Costed Implementation Plan for the National Family Planning Programme, Bangladesh

2016-2020

Ministry of Health and Family Welfare (MOHFW), Bangladesh

Final Report

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Table of Contents

List of Figures, Boxes and Tables

Acronyms

ASRH	Adolescent Sexual Reproductive Health
BCC	Behavior Change Communication
BCEWG	Bangladesh Country Engagement Working Group
BCO	Bangladesh Country Office
BDHS	Bangladesh Demographic and Health Survey
BRAC	Bangladesh Rural Advancement Committee
CC	Community Clinic
CCSD	Clinical Contraception Service Delivery
CPR	Contraceptive Prevalence Rate
CIP	Costed Implementation Plan
DGHS	Directorate-General of Health Services
DGFP	Directorate-General of Family Planning
DP	Development Partners
ELCO	Eligible Couples
FP	Family Planning
FPFSD	Family Planning Field Service Delivery
FPI	Family Planning Inspector
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
GOB	Government of Bangladesh
HTR	Hard-To-Reach
HPNSDP	Health Population Nutrition Sector Development Programme
ICDDR,B	International Centre for Diarrheal Diseases Research, Bangladesh
IEC	Information, Education and Communication
ICT	Information, Communication and Technology
IP	Implementation Plan
IUD	Intra Uterine Contraceptive Device
KII	Key Informant Interview
LAPM	Long-Acting and Permanent Methods
LD	Line Director
LLP	Local Level Planning
M&E	Monitoring and Evaluation
MIS	Management Information System
MOCA	Ministry of Cultural Affairs
MOHFW	Ministry of Health and Family Welfare
MOE	Ministry of Education
MOI	Ministry of Information
MOL&E	Ministry of Labour and Employment
MOLGRD	Ministry of Local Government and Rural Development
MORA	Ministry of Religious Affairs
MOSW	Ministry of Social Affairs
MOY&S	Ministry of Youth and Sports
MOWCA	Ministry of Women and Children Affairs
MSR	Medico Surgical Requisites
NFPP	National Family Planning Program
NGOs	Non-Governmental Organization
NIPORT	National Institute of Population, Research and Training
NSV	Non-Scalpel Vasectomy
OP	Operation Plan
PME	Planning, Monitoring & Evaluation
PSSM	Procurement, Storage and Supply Management

QA	Quality Assurance
SMC	Social Marketing Company
TFR	Total Fertility Rate
TOR	Terms of Reference
UHFWC	Upazila Health and Family Welfare Centre
UN	United Nations
UNFPA	United Nations Population Fund
UPHCP	Urban Primary Health Care Project
WB	World Bank

Executive Summary

Bangladesh committed to the overall goal of 'Ensuring quality and equitable family planning services for all eligible couples by improving access to and utilization of family planning services, particularly by the poor' at the London Summit on Family Planning (FP2020) in July 2012. Specific targets have been set for reducing total fertility rate, increasing contraceptive prevalence rate (CPR) and method-specific coverage, reducing discontinuation rate and reducing overall unmet need for family planning (FP).

To achieve the targets determined at the FP 2020 summit, a Costed Implementation Plan (CIP 2016–2020) is required for Bangladesh to enhance its national FP program (NFPP). Timely mobilization of resources is always a considerable challenge to the implementation of FP program activities; unavailability of financial resources would jeopardize the entire program. Meeting this challenge requires a CIP. The overall objective is to develop a five-year CIP (2016–2020) to strengthen the NFPP to achieve its set goals and objectives by 2021.

Preparation of a CIP involved qualitative and quantitative methods of data collection and analysis within a cost analysis approach. These included document reviews, key informant interviews, consultative workshops, future projection analyses based on CPR and LAPM targets, and estimation of costs of family planning program interventions and impacts. The CIP was prepared through a collaborative, participatory and consultative process involving a wide range of stakeholders in September–October 2014.

Bangladesh CIP 2016-2020 for NFPP reflects six focus areas required to achieve a CPR of 75% and LAPM 20% in 2021 as well as the resources needed and the intended impact. This CPR goal is based on a projected baseline CPR of 62% in 2014. The six focus areas are: FP services delivery; information, education and communication; high-performing staff; procurement and supply management of FP commodities; planning and management; and policy and advocacy. The focus areas are consistent with national policies and existent operational plans. Twenty-six strategies to achieve the objectives were defined across all six focus areas, and the activities which need to be accomplished were described under each strategy. Expected results, success indicators, stakeholders responsible, time frame and costs were also outlined. Unit costs of the inputs and lump sum allocated amounts (in some cases) were used to estimate the cost for each activity each year.

A total of US$1377.36 million will be required to adequately implement all implementation activities for the period 2016 to 2020, rising from US$227.73 million in 2016 to US$327.67 million in 2020. Financial requirements will be high in 2019 (21.67%) and 2020 (23.78%) due to increased demand for services, the need to ensure the quality of services, multi-sectoral engagement and inflation. It should be noted that the CIP includes costs of commodities and services provided by both the public and private sectors. Costs were estimated from an institutional perspective irrespective of the public or private nature of sources. Administrative costs at the national, divisional, district, sub-district and community level were not considered.

The FP services delivery focus area accounts for 91.36% (US$1258.34 million) of the total cost. Procurement of commodities and services (time of service providers and medical supplies) constitute 24.51% and 33.19% of total cost respectively. More funding for these activities will be required, mainly due to the expected increase in demand for services, expansion of coverage and inflation. The procurement and supply management focus area has the second-largest costs (5.27% of total). Policy and advocacy focus areas require relatively minimal funding.

Broader health indicators were measured to assess the impact of FP services between 2016 and 2020. The NFPP will avert 88.31 million pregnancies and 57.97 million births, and 2.72 million and 0.33 million infant and maternal mortalities respectively. Costs of US$18,832.41 million to individual households and national budgets will be saved as a result of the abortions and infant and maternal deaths averted by the NFPP.

DGFP, under the Ministry of Health and Family Welfare (MOHFW), will provide the leadership and political support needed to implement the plan. DGFP will be responsible for developing and updating policies that will be required to accelerate implementation in efficient ways, mobilize resources, and conduct monitoring and evaluation. DGFP will work closely with the FP2020 Bangladesh Country Engagement Working Group (BCEWG) with support from development partners. Effective coordination between national, district and sub-district levels is critical to the successful implementation of the plan.

The CIP presents a well-defined monitoring and evaluation framework. DGFP will take the leadership role in monitoring the activities of the CIP. The BCEWG will be responsible for coordinating the activities of the CIP and monitoring progress. The monitoring and evaluation framework will encompass two broad areas: monitoring implementation of activities in the CIP and evaluation.

The accomplishment of the CIP will depend on the acquisition of financial resources.

- BCEWG should collaborate with national stakeholders and development partners to generate financial resources to fully implement the CIP. They need to work together to prioritize interventions and resource allocation for efficient utilization of available funds.

- The MOHFW should allocate funds for FP from its budget.

- Involvement of the private sector and NGOs needs to be increased for resource mobilization and allocation.

- Private foundations and other innovative financing options for the CIP must be explored.

The DGFP should conduct regular periodic reviews of funding status. Reviews should focus on rigorous budgeting, tracking of funds, prioritization, alignment, efficient resource use and accountability.

When implemented, this CIP will ensure quality and equitable FP services for all eligible couples by improving access to and utilization of FP services, availability of sufficient FP providers at the community and facility level, and the enabling environment for FP.

1. Introduction

Bangladesh has made commendable achievements during the last decade in reducing population growth and improving maternal and child health. The reduction in the total fertility rate (TFR) from 6.3 births per woman in 1975 to 3.4 in 1994 and to 2.3 in 2011 is very encouraging, but since 2011 the TFR has remained stagnant at 2.3 births per woman (BDHS 2014).

The main factors contributing to the achievements have been i) strong political commitment to the family planning (FP) program; ii) multi-sectoral behavior change communications (BCC) interventions to establish a small family norm; iii) improved infrastructure for FP service delivery; iv) substantial socio-economic progress (female education, per capita income); v) increased involvement of non-governmental organizations and vi) strong support from international donor community. However, considerable gaps and unmet need in terms of accessibility and utilization of health services by the poor prevail and affect overall fertility and maternal and child mortality and morbidity.

