increase motivation of the service providers	Overall motivation	17,350	18,304	19,311	54,965	**4,666,501**
1.7 Strengthening sadar/upazila head quarter clinic at all upazila for LARC&PM	Overall motivation	15,000	0	0	15,000	**1,273,500**
1.9 Increasing management capacity of the providers in terms of planning, monitoring and reporting	Overall improve mgt and leadership	1,057,008	0	0	1,057,008	**89,739,940**
1.10 Strengthening all DH & Medical Colleges and other govt. hospitals by providing necessary equipment, MSR FP commodities, and other medical supplies for LARC&PM	Overall policy issue + LARC&PM	1,395,762	1,472,529	1,553,518	4,421,810	**375,411,685**
1.11 Selection and Training of 2 person from each DH on FP methods with special focus on LARC&PM at DH	Overall policy issue + LARC&PM	2,075,284	2,189,424	2,309,843	6,574,551	**558,179,394**
1.12 Expanding FP-MCH and SRHR services among the RMG workers	Overall Policy issue + LARC&PM	36,890	38,919	41,060	116,870	**9,922,254**
1.13 Expansion of FP services through traditional healers (village doctors and medicine shopkeepers)	Overall policy issue + LARC&PM	1,945,507	2,052,510	2,165,398	6,163,416	**523,274,031**
1.14 Developing procurement plan that comprises proper need assessment and projection	Overall Planning	45,347	0	0	45,347	**3,849,930**
1.16 Improve the storage quality in the upazila and union level	Overall logistics	3,701,296	3,050,677	3,218,465	9,970,437	**846,490,138**
1.19 Ensuring emergency contraceptives in one stop crisis cell (OCC) (67) and centers (9)	GBV	1,976,000	2,084,680	2,199,337	6,260,017	**531,475,477**

Activity	Priority area	2020 (USD)	2021 (USD)	2022 (USD)	Total	
					USD	Local Currency
1.20 Understanding the preference for contraceptive varieties	SA + LARC & PM	70,671	0	0	70,671	**6,000,000**
1.21 Introducing self-administering FP method (pilot)	SA + LARC & PM	235,571	248,528	262,197	746,296	**63,360,500**
1.23 Hiring retired and skilled staff (of NGO) in contract basis to fill the gap of lead time between retirement to recruitment	Overall policy issue	30,281,688	31,947,180	33,704,275	95,933,143	**8,144,723,880**
1.24 Reorientation of domiciliary services	Overall policy issue	1,619,552	0	0	1,619,552	**137,500,000**
Total		71,454,785	64,280,249	67,815,663	203,550,696	**17,281,454,130**

Note: Exchange rate is USD 1= BDT 84.90

Table 27: Costing of Strategy 2- Increasing acceptability of LARC&PM through skilled HR and engaging male

Activity	Priority area	2020 (USD)	2021 (USD)	2022 (USD)	Total	
					USD	Local Currency
2.1 Ensuring the quality of services: improving management activities, improving providers' attitude by introducing QIT (Quality Improvement Team) consultant for improving quality of services	Overall + LARC&PM	1,991,529	0	0	1,991,529	169,080,810
2.4 Ensuring counseling on the advantage and side effects of LARC&PM and SA at all level facilities targeting the young and newly married couples	LARC&PM+ SA	5,124,918	5,406,789	5,704,162	16,235,868	1,378,425,228
2.5 Using satisfied clients/champions for the promotion of LARC&PM in the community	LARC&PM	346,996	366,081	386,216	1,099,293	93,330,017
2.6 Systematic collection of clients' feedbacks on services quality to assess clients' satisfaction level through exit interview	LARC&PM	2,562,459	0	0	2,562,459	217,552,770
2.7 Use religious leader for the promotion of LARC&PM: Extensive workshops to sensitize religious leaders (Note: even though these strategies are in place as stated in	LARC&PM	120,766	126,188	133,129	380,083	32,269,050

Activity	Priority area	2020 (USD)	2021 (USD)	2022 (USD)	Total	
					USD	Local Currency
FP OPs, field observation suggested that they were not effectively implemented)						
2.8 Integrate FP services with existing Child Health/ANC/PNC/ Immunization/HIV/STI, fistula, cervical and breast cancer prevention programs	Overall (policy issue)	776,642	798,667	842,594	2,417,903	205,279,986
2.9 Follow up services for LARC&PM via mobile technology by FWAs for better and continuous service	LARC&PM	1,737,922	1,833,508	1,934,351	5,505,781	467,440,822
2.11 Promotion of call centers through enhancing the quality of services and increasing social marketing (Adding the option of choosing gender of representatives)	Overall	245,012	256,691	270,809	772,511	65,586,176
2.12 Increasing targeted promotion	Overall	4,299	4,536	4,785	13,620	1,156,329
2.13 Technical training on FP methods specially LARC&PM on regular basis	LARC&PM	10,748,941	0	0	10,748,941	912,585,060
2.14 Training on motivation, counselling, referrals and client segments for FWVs, FWAs, FPIs, SACMOs	Overall (motivation)	14,267,054	0	0	14,267,054	1,211,272,920
2.15 Special training on side effect management for LARC&PM -Training on gender responsive family planning for FP workers -Audio-visual training -Training for the challenged or disable people and training curriculum should also include one chapter on this	LARC&PM	7,360,260	0	0	7,360,260	624,886,110
2.16 Training on communication skills of the service providers	Overall (communication)	7,360,260	0	0	7,360,260	624,886,110
2.17 Including a service provider with reproductive health skills within its rapid response teams and mainstream the minimum initial service package (MISP) for reproductive health in crisis into its emergency response	Overall+ HTR	37,691	39,764	41,951	119,407	10,137,680
2.18 Including a service provider with reproductive health skills within its rapid response teams and mainstream the minimum initial service package (MISP) for reproductive health in each of the 373 haor areas during monsoon	Overall+ HTR	527,208	556,205	586,796	1,670,210	141,800,799

Activity	Priority area	2020 (USD)	2021 (USD)	2022 (USD)	Total	
					USD	Local Currency
2.19 Strengthen FP contents in the course curriculum for different healthcare providers	Overall (policy issue)	63,832	4,043	4,265	72,140	6,124,717
2.20 Provide capacity building training at district and sub-district levels on using data to set goals, plan and monitor activities	Overall	136,040	0	0	136,040	11,549,790
2.21 Train **Blue Star Service providers** (or similar) pharmacies regarding counseling to the male	Overall +SA	5,218	5,505	5,808	16,530	1,403,435
Total		53,417,050	9,397,977	9,914,865	72,729,892	6,174,767,809

Note: Exchange rate is USD 1= BDT 84.90

Table 28: Costing of Strategy 3- Promoting interval and post-partum contraception (up to 1 year)