Factors on both the demand and supply sides have influenced the delay in reaching replacement level fertility. The demand-side factors include i) child marriages; ii) reliance on temporary methods of contraception; iii) decline in the use of long-acting and permanent methods (LAPM) of contraception; iv) increased rates of discontinuation in the use of contraceptives; v) regional variation in fertility and vi) unmet need for FP (BDHS, 2014).

For the supply side, concerns regarding service delivery of the FP program include i) workforce shortages, especially inadequate numbers of doctors and paramedics; ii) high rates of absenteeism among service providers; iii) poor accountability of service providers at different levels; iv) inadequate, irregular home visits by fieldworkers; v) inadequate coordination between government and non-government providers; vi) interrupted supply of contraceptives; vii) inadequate functioning of local-level service delivery points; viii) inadequate BCC activities; and ix) inadequate physical infrastructure in urban sectors, remote and hard-to-reach (HTR) rural areas (Future of Family Planning Program in Bangladesh 2010).

To address these challenges, the Ministry of Health and Family Welfare (MOHFW) has identified the following priority interventions for population and FP in its Health Population Nutrition Sector Development Program (HPNSDP 2011–2016):

- Promoting delay in marriage and childbearing, use of FP before and after the first birth thus promoting birth spacing and limiting family size.
- Strengthening FP awareness-building efforts through mass communication and BCC activities.
- Using different service delivery approaches for different geographical regions.
- Ensuring uninterrupted availability of quality FP services closer to the people (at the Community Clinic level).
- Registering eligible couples with particular emphasis on urban areas to establish effective communication and counseling.

Bangladesh committed to the overall goal of 'Ensuring quality and equitable Family Planning services for all Eligible Couples (ELCO) by improving access to and utilization of family planning services, particularly by the poor' at the London Summit on Family Planning (FP2020) in July 2012. Specific targets have been set for reducing TFR, increasing contraceptive prevalence rate (CPR) and method-specific coverage, reducing discontinuation rate and reducing overall unmet need for FP (Revised Targets and details of Commitments in Annex 1and 2).

To achieve the targets determined at the FP 2020 summit, a Costed Implementation Plan (CIP 2016–2020) is required for Bangladesh to enhance its national FP program. Hence, the UNFPA Bangladesh Country Office decided to support the Directorate General of Family Planning (DGFP) in developing a national CIP involving key stakeholders including government, development partners, UN agencies, NGOs and civil society. It is expected that the CIP will address the country's FP needs comprehensively and help in achieving the targets.

2. Objectives

The overall objective is to develop a five-year CIP (2016–2020) to strengthen the national FP program to achieve its set goals and objectives by 2021.

The specific objectives of the CIP are to:

Clarify country strategies—The CIP articulates the country's consensus-driven priorities for FP. The consultative CIP becomes a social contract for donors and implementing partners. It helps ensure that all FP activities are aligned with the country's needs, prevents fragmentation of efforts, and guides current and new partners in their FP investments and programs.

Detail activities and an implementation plan—The CIP ensures that all necessary activities are included with defined targets and are appropriately sequenced in a plan designed to reach the country's FP2020 goals.

Define a budget—The CIP determines detailed costs associated with the entire FP program (including commodity costs and program activities).

Determine impact—The CIP includes estimates of the demographic impacts (unintended pregnancies averted, abortions averted), health impacts (maternal deaths averted, child deaths averted, unsafe abortions averted), and economic impacts (healthcare costs saved) of the FP program.

Monitor progress—The CIP's performance management mechanisms measure the extent of activity implementation and help ensure that the country's FP program is meeting its objectives, ensuring coordination, and guiding any corrections.

Secure commitment—The CIP process determines and secures current donor and national government commitments, and develops an advocacy plan to ensure adequate funding is raised.

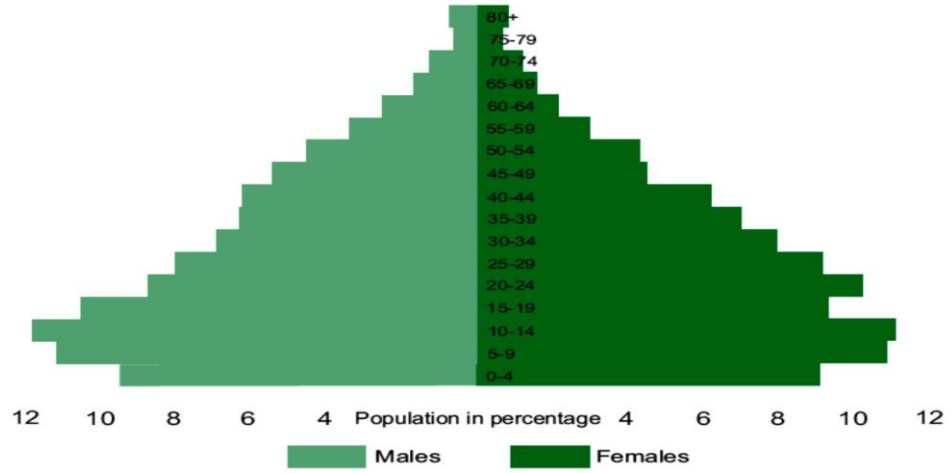
3. Situation Analysis

3.1 Demography and Fertility

Bangladesh is one of the most densely populated countries in the world with a population of approximately 160 million (Bangladesh Bureau of Statistics: http://www.bbs.gov.bd/). The male/female ratio is 104.9/100.0 and the annual population growth rate is 1.37% (Sample Vital Registration System 2011). According to demographers the population in Bangladesh would reach a maximum of 202 million in 2050 and then fall to 169 million by 2100 (World Population Prospects, United Nations, 2015, Key Findings and Advance Tables: Revisions)

The population of Bangladesh is very young (Figure 1). A large cohort of young people will enter reproductive age in the coming decades, a phenomenon partly explaining why the adolescent (15-19) fertility rate of 118 per 1000 women (BDHS, 2011) is not expected to decrease significantly for decades.

Figure 1: Population pyramid by age group, 2011



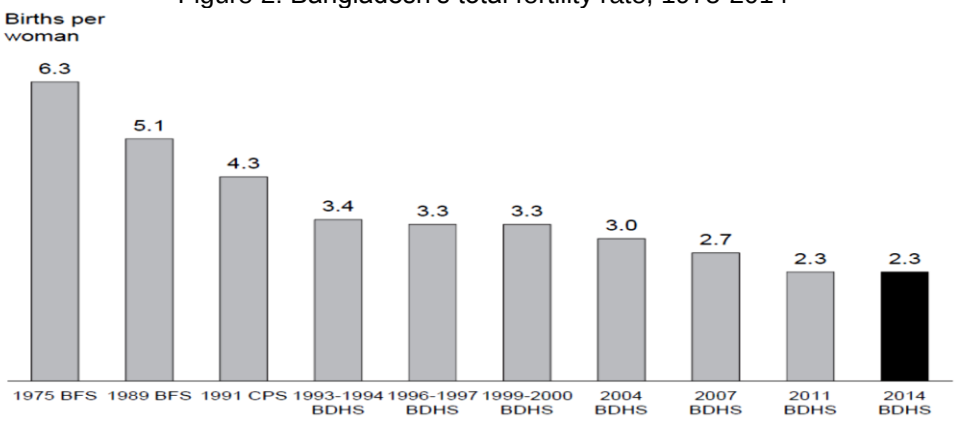
Source: BDHS, 2011

The reduction in Bangladesh's TFR from 6.3 births per woman in 1975 to 2.3 in 2011 is very impressive. Due to this declining fertility trend over the last 35 years, 10.5 million (1 crore 5 lac) births, 30,000 maternal deaths and population growth of 30 million (3 crore) have been averted. Following a decade-long plateau in fertility during the 1990s at around 3.3 births per women the TFR declined further still, but has stagnated at 2.3 births per women since 2011 (Figure 2).

Regional disparity in fertility exists (Figure 3), requiring a more specific and needs-based strategy. It is encouraging to note that four of seven divisions have achieved replacement level fertility (RF=2.2). The Dhaka division is crucial, as it accounts for 1/3 of the population and has a TFR of 2.3. TFR differs between rural and urban areas: the urban TFR is 2.0 and the rural TFR is 2.4 (BDHS 2014).

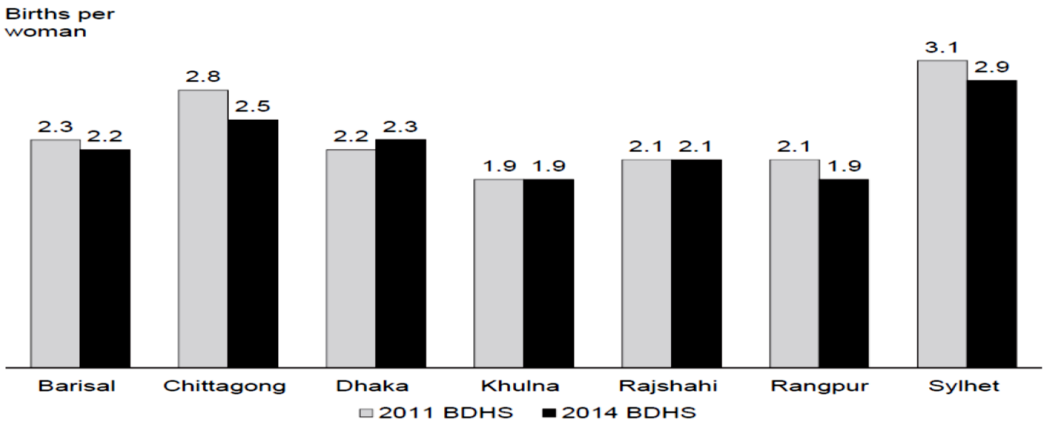
The rich–poor differential in fertility is also high; BDHS 2011 revealed that poor women have one child more than women in the three upper income quintiles. TFR among the poorest quintile is 3.1 and among the richest, 1.9.

Figure 2: Bangladesh's total fertility rate, 1975-2014



Source: BDHS 2014

Figure-3: Trends in total fertility rate by division in Bangladesh, 2011 and 2014



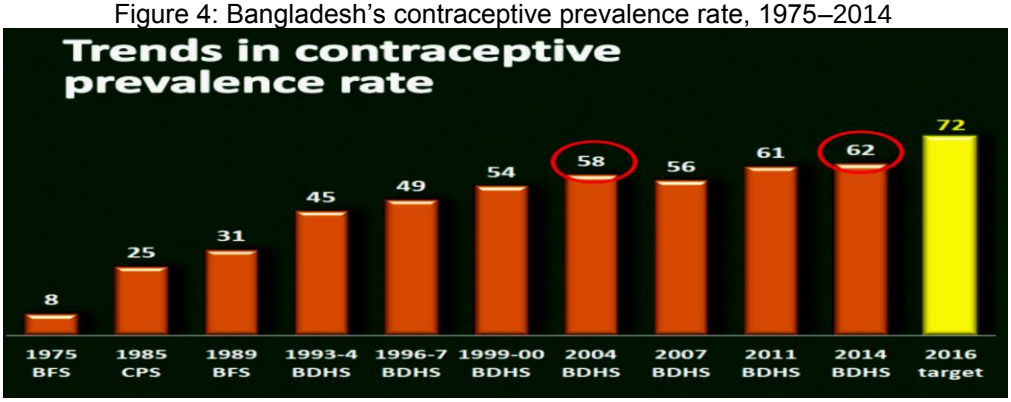
Source: BDHS 2014

Child marriage and motherhood is very common in Bangladesh. The child marriage and teenage childbearing situation has not changed since the 20011 BDHS, which found the median age at which women aged 20-24 reported becoming married was 16.6 years. The BDHS 2014 revealed that 31 per cent of women aged 15-19 have begun childbearing; about one in four teenagers have given birth and another six per cent are pregnant with their first child. Childbearing among teenagers is more common in rural than in urban areas (32 live births versus 27 per 1000 women, BDHS 2014). A large cohort of young Bangladeshis will reach reproductive age in the coming decades, so the adolescent fertility issue must be addressed with highest priority. The adolescent (15-19) fertility rate in Bangladesh is 113 per 1000 women (BDHS 2014) and has not decreased significantly for decades. Adolescent fertility remains a major social and health concern. Despite rapid improvement in female education, women's mean age at marriage has hardly changed.

3.2 Fertility Regulation

Family planning has the greatest direct potential to attain the desired TFR in Bangladesh. The CPR has increased eightfold over the last four decades, to 62% in 2014 (Figure 4). The trend for CPR suggests a plateau in 2004, when the level of injectable contraceptive users fell by three per cent due to a nationwide stock-out (BDHS 2007). The downturn in CPR recovered when supplies became available again in 2008 (Peter Kim Streatfield, Population and Family Planning in Bangladesh, ICDDR,B April, 2013). Under the HPNSDP (2011-2016) Bangladesh aims to increase overall use of contraception to 72 percent by 2016. Note that during 2004–2014, all-method contraceptive use increased from 58 to 62 percent, a 4 percent increase in the last 10 years (BDHS 2014).

Figure 4: Bangladesh's contraceptive prevalence rate, 1975–2014



Source: BDHS 2014

Note that the CPR is much higher in the western districts than in the eastern districts of the country (Table 1).This geographic pattern of wide fertility differentials needs a targeted approach focusing mainly on the current high fertility divisions in the east of the country. Considering the variation in division-level populations, a greater national impact may be achieved by targeting the much larger central divisions.

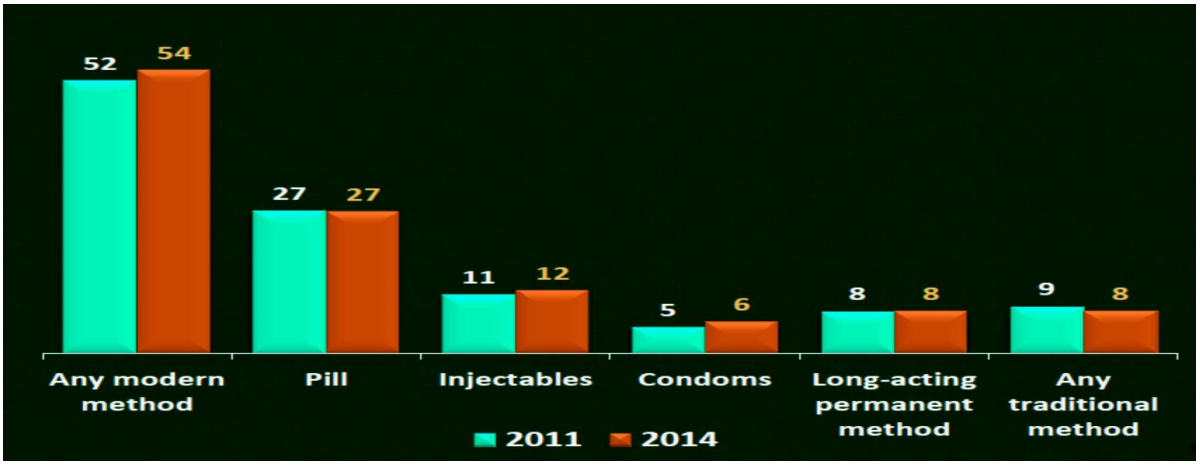
Table 1: Geographical variation in contraceptive prevalence rate, 2014

Division	CPR
Rangpur	63
Rajshahi	61
Khulna	56
Barisal	55
Dhaka	54
Chittagong	47
Sylhet	41

Source: BDHS 2014

Method-wise, FP performance has changed during the past two decades. Use of short-term temporary methods such as the pill, injectables and condoms have increased, but the number of users of permanent methods like sterilization and IUDs decreased over 1994–2014 (BDHS 2014). In the last three years, contraceptive use increased by 1 per cent and modern method use by 2 per cent; traditional method use fell by 1 per cent. Use of oral pills stayed at 27 per cent in 2011 and 2014. Use of injectable rose by 1 per cent and became 12 per cent in 2014. The use of any LAPM remained at 8 per cent between 2011 and 2014. Current levels of male sterilization and implant usage are very low at 1 per cent and 2 per cent respectively (Figure 5).