Activity	Priority area	2020 (USD)	2021 (USD)	2022 (USD)	Total	
					USD	Local Currency
3.1 Make PPFP (all FP) services available in the existing EOC centers and extend to centers both in DGFP and DGHS where those services are still unavailable i.e., providing essential logistics, human resources equipment and financial support	PPFP	750,097	791,352	834,876	2,376,325	201,749,970
3.2 Provision of dedicated counselor for PPFP services in each facility where delivery occur	PPFP	7,166	7,560	7,976	22,702	1,927,426
3.3 Extend model FP clinic in all Public Medical College Hospitals and FP Corners in all District/Sadar/General Hospital under administrative control of DGFP	PPFP	0	0	0	0	0
3.4 Enable clinical staff to provide motivation/counselling services to the mother during post-partum period and to the husband and close relatives such as mother/father in law, sister in law etc.	PPFP	556,825	0	0	556,825	47,274,460
3.5 Orientation/Training/ workshops for DGFP and DGHS officials to initiate PPFP (all methods, imprest fund, record keeping, and reporting	PPFP	818,775	863,807	911,317	2,593,898	220,221,963
3.6 Post MR, PAC FP services, MR with medication (MRM)	PPFP	227,597	0	0	227,597	19,323,000

Activity	Priority area	2020 (USD)	2021 (USD)	2022 (USD)	Total USD	Total Local Currency
3.7 Inclusion of private hospitals and clinics in developing PPFP services	PPFP	92,005	74,608	78,711	245,325	20,828,052
Total		2,452,465	1,737,327	1,832,880	6,022,672	511,324,871

Note: Exchange rate is USD 1= BDT 84.90

Table 29: Costing of Strategy 4- intra and inter sectoral collaboration and co-ordination including NGOs

Activity	Focusing/ Priority area	2020 (USD)	2021 (USD)	2022 (USD)	Total USD	Total Local Currency
4.1 Use of field staff of DG Health for counseling of FP methods	Overall + LARC&PM	5,126,502	5,408,459	5,705,925	16,240,886	1,378,851,201
4.2 Strengthen LARC&PM referral via better collaboration between Health and Family Planning department	Overall	104,099	109,824	115,865	329,788	27,999,005
4.3 Increase coordination with other local government authority i.e., union, upazila and zilla parishad, pouroshova and city corporation etc.	Overall	1,280,995	1,351,450	1,425,780	4,058,225	344,543,311
4.4 Train doctors, nurses, and other DGHS officials on FP methods	Overall	4,195,187	4,425,923	4,669,348	13,290,458	1,128,359,899
4.5 Jointly work with DGHS officials and MoLGRD for undertaking awareness building programs	Overall	65,413	69,011	72,807	207,231	17,593,944
4.6 Orientation workshop for civil society - i.e., journalists, teachers, religious and political leaders, social welfare officers etc.	Overall	466,132	491,769	518,816	1,476,718	125,373,322
4.7 Increase collaboration and co-ordination with NGO	Urban+ HTR	170,914	148,664	156,841	476,419	40,447,984
4.8 Use of NGO volunteers in the community level for promoting and improving the referrals for LARC & PM methods	LARC&PM	932,264	983,538	1,037,633	2,953,435	250,746,644
Total		12,341,506	12,988,639	13,703,014	39,033,160	3,313,915,310

Note: Exchange rate is USD 1= BDT 84.90

Table 30: Costing of Strategy 5-Special focus on hard to reach & urban areas and low performing areas

Activity	Focusing/ Priority area	2020 (USD)	2021 (USD)	2022 (USD)	Total	
					USD	Local Currency
5.1 Develop comprehensive Regional Service Packages (RSPs) for hard-to-reach areas	Urban+ HTR	8,194,431	8,645,125	9,120,607	25,960,163	2,204,017,802
5.3 Recruit and train volunteers until permanent HR are available including UH&FWC and field level	Urban+ HTR	13,185,866	13,911,088	14,676,198	41,773,152	3,546,540,627
5.4 Outsource services to the NGO to target HTR and underserved areas	Urban+ HTR	124,558	131,409	138,637	394,604	33,501,864
5.6 Take initiatives to register all slum and non-slum couples via GO-NGO collaboration and co-ordination	Urban+ HTR	224,566	236,917	249,948	711,431	60,400,456
5.7 Rplicate and scale up Sylhet PPP model in other urban areas *Note: 6.5 crore for 3 years for 25,000 eligible couples in Sylhet*	Urban+ HTR	918,728	969,258	1,022,567	2,910,553	247,105,950
Total		22,648,149	23,893,797	25,207,956	71,749,902	6,091,566,699

Note: Exchange rate is USD 1= BDT 84.90

Table 31: Costing of Strategy 6- Monitoring & Evaluation (M&E) and Research

Activity	Priority area	2020 (USD)	2021 (USD)	2022 (USD)	Total	
					USD	Local Currency
6.1 Establish a central monitoring team	Overall	60,000	0	0	60,000	5,094,000
6.3 Establish a research team at DGFP headquarter	Overall	70,671	74,558	78,659	223,889	19,008,150
Total		**130,671**	**74,558**	**78,659**	**283,889**	**24,102,150**

Note: Exchange rate is USD 1= BDT 84.90

Table 32: Costing of Strategy 7-Targeting adolescent

Activity	Priority area	2020 (USD)	2021 (USD)	2022 (USD)	Total USD	Total Local Currency
7.1 One study on need assessment (with requirement of dissemination in TOR) to realize the current scenario and which will guide for future programming not only for government but also for NGOs/CSOs , nationwide but with more emphasis on the hard-to-reach and low-performing areas as well as reasons for low performance	Adolescents	70,671	0	0	70,671	6,000,000
7.2 Training for the providers on adolescent friendly services with privacy and confidentiality —FWV and SACMO focusing on providing non-judgmental services, accurate information on medical eligibility, communication strategy for adolescents	Adolescents	1,398,631	0	0	1,398,631	118,743,800
7.3 Ensuring private and confidential counselling room with doors and window curtains, partitioning the waiting areas so that adolescents clients do not have to mix adult clients, not conducting history taking and screening in public	Adolescents	289,164	0	0	289,164	24,550,000
7.4 Developing adolescent friendly communication materials and digital health services	Adolescents	546,213	559,187	589,943	1,695,343	143,934,625
7.6 Policy formation	Adolescents	60,000	0	0	60,000	5,094,000
7.7 Integration with web	Adolescents	60,000	0	0	60,000	5,094,000
Total		2,424,680	559,187	589,943	3,573,809	303,416,425