Figure 5: Use of contraception in 2011 and 2014



Source: BDHS 2014

Twelve per cent of currently married women in Bangladesh have an unmet need for FP services. Unmet need has large geographical variation, with the Sylhet division having the highest (BDHS 2014). One of the major concerns for FP programs is the rate at which users discontinue use of contraception. It has been found that 30 percent of contraceptive users stop using a method within 12 months of starting. Discontinuation rates are much higher for temporary methods like condoms (40 per cent) and the pill (34 per cent) than for longer-term methods like implants (7 per cent). However, it is encouraging to note that the all-method discontinuation rate has declined from 36 per cent in 2011 to the current rate of 30 per cent in 2014 (BDHS 2014).

Reaching replacement level fertility by 2016 is one of the priority visions of the government (HPNSDP 2011–2016). In line with this vision, the present (2014) TFR of 2.3 children per woman needs to be reduced to 2.0 to attain a net Reproductive Rate of 1 by 2016 which would be highly challenging as TFR remained unchanged during last three years. Moreover, using the current method mix of mostly temporary method is more costly and logistically complex. For example, a single implant or IUD can substitute for 60 oral pill cycles with 20 resupply visits. Sterilization can substitute for 250+ pill cycles (BDHS Policy Brief 2011).

Women can potentially need FP for more than three decades of reproductive life. Thus, the type of FP should change with the stage of the life cycle. Temporary methods are needed initially for delaying and spacing births, than when childbearing is complete, LAPM can offer considerable convenience for couples as resupply is less of an issue. Also LAPM are much more cost-effective for the FP Program (BDHS 2011 Policy Brief). Most LAPM are provided by the public sector, but for many economically better-off couples the public sector is not their preferred source. The private sector and the NGO sector need to be equipped to respond to the requirements of these better-off couples. Over 90,000 sterilized women pass out of childbearing age every year in Bangladesh; this number of new operations is needed just to maintain the same CPR for female sterilization. In addition, a further 320,000 acceptors (new users) of any FP method are required to achieve a 1 percent increase in CPR (BDHS 2011: Policy Brief). This is a huge challenge for the FP program, and all sectors must be involved. A summary of key issues in fertility and FP is provided below (Box 1).

Box 1: Summary of key fertility and family planning issues

- According to the BDHS 2014, the current TFR is 2.3 births per woman and has not changed since 2011
- Despite rapid improvement in female education, the adolescent fertility rate has not decreased significantly for decades
- Use of contraception has increased by one percentage point in the last three years, with some geographical variation – use in Syhlet and Chittagong divisions remains low
- Prevalence of use of any LAPM remained the same (at 8 per cent) during the last three years
- An increase of 10 percentage points is needed to achieve the HPNSDP target by 2016
- The public sector is the major source of contraceptive supply (49 per cent) but the share of the private sector has increased from 43% in 2011 to 47% in 2014
- Unmet need for FP in Bangladesh decreased from 14 per cent in 2011 to 12 per cent in 2014
- All-method discontinuation rate has declined from 36 percent in 2011 to the current rate of 30 percent in 2014

Source: BDHS 2014

3.3 Family Planning Program in Bangladesh

The government sector remains the major provider of contraceptive methods, catering to almost half of all users (49 percent); government field workers supply 20 percent. The private sector provides contraceptives to 47 percent of all users and NGOs supply 4 percent. Although public sector is the main provider of contraceptives but the share of private sector in supplying contraceptives has increased from 36 percent in 2004 to 47 percent in 2014 (BDHS 2014). About two in five pill users (38 percent) and three in five condom users (60 percent) use a socially marketed brand (BDHS 2011). The private sector, consisting primarily of Social Marketing Company (SMC) pharmacies, is increasingly becoming an important source of temporary

methods. The SMC is a not-for-profit social marketing organization selling its own brand of pills, condoms and injectables at subsidized prices through private sector outlets. Many NGOs funded through different donors are involved in delivering FP services as part of maternal and child health (MCH) interventions.

3.3.1 Urban Family Planning Program

Currently around 30% of Bangladeshis reside in urban areas. As a result of rapid urbanization, this percentage is projected to increase to 60% by 2030 (CIA World Bank Fact Book, July 2011). Urban slum population has been growing very fast and urban slum dwellers have the worst national health indicators, particularly women and children (BDHS 2011). The government of Bangladesh recognizes the urgent need to address urban poverty and development issues in its sixth five-year plan, poverty plan and Vision 2021, and is committed to strengthening urban health care, particularly for poor urban slum dwellers (Strategic Plan of HPNSDP 2012–2016). To address urban health care issues effectively, the Bangladesh Urban Health Strategy (2012) has been drafted by the Ministry of Local Government, Rural Development & Cooperatives, (MOLGRDC) which has the prime responsibility for urban health care. Challenges include lack of financing, infrastructure and skilled human resources for providing the required services, especially for the poor, inadequate coordination between MOHFW and MOLGRDC, and lack of resources and manpower in Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP) to supervise and monitor essential health and FP services in urban areas. The current gap is largely filled through private sector initiatives.

In the previous two decades the Local Government Division of MOLGRDC implemented two projects, namely the Urban Primary Health Care Project (1998-2005) and Second Urban Primary Health Care Project (2005-2011). Based on experience with these projects, the Local Government Division has been implementing, in partnership with 25 local NGOs, an Urban Primary Health Care Services Delivery Project (UPHCSDP, July 2012 to June 2017) with the financial support of the Asian Development Bank, the Swedish International Development Cooperation Agency and the United Nations Population Fund. The project area covers Dhaka South, Dhaka North, Rajshahi, Khulna, Barisal, Sylhet, Comilla, Narayanganj, Gazipur and four district municipalities of Sirajganj, Kushtia, Gopalganj and Kishoreganj. The total population of the project catchment area is around 10 million (Project Summary UPHCSDP, 2014). In addition to this partnership between MOLGRDC and local NGOs, the United States Agency for International Development (USAID)-funded NGO Service Delivery Program is delivering MCH-FP services to a population of 20 million. Moreover, NGOs like EngenderHealth, Marie Stopes, BRAC, the Family Planning Association of Bangladesh and the Population Services and Training Center have been providing FP services in cities throughout the country.

The recently conducted Bangladesh Urban Health Survey, 2013 (NIPORT 2013) has revealed that fertility is considerably below the replacement level in all three surveyed urban areas, including the slums, indicating that the HPNSDP's TFR goal of 2.0 births per woman has already been achieved. However, there has been no change in the incidence of teenage pregnancy over the seven years between 2003-2006 and 2010-2013 in the slums or elsewhere. The Bangladesh Urban Health Strategy, formulated in 2012 in consultation with various stakeholders including the MOHFW, local government, donors, UN agencies and NGOs, is addressing this problem. Several ways to improve family planning services have been identified, such as strengthening coordination between MOHFW and MO-LGRD and increasing the role of city corporations and municipalities, and more focused efforts to strengthen service delivery in partnership with NGOs for underserved urban areas.

3.4 Health, Population Nutrition Service Delivery Program

Family planning programs in Bangladesh have evolved over six decades. Voluntary and semi-government efforts began in the 1950s through the efforts of a group of social and medical workers. Government-sponsored clinic- and field-based FP services started in the 1960s, and from the mid-1970s MCH-based FP services were introduced to address rapid population growth as the country's number one problem. A Sector Wide Approach (SWAp), aimed at reforming the health and population sector, was introduced during the late 1990s. The program entails provision of a package of essential and quality health care

services responsive to the needs of the people, especially those of children, women, elderly and the poor. The present HPNSDP (2011–2016) is the third SWAp and is designed to improve access to and utilization of essential health, population and nutrition services, particularly by the poor. The objective of the HPNSDP is to ensure quality and equitable health care service for all citizens by improving access to and utilization of health, population and nutrition services. The key components of the HPNSDP are:

(i) Improving health services, which is divided into two sub-components:
   a. Improving health services
   b. Improving service provisions

(ii) Strengthening the health system.