Note: Exchange rate is USD 1= BDT 84.90

Table 33: Costing of Strategy 8- Targeting adolescent with special focus on male

Activity	Focusing/ Priority area	2020 (USD)	2021 (USD)	2022 (USD)	Total	
					USD	Local Currency
8.2 Training for serving differently abled adolescents	Adolescents	1,280,995	1,351,450	1,425,780	4,058,225	344,543,311
8.3 Introducing counseling requirement for marriage registration, especially for the bridegroom/bride: one before marriage and one after marriage	Adolescents	5,804	6,123	6,459	18,386	1,560,949
8.5 Counselling and meeting for parents, providers, religious leaders, and other influential adults (public representatives and local elites etc.) who can foster a supportive environment in health facilities, schools, religious places of worship, and in homes	Adolescents	1,497,257	1,579,606	1,666,484	4,743,347	402,710,151
8.6 Developing effective sexually education guidelines	Adolescents	29,446	0	0	29,446	2,500,000
Total		2,813,502	2,937,179	3,098,723	8,849,404	751,314,411

Note: Exchange rate is USD 1= BDT 84.90

Table 34: FP Commodity Projection (Method-mix)

Method	2019 (%)	2020 (%)	2021 (%)	2022 (%)
CPR	67.2	69.8	72.4	75.0
MCPR	56.3	58.5	60.7	62.9
All LA or PM Method	9.33	9.69	10.06	10.42
Male sterilizations	1.19	1.24	1.29	1.33
Female sterilizations	5.21	5.41	5.61	5.82
IUDs	0.65	0.68	0.70	0.73
Implants	2.28	2.37	2.46	2.54
Injectables	11.61	12.06	12.51	12.96
Pills	27.55	28.63	29.70	30.78
Male condoms	7.81	8.11	8.42	8.72
Other traditional methods (e.g. massage)	10.85	11.27	11.69	12.12

Table 35: Cost of contraception by the government

Methods	Imprest fund per client	Unit cost of product	Government share (%)	Units per user per year	2020		2021		2022		Total		
					Units	USD	Units	USD	Units	USD	Units	USD	Local Currency
Male sterilizations*	48.97	0.00	87.50%	1	73,327	3,591,019	75,864	3,591,019	73,446	3,596,847	222,636	10,778,885	915,127,378
Female sterilizations*	51.87	0.00	63.10%	1	311,993	16,182,956	322,220	16,713,426	336,986	17,479,333	971,199	50,375,715	4,276,898,172
IUDs*	11.51	0.27	78.80%	1	84,535	990,958	83,698	981,147	91,407	1,071,515	259,640	3,043,620	258,403,345
Implants*	22.26	12.86	87.80%	1	391,828	13,147,034	409,316	13,344,526	421,866	14,154,901	1,223,010	40,646,461	3,450,884,553
Injectables	0.00	0.54	51.20%	4	23,069,985	6,333,034	24,176,590	6,636,813	25,287,012	6,941,639	72,533,587	19,911,486	1,690,485,187
Oral Pill (COP-2nd generation)+	-	-	39.40%	13	118,518,827	12,956,419	-	-	-	-	118,518,827	12,956,419	1,099,999,973
Oral Pill (COP-3rd generation)+					46,545,576	21,929,600	173,527,808	81,756,329	178,561,830	84,128,071	398,635,214	187,814,000	15,945,408,560
Oral Pill (POP)					12,929,327	1,413,428	13,014,586	1,413,428	16,622,297	1,531,213	42,277,532	4,358,068	370,000,000
Male condoms	0	0.03	17.80%	98	380,090,429	2,271,141	398,672,159	2,382,172	416,845,472	2,490,762	1,195,608,060	7,144,075	606,531,969
Other traditional methods (e.g. massage)	-	-		1	5,389,692	0	5,647,968	0	5,912,010	0	16,949,670	0	0
Contraception Total					587,405,519	78,815,589	615,930,209	126,818,860	644,152,326	131,394,281	1,847,488,053	337,028,730	28,613,739,179

Note: Exchange rate is USD 1= BDT 84.90

+ DGFP will not procure 2nd generation OCP from 2021 and onwards. So, 3rd generation OCP was considered for the rest two years: 2021 and 2022

* All LARC&PM cost includes the imprest fund

Considering only the share of government in total cost for contraception, a total of USD 337.03 million is required for FP contraception over the three years to be funded by the government (see table 35). 2020 requires USD 78.82 million, 2021 requires USD 126.82 million and 2022 needs USD 131.39 million. DGFP will not procure 2nd generation OCP from 2021 and onwards. So, 3rd generation OCP was considered for the rest two years: 2021 and 2022. This increased the oral pill cost for the last two years. In addition, increase of contraception users and effect of inflation also contributed to the increase of total costs. Considering both government expenses and private sector expenses on contraceptives, a total of USD 550.74 million is required over the three years. Detailed cost of contraception by private sector is attached in annex Table 5.

4.4 Cost of filling up the vacant posts

This subsection provides a brief costing for filling up the existing vacancy of field level staff throughout the country. In addition to the cost of strategies and contraception, cost for filling up the existing vacancy must be considered in CIP. Though filling up the posts is a lengthy and complicated bureaucratic process, especially during this CIP period, this CIP just summarizes the costs that will be required to fill up the posts. This is to be noted that, without filling up the vacancy of human workforce, achieving the FP2020 and HNPSP goals may not be possible as FP services engage a huge number of personnel, especially the field staff. The amount needed for this purpose is assumed here to remain fixed over the years. Monthly average salary of the DGFP personnel are obtained from FPSA 2018-2019 (Hamid S. A., Sultana, Ifteakhar, & Azim, 2020). Detailed costing of HR is attached in the table 36. It is seen that maximum amount is required for filling up the posts of FWA. This study estimates the costs for filling all vacant posts which could be difficult administratively. However, if technology can aid and replace many activities such as monitoring, supervision, information provision, tracking, etc., then the same objectives can be achieved with fewer human resources. If domiciliary based services need to be strengthened to achieve objectives, then human resource would be instrumental.

Table 36: Salaries required for the vacant posts (thousands of USD)

Division	TFPA	OA	SACMO	FWV	FPI	FWA	Total
Khulna	90.10	0.00	363.36	312.99	412.89	3,851.89	**5,031.23**
Chottogram	292.83	31.54	867.02	1,010.92	975.93	5,180.24	**8,358.48**
Dhaka	165.19	10.51	442.50	863.42	914.93	6,413.97	**8,810.52**
Barishal	15.02	3.50	219.45	277.01	300.29	2,264.17	**3,079.44**
Maymensingh	67.58	0.00	230.25	453.30	145.45	1,994.29	**2,890.87**
Rangpur	75.08	3.50	111.52	0.00	337.82	3,869.41	**4,397.33**
Rajshahi	67.58	0.00	201.46	550.43	577.11	4,304.02	**5,700.60**
Sylhet	142.66	38.55	471.28	273.42	337.82	1,507.11	**2,770.84**
Total	**916.04**	**87.60**	**2,906.84**	**3,741.49**	**4,002.24**	**29,385.10**	**41,039.31**

Note: TFPA-Thana Family Planning Assistant, OA- Office Assistant, SACMO- Sub-Assistant Community Medical Officer, FWV-Family Welfare Visitor, FPI-Family Planning Inspector, FWA-Family Welfare Assistant. The salaries are calculated as per the pay scale[13].

4.5 Cost summary of CIP

The following table 37 summarizes the cost of CIP in the three years (2020-2022). Total cost equals USD 865.94 million in the three years. Year 2022 requires much more than the other two years, USD 294.68 million. The first and second years requires USD 287.54 million and USD 283.72 million, respectively. This is due to the inflation rate and increased number of FP contraceptive users projected

13

Posts	TFPA	O/A	SACMO	FWV	FPI	FWA
Basic Salary/month (USD)	536.32	250.35	256.97	256.97	335.14	250.35

earlier. On the other hand, implementing the strategies recommended in this CIP will cost almost half (46.86%) of the total cost of CIP. The rest half is for timely and adequate procurement of contraceptive methods. Cost of summary is shown in bar diagram below.

Table 37: Cost summary of CIP

Method	2020 (USD)	2021 (USD)	2022 (USD)	Total	
				USD	Local Currency
Strategies Total	167,682,808	115,868,914	122,241,704	**405,793,426**	**34,451,861,867**
Contraception Total	78,815,589	126,818,860	131,394,281	**337,028,730**	**28,613,739,179**
Filling up vacant HRs	41,039,310	41,039,310	41,039,310	**123,117,930**	**10,452,712,257**
Total CIP expenditure	**287,537,707**	**283,727,084**	**294,675,295**	**865,940,086**	**73,518,313,303**

Note: Exchange rate is USD 1= BDT 84.90

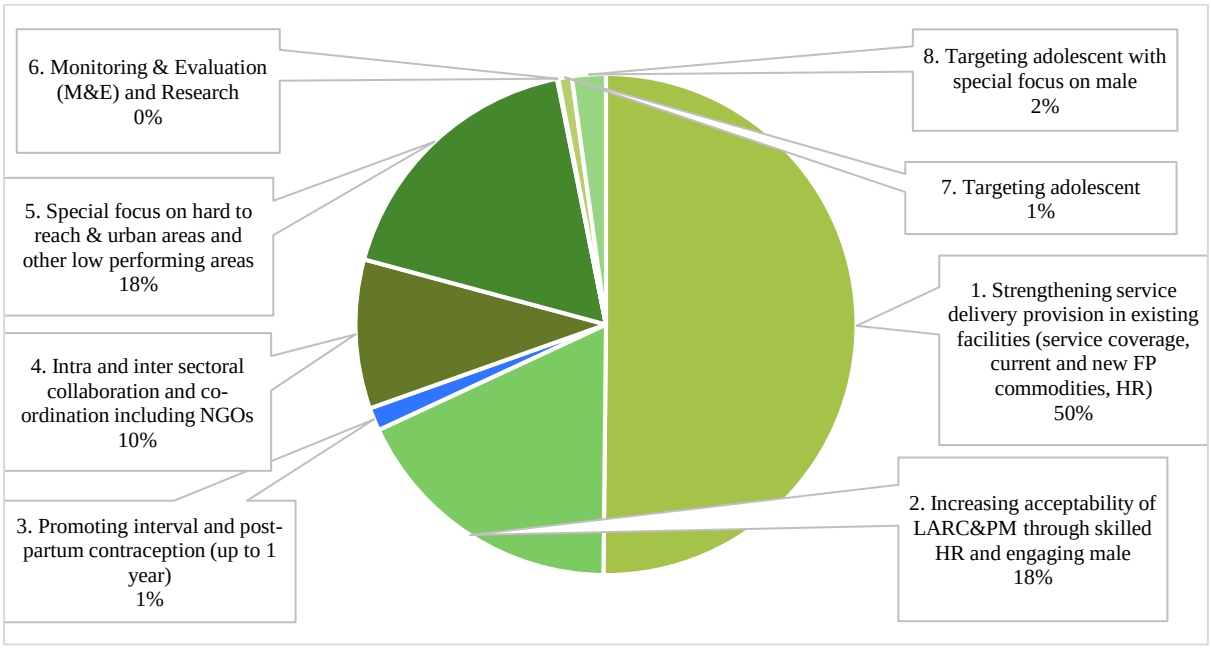
The following table 38 summarizes the cost of proposed strategies by administrative levels. Around 70% of the total cost will be spent at the upazila level. 17.32% and 7.37% of the total cost will be spent at the union and national level. Ward/ community level and district level requires around 3% each.

Table 38: Cost of proposed strategies by administrative level

	Cost (USD)			Total Cost	
Level	**2020**	**2021**	**2022**	**USD**	**Local Currency**
Ward/Community	4,055,152	4,278,185	4,513,485	**12,846,823**	**1,090,695,250**
Union	22,183,749	23,403,855	24,691,067	**70,278,672**	**5,966,659,235**
Upazila	119,326,348	78,326,960	82,634,942	**280,288,250**	**23,796,472,388**
District	3,990,747	4,128,453	4,355,518	**12,474,717**	**1,059,103,485**
National	18,126,812	5,731,461	6,046,691	**29,904,964**	**2,538,931,447**
Total	**167,682,808**	**115,868,914**	**122,241,704**	**405,793,425**	**34,451,861,806**

The following figure 8 depicts the share of the cost of strategies.

Figure 8: Percentage share of the strategies



Strengthening service delivery provision in existing facilities (service coverage, current and new FP commodities, HR) will cost half of the total cost. Other three of the nine strategies: increasing acceptability of LARC&PM through skilled HR and engaging male; special focus on hard to reach & urban areas and other low performing areas; and intra and inter sectoral collaboration and co-ordination including NGOs will cost about 46% of the total cost of strategies. The rest five strategies will require around 4% of the total cost.

Some of the activities costed in this CIP are already costed in several OPs of HNPSP. In most of the cases, to achieve FP2020 goals DGFP will need to spend much higher than current budget of OPs. Table 39 compares the costing of CIP with those costed in several OPs of HNPSP. About USD 180.1 million is required more for training, workshop, study and consultancy purpose. USD 158.4 million more is needed for adequate procurement of contraceptives, purchase of consumable stores; and vaccines & other drugs. However, the current budget of OPs exceeds the costs allocated for advertising and similar activities.