The HPNSDP has 32 Operational Plans (OPs), and FP activities are included in seven OPs under the DGFP: i) Clinical Contraception Service Delivery (CCSD); ii) Family Planning Field Service Delivery (FPFSD), iii) Planning, Monitoring & Evaluation (PME-FP), iv) Management Information System (MIS), v) Information Education and Communication (IEC) and vi) Procurement, Storage and Supply Management (PSSM). The National Institute of Population, Research and Training (NIPORT) is the main institutional supplier of training for different cadres of FP personnel and undertakes population-related research.

To address both demand and supply-side challenges of FP, priority areas have been identified and included in those seven OPs:

- Promoting delay in marriage and childbearing, use of post-partum FP, post-abortion FP and FP for appropriate segments of the population.
- Strengthening FP awareness-building efforts through mass communication and IEC activities and considering local specificities.
- Using different service delivery approaches for different geographical regions and segments of the population.
- Maintaining focus on commodity security and ensuring uninterrupted availability of quality FP services closer to the people (at the Community Clinic level).
- Registering eligible couples with particular emphasis on urban areas to establish effective communication and counseling.
- Compensating for lost wages (reimbursement for opportunity costs) for LAPM contraceptive performance.
- Strengthening FP services, especially post-partum and post-abortion FP, and demand generation through effective coordination of services with DGHS.

The priority interventions are grouped in six focused areas under seven FP-related OPs (Table 2).

1. Service delivery
2. Information, Education and Communication
3. Skilled workforce
4. Procurement and supply management of FP commodities
5. Management Information System
6. Planning and management

Table 2: List of key interventions (components) of FP related OPs of HPNSDP

Focus Area	Key Interventions (Components)	Name of OP
Family Planning Service Delivery	• Distribution of contraceptives (temporary methods: oral pills, condom and injectables) • Provision of clinical contraceptives (LAPM): tubectomy, vasectomy, intrauterine contraceptive device (IUCDs) and implants) • Quality Assurance (QA) • Registration of eligible couples in urban slums. Improve supply of clinical contraceptives commodities to HTR and urban slum areas through NGOs and private sector	FPFSD CCSD
Information, Education and Communication	• Country wide awareness building campaigns on FP • Focus on adolescents and youth / low-performing and HTR areas • Use of print, electronic and social media (including outdoor) • Organize training programs on IEC for different stakeholders	IEC
Skilled workforce	• Develop/upgrade FP course curriculum for different cadres of service providers • Basic and refresher training on clinical contraception, communication skills etc. for service providers • Skill development of supervisors and managers • Faculty development and improvement of training facilities	NIPORT FPFSD CCSD IEC
Procurement and supply management of FP commodities	• Procurement planning, monitoring & evaluation • Product QA and material standardization • Commodity shipment, clearing and delivery • Record-keeping and feedback mechanisms • Modern warehousing practices • Warehouse inventory management system • Capacity building and technical assistance (TA) • E-procurement and web-based information systems	PSSM
Management Information System	• Service Statistics • Logistics Management Information Systems (LMIS) • Personnel and Hospital Management Information Systems	MIS
Planning and Management	• Coordination and preparation of OPs for the population sub-sector • Program Monitoring including Annual Program Review (APR) and Mid-Term Review (MTR) • Local level planning • GO-NGO collaboration	PME-FP

Sources: PIP, HPNSDP

4. FP2020

Family Planning 2020 (FP2020) is a global initiative which supports the rights of 120 million additional women and girls in the world's poorest countries to use contraceptive information, services and supplies. Through the FP2020 initiative, a greater partnership has evolved globally among governments, civil societies, multilateral organizations, donors, academic and research institutions and the development community. To enhance the FP2020 partnership, the London Summit on Family Planning was hosted in 2012 by the UK Government, the Bill & Melinda Gates Foundation, UNFPA and other partners. More than 20 governments of developing countries across the world made commitments (including setting targets) to remove policy, financing, service delivery and socio-cultural barriers to women and girls accessing quality and equitable FP services by 2020. Guidelines on the FP2020 program process have been developed, and for policy guidance and monitoring of implementation progress an 18-member Reference Group has been formed and is being supported by different technical working groups and a task team. To monitor progress at the country level, Country Engagement Working Groups (CEWGs) have been formed comprising representatives from government and the private sector, including multilateral organizations, donors and NGOs (Policy Brief, Nov. 2013, Health Policy Project: www.healthpolicyproject.com)

5. Costed Implementation Plan (CIP) for Family Planning

The CIP consists of specific program activities which are required to achieve national targets in a cost-efficient way. To improve FP programs, the CIP includes different evidence-based innovative strategies and approaches. The CIP shows all activities sequentially (Box 2: Benefits of CIP). Demand- and supply-side components like awareness-raising, skilled personnel, adequate infrastructure, supply of commodities, quality and equity-based service delivery for the target groups, planning and management, resource mobilization and utilization, and performance monitoring are the key elements of the CIP. Strong planning and funding are vital for effective FP programs. It has been shown that increased access to FP significantly reduces poverty and maternal and child mortality.

Box 2: Benefits of costed implementation plans for family planning

Clarify country strategies—CIPs articulate the country's consensus-driven priorities for FP
Detail activities and an implementation roadmap—Ensure that all necessary activities are included with defined targets
Determine impact—Develop estimates of the demographic, health, and economic impacts of the national FP program
Define a budget—Determine detailed costs associated with the national FP program
Secure commitment—Determine and secure current donor and national government commitments, identify funding gaps, and develop an advocacy plan to ensure adequate funding is raised
Monitor progress—Measure activity implementation to help ensure country objectives are met

Source: Strategic Budgeting Process for Scale-Up of Family Planning, Nov. 2013 Health Policy Project.

6. Costed Implementation Plan for the National Family Planning Program (2016–2020), Bangladesh

In July 2012, at the London Summit on Family Planning (FP2020), Bangladesh committed to the overall goal of 'Ensuring quality and equitable Family Planning services for all Eligible Couples (ELCO) by improving access to and utilization of FP services, particularly by the poor'. Highlights of the commitments and targets are as follows (Revised targets and detailed commitments and are shown in Annex 1& 2).

- Bangladesh will increase access to and use of LAPMs and post-partum and post-abortion services by poor people in urban and rural areas.
- The government will work with the private sector and NGOs to address the needs of young people, especially young couples; reduce regional disparities through working with leaders and communities to delay early marriage and child birth; and increase male involvement in FP.
- One third of Maternal Newborn and Child Health (MNCH) centers will provide adolescent Sexual and Reproductive Health and Rights (SRHR) services.
- Monitoring to ensure quality of care will be strengthened, including informed consent and choice, and to support women to continue use of FP.

[Source: Bangladesh's Announcement at the London Summit on Family Planning, July 2012]

Committed Targets (Revised)

1. Reduce Total Fertility Rate (TFR) from 2.3 to 2.0 by 2021*
2. Increase the Contraceptive Prevalence Rate (CPR) from 62% to 75% by 2021
3. Increase the share of LAPM from 8.1% to 20% by 2021
4. Reduce unmet need for family planning from 12% to 10% by 2021
5. Reduce discontinuation rate of FP method from 30% to 20% by 2021

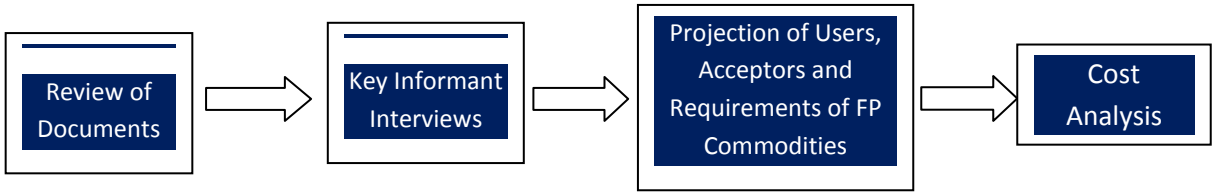
Source: 1. Bangladesh's Announcement at the London Summit on Family Planning | Bill & Melinda Gates Foundation [https://www.youtube.com/watch?v=1UeTlnxi8uo]. 2. Revised Family Planning Targets: Memo no. 45.169.005.00.00.005.2014-323, Ministry of Health and Family Welfare, 21.09.2015 . 3. BDHS 2014

To achieve the targets to which Bangladesh committed at the FP 2020 summit, a CIP is needed. The CIP will align FP resources with the country's needs and harmonize approaches undertaken by both public and private stakeholders. The CIP will enable achievement of FP2020's goal-specific activities and targets. The CIP will determine the detailed costs associated with the entire FP program, including human, financial, and technical resources, as well as commodities and equipment. To strengthen stakeholders' commitment on FP and mobilize adequate resources, an advocacy plan will be developed through the CIP. The performance measurement framework of the CIP will help monitor FP interventions at different levels.