Table 39: Comparison of cost in CIP and OPs for matched inputs

Inputs	Projected cost of CIP (USD)	Source of Funds (USD)				Difference (projected-current) from current funding
		GOB	GoB through RPA	DPs	Total (USD)	
Training, workshop, consultancy and study	180,061,869	8,653,110	8,341,060	4,670,742	21,664,911	158,396,958
Advertisement	776,334	3,320,024	7,265,017	283,863	10,868,904	(-) 10,092,570
Contraception methods	198,541,271	14,618,516	137,106,125	3,914,299	155,638,940	42,902,331

Note: Exchange rate is USD 1= BDT 84.90

Table 40 compares some specific common activities of this CIP with those of OPs. Most of the matched activities require larger cost compared to the amount already budgeted in OPs except for some including Technical training on post MR, post abortion care (PAC) FP services, MR with medication (MRM); android app development; advertisement on TV/Radio/social media; and training on LARC&PM.

Table 40: Comparison of cost in CIP and OPs for the matched activities

	Projected cost of CIP (USD)	Cost in OPs (USD)	Difference (projected-current) from current funding
1.1.6 Prepare guideline and fund allocation for courtyard meeting	5,505,781	1,126,031	4,379,750
2.5 Using satisfied clients/champions for the promotion of LARC&PM in the community	1,099,293	784,664	314,629
3.6 Technical training on post MR, post abortion care (PAC) FP services, MR with medication (MRM) at places where delivery takes place	227,597	820,495	(-) 592,898
7.4.3 Android App development with FP contents	1,178	141,343	(-) 140,165
2.11.3 Advertisement on TV, Radio (daily one 30 sec add on TV, daily 2 add on radio), social media (Facebook, YouTube)	762,714	3,981,154	(-)3,218,440
6. Monitoring & Evaluation (M&E) and Research	283,889	135,453	148,436
1.3.1 Training on LARC&PM (FWVs, MOs from each selected MCWC, 5 days training in	164,049	936,631	(-) 772,582

	Projected cost of CIP (USD)	Cost in OPs (USD)	Difference (projected-current) from current funding
first year and 1-day refresher training for last two years)			
3.5 Orientation/Training/ workshops for the DGFP and DGHS officials to initiate post-partum contraception (PPFP methods, imprest fund, record keeping and reporting	2,593,898	850,495	1,743,403
5.6.2 One-day workshop for planning data collection process and technique (15 participants in each HTR upazila)	675,608	325,089	350,519
4.6 Orientation workshop for civil society i.e., journalists, teachers, religious and political leaders, social welfare officers etc.	1,476,718	21,201	1,455,517

Adjusting for the costs already included in OPs, the additional costs required to carry out all the suggested strategies and the cost of CIP is presented in Table 41. To conduct all the strategies suggested in this study, additional funding required is USD 373.26 million while this amount will turn into USD 677.77 million if the cost of contraceptives is included.

Table 41: Additional cost required for strategies and CIP

Cost of strategies excluding contraceptives (USD)		Cost of CIP including contraceptives (USD)	
Strategies costed in CIP	405,793,426	Cost of CIP	865,940,086
Strategies costed in OP	32,533,815	Costed in OP	188,172,755
Additional requirement	**373,259,611**	**Additional requirement**	**677,767,331**

5. POSSIBLE IMPLEMENTATION CHALLENGES[14]

Although the current CIP exercise has identified interventions to achieve FP2020 and HNPSP 2017-2022 goals, some challenges remain which may impede or slow down the implementation.

1. Even though both health and family planning sectors are committed to achieve SDG and HNPSP 2017-2022 goals, the bifurcated service system—both at central and field level—pose a serious threat to the implementation. There is an evident and stark lack of coordination between these two divisions of MOHFW which may limit the possibility of increased service coverage and quality service provision. For instance, improving PPFP services and increasing service coverage in DGHS facilities require coordinated efforts.
2. A significant number of field level staff are going to retire soon which will exacerbate human resource crisis since hiring new staff involves lengthy bureaucratic procedures. Alternative suggestions--hiring volunteers, hiring retirees on a contract basis, and outsourcing services to NGOs--will require some changes in policy. To do so, inter-ministerial coordination will be immensely important, and a lack of effective collaboration can pose a threat.
3. Policy changes will also be needed for making attending compulsory counselling sessions with marriage registration, providing training to traditional providers and pharmacy shopkeepers, increasing the contents of FP in the medical curriculum. All of these actions will necessitate a common understanding on the importance of FP for achieving overall health sector goals which might be challenging.
4. Lack of motivation among FP service providers, managers and field level staff is pervasive. Achieving FP2020 goals requires not only an effective participation and strong strides in the

[14] Several resources are available for implementation and stakeholder's engagement. These guidelines can be useful; still some implementation challenges may remain. The links of those guidelines are: Performance review process guide, Dashboard tool and user guide, and Communicating with Multisectoral Stakeholders about Costed Implementation Plans

activities suggested but also strong motivation to do so. The current promotional structure — where it is difficult to motivate the staff—may prove to be a barrier in improving service. Although some motivational interventions are suggested, increasing motivation would be extremely challenging without an overhaul of family planning organogram.

5. Carrying out all activities suggested would require facility readiness of both DGFP and DGHS facilities. Timely facility readiness can be challenging which can imperil a successful implementation.

6. Currently, DGFP cannot fully utilize the allocated development budget, and hence, it can be challenging to convince finance division for allocation of additional funds.

6. LIMITATION OF THE STUDY

The study has some limitations which are worth mentioning. First, even though private sector contribution has been taken into consideration for product or commodity projections and costing, the costing for other activities are not included. Second, since the study focuses on policy makers' buy-in and was therefore carried out in such as a way that it would understandable to policy makers, this CIP might have some differences compared to the CIPs of other countries. Third, though an attempt has been made to take the costs of activities already included in OPs in the adjusted cost calculations, this estimation is less precise than would be desired due to lack of detailed breakdown of the costs in the OPs. Fourth, the physicians of private facilities may not have the required technical expertise to perform FP services, especially LARC&PM service, and orientation workshop suggested in the CIP (strategy 3.7.4) may not be enough. Therefore, if long term training is required then total costs of CIP will be slightly higher. Fifth, though strategies have been suggested for adolescents based on the expert opinion, consultative workshop, adolescents were not consulted directly.

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Annex

Table 1: Cost of inputs				
Type of input	**Item**	**Unit cost (USD)**	**Unit**	**Source**
Commodities	Male sterilizations	48.97	per procedure	FPSA 2018-2019
	Female sterilizations	51.87	per procedure	FPSA 2018-2019
	IUDs	11.51	per insertion	FPSA 2018-2019
	Implants	22.26	per insertion	FPSA 2018-2019
	Injectables	0.54	per injection	FPSA 2018-2019
	Pills	0.47	per cycle	FPSA 2018-2019
	Male condoms	0.03	per item	FPSA 2018-2019
	Financial support to clients of permanent method	27.09	per client	practicing rate
	Proposed Financial support to clients of permanent method	58.89	per client	Proposed
	Emergency Contraceptive Pill (ECP)	52.00	per cycle	FPSA 2018-2019
Salary/ Per Diem	Allowance - Volunteer	3.77	daily	OP-CCSDP
	Allowance - Campaigner	3.77	daily	OP-CCSDP
	Consultant Per Diem - Local	500.00	daily	Researchers' experience
	Consultant Per Diem - International	1,000.00	daily	Researchers' experience
	Government Official Per Diem	23.56	daily	practicing rate
	Hotel Per Diem - Capital	35.34	daily	Researchers' experience
	Hotel Per Diem - Outside Capitol	23.56	daily	Researchers' experience
	Salary - Midwife - entry level	171.80	monthly	FPSA 2018-2019
	Salary - Nurse - entry level	236.73	monthly	FPSA 2018-2019
	Salary - FPI	335.14	monthly	FPSA 2018-2019
	Salary - Cleaner	277.03	monthly	FPSA 2018-2019
	Salary - Counsellor	372.56	monthly	FPSA 2018-2019
	Salary - Driver	358.87	monthly	FPSA 2018-2019
	Salary - FWA	250.35	monthly	FPSA 2018-2019
	Salary – FWV/SACMO	256.97	monthly	FPSA 2018-2019
	Salary - Pathologist	512.90	monthly	FPSA 2018-2019
	Salary - Statistician	537.66	monthly	FPSA 2018-2019
	Salary - MO-Clinic	743.36	monthly	FPSA 2018-2019
	Salary - UFPO	536.32	monthly	FPSA 2018-2019
	Salary - DD-FP	1,229.45	monthly	FPSA 2018-2019
	Salary - AUFPO	267.61	monthly	FPSA 2018-2019
	Salary - Midwife - principal	171.80	monthly	FPSA 2018-2019
	Salary - Nurse - principal	236.73	monthly	FPSA 2018-2019
	Salary - Project Director	490.52	monthly	FPSA 2018-2019
	Salary - MO-MCH	490.52	monthly	FPSA 2018-2019
	HTR allowance- Midwife - entry level	34.36	monthly	FPSA 2018-2019
	HTR allowance- Nurse - entry level	47.35	monthly	FPSA 2018-2019
	HTR allowance- FPI	67.03	monthly	FPSA 2018-2019
	HTR allowance- Cleaner	55.41	monthly	FPSA 2018-2019
	HTR allowance- Counsellor	74.51	monthly	FPSA 2018-2019
	HTR allowance- Driver	71.77	monthly	FPSA 2018-2019
	HTR allowance- FWA	50.07	monthly	FPSA 2018-2019
	HTR allowance - FWV	51.39	monthly	FPSA 2018-2019
	HTR allowance- Pathologist	102.58	monthly	FPSA 2018-2019
	HTR allowance - Statistician	107.53	monthly	FPSA 2018-2019

	HTR allowance - MO-Clinic	148.67	monthly	FPSA 2018-2019
	HTR allowance - UFPO	107.26	monthly	FPSA 2018-2019
	HTR allowance - DD-FP	245.89	monthly	FPSA 2018-2019
	HTR allowance - AUFPO	53.52	monthly	FPSA 2018-2019
	HTR allowance - Midwife - principal	34.36	monthly	FPSA 2018-2019
	HTR allowance - Nurse - principal	47.35	monthly	FPSA 2018-2019
	HTR allowance - MO-MCH	98.10	monthly	lump sum
	Mobile (Cell phone) allowance	3.53	monthly	lump sum
	Volunteers replacing permanent HR	111.90	monthly	lump sum
Communication & Outreach	Billboard - printing, installation and one-year lease	23,557.13	per item	Market rate
	Newspaper publication - color	2,944.64	per item	Market rate
	Newspaper publication – black & white	2,355.71	per item	Market rate
	Pamphlet printing - 100 color	0.06	per item	Market rate
	Pamphlet printing - 100 black &white	0.04	per item	Market rate
	Radio - 30 second spot	58.89	per item	Market rate of top channel
	Poster printing - 11.3" X 17.3" poster	0.27	per item	Researchers' experience
	Poster printing - 18" X 24" poster	0.53	per item	Researchers' experience
	Poster printing - 24" X 36" poster	1.06	per item	Researchers' experience
	Brochure printing - 100 black & white	0.06	per item	Market rate
	Brochure printing - 100 color	0.09	per item	Market rate
	Policy document printing - 100 black & white	0.09	per item	Market rate
	Policy document printing - 100 color	0.12	per item	Market rate
	SMS per message	0.00	per item	Market rate
	Website hosting page	176.68	per year	Market rate
	Website design	588.93	per item	Market rate
	TV - 30 second spot	530.04	per item	Market rate of top channel
	T-shirt	1.18	per item	Market rate
	Cap	0.59	per item	Market rate
	Sticker - small	0.07	per item	Market rate
	Sticker - bumper sticker	0.11	per item	Market rate
	Sticker - medium	0.14	per item	Market rate
	Jacket	9.42	per item	Market rate
	Plaque	5.89	per item	Researchers' experience
	Umbrella	5.30	per item	Market rate
	Stand banner	5.30	per item	Market rate
	Android app development	1,177.86	per item	Researcher's assumption
	Advertisement on social media (Facebook, Instagram)	11.78	per day	lump sum
	Cost of Sylhet model	6.12	per eligible couple	
	National consultative study for reorientation of DGFP's domiciliary service	235,571.26	for one study	lump sum
	Providing supportive logistics (e.g., bag, umbrella etc.)	58.89	per FWA	lump sum

Meetings	Capital hotel conference package	85.16	per person	Researchers' experience
	Regional hotel conference package	65.72	per person	Researchers' experience
	District/upazila hotel conference package	47.47	per person	Researchers' experience
	Meeting cost- National	9.19	per person per day	Researchers' experience
	Meeting room large - capital	353.36	daily	Researchers' experience
	Meeting room small - capital	176.68	daily	Researchers' experience
	Meeting room large - regional	294.46	daily	Researchers' experience
	Meeting room small - regional	117.79	daily	Researchers' experience
	Meeting room large- district/upazila	235.57	daily	Researchers' experience
	Meeting room small- district/upazila	117.79	daily	Researchers' experience
	Pen	0.12	per item	Researchers' experience
	Notepad	0.59	per item	Researchers' experience
	Didactic materials	0.59	per item	Researchers' experience
	Drink	0.24	per person per day	Researchers' experience
	Refreshments	1.18	per person per day	Researchers' experience
	Lunch/Dinner	4.71	per person per day	Researchers' experience
	Lunch per diem/person - capital	5.30	per person per day	Researchers' experience
	Lunch per diem/person - regional	3.53	per person per day	Researchers' experience
	Lunch per diem/person - district/upazila	2.94	per person per day	Researchers' experience
	Hotel per diem/person - capital	35.34	per person per day	Researchers' experience
	Hotel per diem/person - regional	29.45	per person per day	Researchers' experience
	Hotel per diem/person - district/upazila	23.56	per person per day	Researchers' experience
	Survey - regionally	35,335.69	per survey	Researchers' experience
	Survey- nationally	70,671.38	per survey	Researchers' experience
	Survey - district	17,667.84	per survey	Researchers' experience
	Meeting total per person	9.19	per person per day	Researchers' experience
	Travel per diem per person - National	75.97	per person per day	Researchers' experience
	Travel per diem per person - Regional	56.54	per person per day	Researchers' experience
	Travel per diem per person - State	38.28	per person per day	Researchers' experience
	Technical Allowance	235.57	per person per day	lump sum
	Honorarium - First class (above DS)	35.34	per person per day	Practicing rate
	Honorarium - First class (below DS)	18.85	per person per day	Practicing rate
	Honorarium - Second class (FPI, Sr. FWV)	13.55	per person per day	Practicing rate
	Honorarium - Third class (FWV, FWA)	9.42	per person per day	Practicing rate
	Honorarium (Average) - First class	23.56	per person per day	Practicing rate