7. Methods

Preparation of a Costed Implementation Plan for the National Family Planning Program, Bangladesh, involved qualitative and quantitative methods of data collection and analysis within a cost analysis approach. A step-by-step method was followed to develop the CIP (Figure 5).

Figure-5: CIP development flow chart



7.1 Review of documents

Documents collected and reviewed:

- Bangladesh Demographic and Health Survey Report – Key Indicators, 2014
- Bangladesh Demographic and Health Survey Report 2011
- National health and population policies
- FP performance report
- Projection reports of FP commodities
- HPNSDP's strategic plan (including OPs) on FP
- Official reports of the DGFP
- Different assessment/research reports
- Strategic documents including the LAPM and Adolescent Reproductive Health Strategy
- Urban Health Strategy (draft)
- Annual review reports of HPNSDP and other health-related departments.

The documentary review also analyzed information provided on the FP2020 website (see List of References).

7.2 Key informant interviews

Eighteen key informant interviews with officials of the DGFP, NGOs and Urban Primary Health Care Services Delivery Project at the national level were conducted. A snowball sampling procedure was used to identify key informants. Annex 2 presents names of key informants and other officials interviewed.

Key informants were asked about their opinions and experiences relevant to the planned CIP. Unit costs of different FP commodities, training activities and services were collected from concerned key informants. These key informants were also asked about target and lump sum amounts of certain activities for which unit costs are not considered. Medical Officers (MCH), Family Welfare Visitors and Family Welfare Assistants working in the Thakurgaon district were asked about the average time required to provide different temporary and permanent FP methods to clients. They also provided average costs of different medical supplies. Key informants were interviewed using a guideline to elicit qualitative responses. Key informants were guaranteed anonymity to encourage open expression of views.

7.3 Projection of users, acceptors and requirements of FP commodities

The Reality ✓ (V) tool was used to project the number of FP users, new acceptors, requirements of FP commodities and estimate couple-years of protection (CYP). These were projected based on CPR as a goal. Bangladesh committed to achieve 75% CPR by 2021. Table 5 presents required CPR annual growth over 2016–2020 to achieve 75% CPR in 2021. The annual basis on which CPR goals were projected was based on Bangladesh's 2011 CPR of 61.2 percent (BDHS 2011). (Note that Kenya, Tanzania and Nigeria also developed projections for their CPR goals in order to prepare CIPs.)

Table 3: CPR goals by year, 2016 - 2020

Year	2016	2017	2018	2019	2020
CPR (%)	66.0	67.8	69.6	71.4	73.2

7.4 Development of costing tool

A costing tool was prepared to determine the cost of implementing the FP activities. The tool is a set of Excel spreadsheets with the list of all inputs to be used, unit costs (lump sums in some cases) and quantity (target) by years. Excel spreadsheets provide information on each inputs associated with an activity. The tool is based on the ABC method, which combines the "ingredients" and "adaptation" approaches for cost calculations.

7.5 Cost analysis

Activity-based costing techniques were used to estimate the costs of the national FP program (NFPP) (2016–2020). Costs were for activities related to six proposed strategic focus areas and outputs. An inflation rate of 7% was used to remove the effect of inflation on the cost estimates.

Activity-based costing (ABC) is an appropriate method for cost analysis of major FP activities in key strategic focus areas. This method is useful for understanding key intervention activities and to identify (i) implementation levels and composition of costs; (ii) variations in how an intervention is implemented over time and associated cost implications; (iii) costs of increasing coverage of FP interventions and (iv) how an FP intervention could be more cost-efficient. This method is flexible so it fits with a developing country context. Costing was performed from an institutional perspective, irrespective of the public or private nature of the sources.

8. Processes

8.1 The CIP was prepared in line with the outcomes of the FP2020 BCEWG meeting held on 7 September 2014 at the DGFP in Dhaka and the consultative workshop on the development of CIP (DGFP, 23 September 2014). DGFP officials and development partners were invited to the meeting and workshop. Targets were revisited in consultation with the key stakeholders based on the BDHS 2014 findings.

8.2 FP2020 BCEWG meeting: Methods and data analysis plans were presented and an opportunity was given for comments on the proposed method. Participants recommended prioritizing key FP needs.

8.3 Workshop: Six focus areas with activities, number of users and acceptors, requirements of commodities, unit costs and costs by focus areas were presented and discussed. In addition, impact, institutional arrangements and a monitoring framework were discussed. Participants provided comments to tailor the CIP. Their suggestions for changes were discussed and consensus was reached.

8.4 At the national level, structured consultation workshops were organized jointly by USAID and UNFPA with government, United Nations and bilateral/multilateral donor agencies, academic institutions, professional bodies, civil society organizations and NGOs. Several priority actions were identified to speed up the FP program (Box 3).

Box 3: List of priority actions identified by the stakeholders

- QA with emphasis on structured "counseling on FP by the service providers at all levels
- Utilize patients' feedback and advocacy
- Improve training for, and make better use of, field workers and volunteers, including for referrals
- Implement youth-friendly services with additional specific attention to newlywed couples
- Integrate FP services into MNCH, immunization and nutrition activities
- Increase District Hospitals' and Medical Colleges' provision of post-partum and interval FP

- Reaching the unreached, including urban poor
- Focus on adolescent reproductive health to reduce early marriage and pregnancy
- LAPM by informed choice
- Increase mass media coverage, organize special campaigns, translate BCC materials into local dialects, increase use of community radios
- Increase and speed up multi-Ministry involvement (Women and Children, Social Welfare, LGRDC, Youth and Sports, Religious Affairs)
- Improve coordination between DGHS and DGFP for more comprehensive FP services
  Develop a comprehensive costed human resources strategy with realistic implementation plan and support, buy-in, commitment and accountability of all stakeholders
- Review workload of the government FP field workers
- Use information and communications technologies to support the accountability of deployed staff
- Increase pre-service FP education and training
- Institutionalize supportive supervision with documented findings and follow-up processes
- Introduce quality monitoring indicators, i.e. Total Quality Management
- Improve regional warehouses for more effective supply of commodities
- Increase monitoring and supportive supervision by regional QA teams
- Make the existing Logistics Coordination Forum more effective at resolving LMIS issues
- Increase public–private partnerships
- Advocacy to mobilize more resources
- Operations research and policy advocacy
- Decentralized planning process

Source: Highlights of stakeholder consultations on Review of FP Issues and Challenges organized by Government, USAID and UNFPA during September 28- October 01, 2014

8.5 Sharing the draft CIP with all key stakeholders including FP2020 BCEWG

8.6 Finalization of the CIP document taking into account comments and suggestions from the stakeholders.

9. Guiding principles of the CIP

The CIP on FP was guided by the following principles:

A. The CIP is in alignment with the National Population Policy of Bangladesh which aims to contribute in developing a healthy, happy and prosperous nation through an equity-based, well-planned and coordinated population program

B. Bangladesh's FP2020 Commitments (political/ policy, programming and financial) (Annex 1)

C. The strategies are equity-based and gender–sensitive, with special focus on HTR populations including urban slum dwellers

D Focus on quality service provision and system strengthening

E. Greater stakeholder participation though public-private partnership

10. Key Strategies and Activities

The main purpose of developing the CIP is to assist the Bangladeshi government to achieve the FP2020 targets through a greater public-private partnership than exists in current FP arrangements. Specific objectives included i) improving access to quality FP services by the target population; ii) improving awareness of FP by strengthening IEC activities; iii) improving the knowledge and skills of FP service providers, supervisors and managers; iv) strengthening procurement and supply of FP commodities ; v) strengthening planning and management systems, including resource allocation; and vi) strengthening policy advocacy efforts. Based on key country documents including OPs of HPNSDP, FP2020 guidelines and extensive stakeholder consultations, these objectives are grouped under six complementary focused programming areas [Box 4].