	Honorarium (Average) - Second/Third class	11.78	per person per day	Practicing rate
	Courtyard meeting	3.53	per meeting per FWA	lump sum
	Promotional workshop	353.36	per workshop	lump sum
Transport	Transport - liter of fuel	1.06	per liter	Market rate
	Transport allowance - capital	35.34	per person per day	Researchers' experience
	Transport allowance - regional	23.56	per person per day	Researchers' experience
	Transport allowance - district/upazila	11.78	per person per day	Researchers' experience
	Transport - International Flight	706.71	per trip-one way	Researchers' experience
	Transport - vehicle repair and maintenance	1,934.63	monthly	FPSA 2018-19
	Transport- local	5.89	per person per day	lump sum
	Transport for RRT	588.93	per year per district	lump sum
	Transport for RRT to Haor unions	1,413.43	per union per 6 months	lump sum
Other costs	Phone line	17.67	monthly	lump sum
	Pens	0.06	per item	market price
	Paper	4.12	per box	market price
	Electricity/monthly	8,833.92	monthly	lump sum
	Printing 1 page	0.01	per page	market price
	Curtain	5.89	per item	Researchers' experience
	Register books	4.71	per item	Researchers' experience
	Crest for FWA/FWV/FPI	11.78	per item	Researchers' experience
	Piloting for self-administering FP method	235,571.26	per pilot	lump sum
	Soundproof partition wall	117.79	per wall	lump sum
	AC	824.50	per AC	Researchers' experience
	Maintenance and renovation of UHC	5,889.28	per upazila per year	lump sum
Capital	Vehicle - sedan (Corolla)	18,845.70	per item	market price
	Vehicle Maintenance - sedan (Corolla)	58.89	monthly	lump sum
	Vehicle - truck (Hilux)	141,342.76	per item	market price
	Vehicle Maintenance - truck (Hilux)	58.89	monthly	lump sum
	Vehicle - 4X4 SUV (Prado)	141,342.76	per item	market price
	Vehicle Maintenance - 4X4 SUV (Prado)	94.23	monthly	lump sum
	Vehicle - motorcycle (125 cc)	1,766.78	per item	market price
	Vehicle Maintenance - motorcycle	11.78	monthly	lump sum
	Vehicle - Ambulance	48,292.11	per item	FPSA 2018-19
	Vehicle Maintenance - Ambulance	58.89	monthly	lump sum
	One room building - regional	3,533.57	per item	market price
	Examination light	23.56	per item	market price
	Examination table	159.01	per item	market price
	Couch	176.68	per item	market price
	Chair	35.34	per item	market price
	Desk	117.79	per item	market price
	Tent	17.67	per item	market price
	Medical bags	29.45	per item	market price
	LED TV	282.69	per item	market price

	DVD player	35.34	per item	market price
	Laptop	588.93	per item	market price
	Printer	259.13	per item	market price
	Mobile phones buy	176.68	per item	market price
	Internet bills	11.78	monthly	market price

Literature Reviews

In a tripartite workshop organized by MOHFW, it was identified that the utilization of resources, accountability, manpower planning and management, proper monitoring on service provider and FP materials availability, quality FP services, is important for the sustainability of family planning program. It was also stated that redesign of implementation strategies towards the collaboration of community and institutional services from the community versus institutions (Ministry of Health and Family Welfare, 2018). (Malhotra & Bhat, 2014). In the literature, it is evident that the fertility rate for adolescents very high (Nabi). Hence, a special focus on adolescent is required.

It is stated in the literature that expanding the basket of contraceptives i.e. introducing new FP products to the methods mix which have fewer side effects and are more user-friendly is important for the FP program to go forward. Moreover, for reducing TFR it is important to give more emphasis on LAPM which currently very low. In addition, reducing the knowledge and information gap about the contraceptive methods: Introducing FP related counseling for clients in FP service provision, training on FP related counseling for the provider (Malhotra & Bhat, 2014).

For expanding access to FP services and product strategies like provision of cost-effective contraceptives, more sales outlets, introducing FP services in other facilities including Upazila and district level hospital, vaccination Centre etc. rather than restricting it to only FP offices.

Form the websites of high impact practices several effective strategies have been identified. For example, enhance the motivation, retention for the community workers, and immediate postpartum family planning services. To arrange FP service for adolescent the high impact practices are reducing provider bias, improving confidentiality and privacy, and reducing financing barriers (i.e., transportation costs) (Jhons Hopkins University, 2019).

Gwyn Hainsworth et al, 2014, from the experience of five African countries, showed that successful adolescent programs need to be pursued expansion and institutionalization for sustainable scale-up. Advocacy along with comprehensive capacity building at all levels of the health system is required to improve the adoption of adolescent family planning services

Table 2: Some Costing from OP

	GOB	GoB through RPA	DPs	Total (BDT in lac)
CCSDP				
Training	1097.52	561.6	1020	2679.12
Conference	1135.22	17.96	34	1187.18
Audio/Video film making	0	0	0	0
Advertising & Publicity	40	0	0	40
Purchase of consumable stores	453.42	0	0	453.42
Vaccines & other drugs'	533.2	1619.6	0	2152.8
Contraceptives	6637.5	5170	0	11807.5
Survey Study	500	0	0	500
	0	0	0	0