Box- 4: Focused areas of CIP

Focus Areas of CIP
1. Family Planning Service Delivery 2. Information, Education and Communication 3. High-Performing Staff 4. Procurement and supply management of FP commodities 5. Planning and management 6. Policy and advocacy

In order to achieve the objectives of the CIP, several strategies will be undertaken and a wide variety of stakeholders will be involved. The following section describes the strategies required to achieve the objectives and the activities which need to be accomplished. Expected results, success indicators and key roles are also mentioned.

10.1 Key Focus Area 1: Family Planning Service Delivery

Method-wise FP performance has changed over the past two decades in Bangladesh. The most popular contraceptive method is the oral pill (27%), followed by injectables (12.4%) and tubectomy (4.6%) (BDHS 2014).

To increase the use of both temporary and permanent contraceptive methods, activities designed to strengthen FP service delivery, involving different stakeholders, have been emphasized at the national level. Priority focus areas included i) increasing usage of FP before and after the first birth; ii) promotion and usage of LAPMs; iii) strengthening the QA system; iv) strengthening service provision for HTR areas and urban slums; and v) strengthening GO-NGO collaboration.

Objective: Ensuring equity-based quality family planning services for the target population

Strategies	Key Actions	Results: By 2020	Success Indicators	Key Role
Improve provision of FP services for the FP clients	• Procurement of contraceptives • Distribution of contraceptives (temporary methods like condoms, oral pills and injectables) to eligible couples by trained field workers • Provide LAPM through skilled service providers at designated public and private facilities • Strengthening LAPM services	Targeted clients are provided with quality FP services	CPR Share of LAPM Unmet need # of acceptors for both temporary and permanent/long acting methods	DG-FP, DG-HS Private sector including (SMC and NGOs)

	• Strengthening domiciliary services • Provide youth-friendly services with additional specific attention to newlywed couples • Integrate FP services with existing HIV/STI, fistula, cervical and breast cancer prevention programs • Provide post-partum FP services • Increase FP service provisions at District Hospital and Medical Colleges • Strengthen coordination with private sector providers			Professional Bodies and Technical Committees including BCEWG MOLGRD Development Partners
Strengthen systems and facilities to provide FP services at different levels	• Ensuring skilled service providers at all service delivery levels • Strengthening Family Welfare Centre (FWC) and satellite clinics • Procurement of supplies and materials	Improved FP services are available	# of service providers available # of facilities improved Functioning equipment and drugs and medical supplies available	<u>Lead</u> : MOHFW
Improve QA mechanism for FP services	• Use of evidence–based standards, guidelines and protocols • Formation of QA Teams at different level • Increase supervision and monitoring visits by QA teams • Establish help desk/information corner at facility level • Systematic collection of patients' feedback on services quality to assess clients' satisfaction level • Implement Patients' Charter of Rights • Increase use of QA tools by the service providers and supervisors like for counseling, infection prevention, clinical procedures etc.	Quality of services (including LAPM) improved QA system functioning at all level QA tools including Patients' Charter of Rights introduced and used	# of supervisory visits Client satisfaction level	
Strengthen FP services in HTR areas, low performing and urban slums	• Mapping of existing FP interventions in low performing districts • Registration of eligible couples in urban slums. • Outsourcing of FP services to NGOs working in slums and hard-to reach areas • Establish referral linkage between government and NGO urban slum and FP service centers • Improve supply system for clinical contraceptives commodities all over the country, including HTR and urban slum areas • Introduce mobile team for services in HTR areas in coordination with NGOs	HTR, low performing and urban slum service delivery mechanism improved with involvement of relevant NGOs	- Service coverage in HTR areas, low performing and urban slums - # of Roving Teams	
Strengthen GO-NGO/private sector collaboration	• Develop and strengthen existing partnership with NGOs/private sector to expand FP services (both clinical and non-clinical).	Partnership with NGOs/private sector developed and FP services available	# of new partnership developed with NGOs/ private sector	

10.2 Key Focus Area 2: Information, Education and Communication (IEC)

To develop the IEC activities, the National Communication Strategy for Family Planning and Reproductive Health (2008) was taken into consideration. IEC activities undertaken by the government and other stakeholders have contributed in raising FP-related performance, but BCC interventions need to be strengthened further. According to BDHS 2011, exposure to FP messages declined since the 2007 BDHS and only one in three women were exposed to FP messages from any source (radio, TV, newspapers, magazines, community workers, or posters). About half of men were exposed to such messages. Unfortunately only six percent of women recalled receiving any FP messages from a government community health worker and only one percent from a nongovernment community health worker (BDHS 2011).

There is a large difference between poor and rich in terms of exposure to messages from mass media. More than 90 percent of the poorest women have not been exposed to any FP messages via mass media compared to half of the richest women, who are more likely to own a television (BDHS 2011). The focus of the awareness-raising activities will be on advocating for social and gender issues including the need for delayed marriage, delayed first child and birth spacing. To address the geographical variations in TFR, special focus will be given to low-performing districts, upazilas and HTR areas including urban slums.

Objective: Strengthening Family Planning awareness building efforts

Strategies	Key Actions	Results: By 2020	Success Indicators	Key Role
Increase awareness and motivation	• Organize country-wide awareness-building campaigns on FP • Orientation workshops for religious leaders/professional groups (health, education, social welfare, information etc.) • Orientation workshop for youth in low performing and HTR areas • Motivational meetings (low performing and hard to reach areas) • Observation of special days and service week • Mobile voice call from Prime Minister or key personalities	Knowledge on FP increased More target people are seeking FP services Increased stakeholders' participation in FP message dissemination Service providers are more skilled in message dissemination	# of campaigns organized # of workshops held # of motivational meetings held # of special days observed # of messages delivered through mobile phone	DGFP, DGHS MOI MOY&S MOCA MOE MOLGRD MOL&E MORA MOSW MOWCA Professional groups/bodies/ associations BCEWG Development Partners NGOs <u>Lead</u>: MoH&FW
Ensure production, distribution and dissemination	• Message dissemination in low performing and hard to reach areas • Production of IEC materials (short film, TV drama, TV magazine, TV spot) • Advertise through newspapers • Establish electronic billboards (outdoor media)		# of BCC materials produced by type # of BCC materials distributed by type # of advertisements # and type of outdoor media	
Conduct media campaign and transmission	• Radio program through population cell • TV program through public and private channels • Country-wide film show program • Motivational program in low performing and HTR areas • Folk song / jari gan • Musical show using local teams with local issues		# of radio programs # of TV programs # of film shows # of motivational programs # of folk songs # of musical shows	

10.3 Key Focus Area 3: High-Performing Staff

According to a worldwide poll of nearly 500 health care professionals conducted in 2007, a sufficient, well-trained, supervised, and motivated staff is the most important element of success in FP (Population Report 2008, CCP, Johns Hopkins University). Programs can address challenges like training, supervision and staff turnover by strengthening human resource systems that create a supportive working environment, improve performance and build the sustainability of the health care workforce. Task-shifting and performance improvement interventions will increase the efficiency of existing staff and the quality of its work. Strengthening pre-service education and conducting in-service training are the best ways to improve knowledge and skills. Effective supervision that includes mentoring, joint problem-solving and two-way communication between supervisors and staff members creates enabling environments that increase staff performance.

NIPORT and Regional Training Centers have been playing a crucial role in improving the knowledge and skills of the different categories of staff involved in FP activities. The main objective of NIPORT is to provide skill development training to paramedics, field workers and program managers on maternal, child and reproductive health, including FP. To develop Master Trainers who can provide training of trainers (TOT) at national, district and other levels is one of the key goals of NIPORT. To improve FP program performance, the Bangladesh government has decided to strengthen NIPORT's capacity for effective in-service training of FP personnel, including nurses and midwives. Technical assistance provided through different donors and international agencies in both the public and private sectors are considered crucial for developing high-performing staff.