	GOB	GoB through RPA	DPs	Total (BDT in lac)
Strategy and Activities				
Courtyard meeting (Uthan Baithok)	0	0	0	956
Financial support to NGO grant for LARC & PM services (BAVS and other NGOs)	0	0	0	3808
Training for LAPM Local in batch	0	0	0	795.2
PPFP training-Local in batch	0	0	0	722.07
Seminar Workshop/training for satisfied LAPM clients	0	0	0	666.18
	0	0	0	0
FSD				
Training	205	430	0	635
Conference	345	170	0	515
Audio/Video film making	0	0	0	0
Advertising & Publicity	3	0	0	3
Purchase of consumable stores	12	0	0	12
Vaccines & other drugs'	0	0	0	0
Contraceptives	0	73519.5	0	73519.5
Survey Study	0	0	0	0
Research	150	0	0	150
Consultancy	15	0	0	15
	0	0	0	0
MCRAH				
Training	750	1875	1291.46	3916.46
Conference	1050	1150	1600	3800
Audio/Video film making	0	0	0	0
Advertising & Publicity	52	0	0	52
Purchase of consumable stores	36	0	0	36
Vaccines & other drugs'	3750	29500	1673.24	34923.24
Medical and surgical supplies	950	6594	1650	9194
Contraceptives	0	0	0	0
Survey Study	0	0	0	0
Research	0	0	0	0
Consultancy	0	0	0	0
Training on VIR & PAC for Doctors and FWVs	0	0	0	396.6
Training on MRM	0	0	0	300
IEC				
Training	204.5	700	20	924.5
Conference	375	425	0	800
Audio/Video film making	530	955	75	1560
Advertising & Publicity	1962.2	5213	166	7341.2
Purchase of consumable stores	39	0	0	39
Vaccines & other drugs'	0	0	0	0

	GOB	GoB through RPA	DPs	Total (BDT in lac)
Medical and surgical supplies	0	0	0	0
Contraceptives	0	0	0	0
Survey Study	0	0	0	0
Research	100	0	0	100
Consultancy	0	0	0	0
Mobile Apps	0	0	0	120
Pre marriage counseling	0	0	0	200
Skill training on IPC for FWA, FWV, FPI, SACMO	0	0	0	80
Radio program	0	0	0	885.97
Media campaign via TV and Radio	0	0	0	3380
Monitoring and research	0	0	0	115
PSSM-FP				
Training	40	67	0	107
Conference	10	20	0	30
Audio/Video film making	0	0	0	0
Advertising & Publicity	216	0	0	216
Purchase of consumable stores	0	0	0	0
Vaccines & other drugs'	0	0	0	0
Medical and surgical supplies	0	0	0	0
Contraceptives	0	0	0	0
Survey Study	0	0	0	0
research	0	0	0	0
consultancy	0	20	0	20
MIS				
Training	42	625	0	667
Conference	1320	0	0	1320
Audio/Video film making	0	0	0	0
Advertising & Publicity	15	0	0	15
Purchase of consumable stores	0	0	0	0
Vaccines & other drugs'	0	0	0	0
Contraceptives	0	0	0	0
Survey Study	0	0	0	0
research	0	0	0	0
consultancy	0	0	0	0
Strategy and Activities				
Workshop on focus group on data monitoring & supervision	0	0	0	90
Workshop on data accuracy through field visit	0	0	0	276

	GOB	GoB through RPA	DPs	Total (BDT in lac)
PME-FP				
Training	7.25	105	0	112.25
Conference	0	935	0	935
Audio/Video film making	0	0	0	0
Advertising & Publicity	0.5	0	0	0.5
Purchase of consumable stores	2.5	0	0	2.5
Vaccines & other drugs'	0	0	0	0
Contraceptives	0	0	0	0
Survey Study	0	0	0	0
research	0	0	0	0
consultancy	0	0	0	0
	0	0	0	0
Workshop on GO & NGO/Garments Collaboration at Central & Divisional level	0	0	0	18

Table 3: Vacant Posts by Category and District Level

Division	DD	UFPO	MOMCH-FP	MO-CC	TFPA	SACMO	FWV	FPI	FWA
Khulna	0	0	0	0	12	101	87	88	1099
Chottogram	0	0	0	0	39	241	281	208	1478
Dhaka	0	0	0	0	22	123	240	195	1830
Barishal	0	0	0	0	2	61	77	64	646
Maymensingh	0	0	0	0	9	64	126	31	569
Rangpur	0	0	0	0	10	31	-39	72	1104
Rajshahi	0	0	0	0	9	56	153	123	1228
Sylhet	0	0	0	0	19	131	76	72	430
Total	0	0	0	0	122	808	1001	853	8384

Table 4: Salaries required for Vacant Post in millions of USD

Division	DD	UFPO	MOMCH-FP	MO-CC	TFPA	SACMO	FWV	FPI	FWA
Khulna	0	0	0	0	0.090102	0.363356	0.312989	0.412892	3.851885
Chottogram	0	0	0	0	0.292831	0.867017	1.01092	0.975928	5.180242
Dhaka	0	0	0	0	0.165187	0.442502	0.863419	0.914932	6.413967
Barishal	0	0	0	0	0.015017	0.219452	0.277014	0.300285	2.264165
Maymensingh	0	0	0	0	0.067576	0.230245	0.453295	0.145451	1.994288
Rangpur	0	0	0	0	0.075085	0.111525	-0.14031	0.337821	3.86941
Rajshahi	0	0	0	0	0.067576	0.201464	0.55043	0.577111	4.304017
Sylhet	0	0	0	0	0.142661	0.471283	0.273416	0.337821	1.507107
Total	0	0	0	0	0.916035	2.906845	3.601178	4.002242	29.38508

Table 5: Cost of Contraception by Private Sector

Method	Unit cost (USD)	Pvt. Share	2020 (Pvt.)		2021 (Pvt.)		2022 (Pvt.)		Total		
			Units	**USD**	**Units**	**USD**	**Units**	**USD**	**Units**	**USD (Pvt.)**	**Local Currency (Pvt.)**
Male sterilizations	0.00	12.50%	73,327	-	75,864	-	73,446	-	222,636	-	-
Female sterilizations	0.00	36.90%	311,993	-	322,220	-	336,986	-	971,199	-	-
IUDs	0.27	21.20%	84,535	4,872	83,698	4,824	91,407	5,268	259,640	14,964	1,270,408.13
Implants	12.86	12.20%	391,828	614,852	409,316	642,293	421,866	661,987	1,223,010	1,919,132	162,934,284.24
Injectables	0.54	48.80%	23,069,985	6,036,173	24,176,590	6,325,712	25,287,012	6,616,250	72,533,587	18,978,135	1,611,243,693.56
Pills	0.47	60.60%	177,993,730	50,819,411	186,542,393	53,260,160	195,184,127	55,727,482	559,720,249	159,807,053	13,567,618,835.76
Male condoms	0.03	82.20%	380,090,429	10,488,078	398,672,159	11,000,816	416,845,472	11,502,284	1,195,608,060	32,991,178	2,800,951,002.16
Contraception Total			582,015,827	67,963,386	610,282,240	71,233,805	638,240,316	74,513,271	1,830,538,381	213,710,462	18,144,018,223.85


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