Objective: Build capacity of FP service providers, supervisors and managers

Strategies	Key Actions	Results: By 2020	Success Indicators	Key Role
Knowledge and skill development of the service providers, supervisors and managers	• Develop/upgrade FP course curriculum for different cadres of service providers • Organize and implement courses on/for: -Basic and refresher training on clinical contraception for Medical officer, FWV (Family Welfare Visitor), Nurse, Paramedic - Skill development training for service providers on QA with special emphasis on counseling - Orientation workshop for FWVs, community members and newlywed couples - Refresher training on FWA register and forms - Basic and advanced computer training - LAPM user training and bottom-up projection • Train service providers, supervisors, managers on clients charter of rights, quality of care including counseling • Audio-visual training • Communication skills • Design and material development • Awareness-raising on emergency preparedness • Provide skills development training for the service providers from NGO/private sector	Training programs are organized as per plan Performance of staff including service providers improved Staff performance appraisal system in place Training follow-up mechanism in place	Comprehensive five-year training plan available # of staff/service providers trained on different courses # of training courses organized Year-wise Training performance shared with relevant stakeholders Reports on training follow-up activities	DGFP, DGHS NIPORT Development Partners Professional Bodies BCEWG NGOs <u>Lead</u> : MOHFW

	• Strengthen staff performance appraisal system • Develop comprehensive training follow-up mechanism			
Strengthening planning and management skills	• Develop management skills of supervisors and managers on local level planning, (LLP), implementation, monitoring and evaluation of the NFPP • Conduct external and internal study tours to learn best practices	Planning and management capacity of managers and FP officials strengthened	# of workshops and training courses arranged and conducted # of staff who attended workshops and training courses	
Capacity strengthening for decentralized planning process	• Provide training at district and sub-district levels on local level planning (LLP) process using data to set goals, plan and monitor NFPP activities	Capacity of key staff strengthened to develop decentralized plan	Key staff trained in use of data for planning and monitoring performance, developing decentralized plans	
Capacity strengthening reporting, monitoring and evaluation system	• Training of personnel on M&E including computerized MIS	Personnel trained on M&E and MIS	Staff trained in data collection and reporting systems	
Strengthen capacity of NIPORT, Specialized Centers and Regional Training Centers	• Develop/expand FP master trainers' pool with special focus on counseling, quality of care and different FP methods including LAPM • Faculty development and improve training facilities with adequate supply of training materials and logistics	Pool of Master Trainers functional Training institutes can deliver necessary skill development training	# of master trainers developed # of improved training facilities Training institutes performance report is available and shared with relevant stakeholders	
Strengthen Technical Cooperation with development partners, including UN agencies	• Joint planning workshops, meetings and reviews to develop plan to provide technical and financial support for capacity strengthening activities	Technical assistance (TA) provided by the development partners at different level for different activities	# of meetings and discussions held # of TA sessions provided	

10.4 Key Focus Area 4: Procurement and Supply Management of Family Planning Commodities

An efficient supply management system plays a vital role in the successful implementation of an FP program. Short-acting methods require regular resupply. Efficient procurement reduces costs and maximizes economies of scale. The NFPP will require an increased supply of commodities in time due to an increase in the number of contraceptive users.

The availability of quality and affordable contraceptives depends on factors such as institutional arrangements, QA and standardization, procurement planning, monitoring and evaluation. Good progress has been made in strengthening procurement and supply management of FP commodities by the MOHFW through a USAID-funded SIAPS (Systems for Improved Access to Pharmaceuticals and Services project implemented by Management Science for Health (MSH), but human resource capacity in terms of proper forecasting at district and sub-district level is still very limited. Central warehouses, regional warehouses and upazila stores are inadequately designed and need refurbishment. Procurement procedures should be simplified to reduce delay in processes.

Effective e-procurement and online procurement systems will ensure improvement in service delivery and reduce emergency orders. Product quality and material standardization have to be ensured. Investments will be required in both the existing infrastructure and supply management systems to improve supply-chain efficiency. Strengthening of procurement and supply management will benefit contraceptive security.

The broad strategy is to strengthen the systems and capacity to procure and supply all the required contraceptives and other FP commodities to the service delivery points throughout Bangladesh in time at the optimum price/quality combination.

Objective: Implement reliable and efficient systems for procurement and supply of FP commodities

Strategies	Key Actions	Results: By 2020	Success Indicators	Key Role
Streamline procurement and supply chain management system	• Continuous monitoring to reduce procurement process time • Shipment, clearing and delivery • Supply chain management • Record-keeping and feedback	Efficient procurement management Timely procurement of FP commodities	Time spend in procuring FP commodities	DGFP, DGHS Development Partners BCEWG Professional Bodies NGOs <u>Lead</u> : MOHFW
Develop infrastructure for better storage condition	Implementation of modern warehousing practice	Improved physical infrastructure meeting best practice storage conditions	Number of standard warehouses	
Strengthen product QA and material standardization	• Appropriate testing and surveillance of contraceptive commodities & supply	Protect the health of the population Control fertility	QA products are available	
Strengthen ICT for detection of supply shortages at service delivery points	• Warehouse inventory management system • Upazila inventory management system • eLMIS	Absence of stock-outs Continuity of services ensured Simplification and expedition of procurement process	Regular stock status reports Eliminate stock-outs, overstocks, wastage (thefts, expired products) Procurement is tracked using online system	

10.5 Key Focus Area 5: Planning and Management

Comprehensible planning and strong management capacities are needed to achieve the goals of the NFPP. To facilitate coordination and management, the NFPP will use, as far as possible, existing structures at all levels. Capacities and skills of managers of different levels to develop pragmatic and operationally feasible plans and NFPP implementation in time will be enhanced.

Decentralization as a policy is also reflected in the national population policy document (Bangladesh Population Policy, 2012 (Bangla version, MOHFW). Community needs, priorities, problems and issues at local level can be addressed through decentralized planning. The process requires facilitated planning and participation of FP stakeholders in the formulation of different FP plans and programs. Note that Local Level Planning (LLP) is one of the components of the PME-FP operation plan and planning tools are in use to develop plans at Upazila level, but this process requires further strengthening.

Management systems at the national, district, upazila and community levels must be strengthened. FP services confront shortages of providers, managers and commodities, which are often attributable to insufficient financial resources and weak management. The systems will ensure availability of resources, including funds, to implement the NFPP activities in time.

Coordination within the FP sector will ensure collection and compilation of the implementation progress of approved plans. Suggestions for further improvement of program activities need coordination and information dissemination. Involvement of stakeholders in activities and sharing knowledge and experiences remove barriers in implementation and harmonize relationships, thereby avoiding overlapping and duplication of activities and allowing rationalization of resources.

NGOs are playing an important role in FP, especially in urban areas. The NFPP emphasises GO-NGO collaboration. GO-NGO collaboration is extremely important in increasing demand and reaching groups who are not users of FP methods. There is collaboration between GO-NGO service deliveries at the field level, but this could be further strengthened through planning and coordination.

Well-designed research and an effective health management information system (HMIS) are useful for knowing clients' needs and for planning and implementation. Research and HMIS gather the data required to overcome policy and implementation barriers. These two mechanisms can be used to monitor program implementation to ensure quality of care and effective service delivery. Research allows planners to design and implement "mid-course" corrections in programmatic strategies and direction.

Concerns have been raised over the lack of quality data for management, monitoring and evaluation purposes. Strengthened MIS through linkage with existing MIS in DGHS and DGFP will be utilized to facilitate development of the monitoring and evaluation framework.

Objective: Strengthening planning and management systems to ensure quality FP services

Strategies	Key Actions	Results: By 2020	Success Indicators	Key Role
Strengthening decentralized planning process	• Workshops to develop local level plans with participation of other ministries, NGOs and civil society	Plans developed, approved, quality assured and being implemented	# of decentralized plans implemented on time	DGFP, DGHS NIPORT Development Partners BCEWG Lead: MOHFW
	• Prepare monitoring reports on implementation of the NFPP	Monitoring mechanisms in place	Monitoring reports on implementation of plans	
Strengthening exchange of information and coordination	• Organizing FP committee meetings at national, district, sub-district, union and ward levels	Committees are active	# of committee and coordination meetings	DGFP BCEWG
	• Develop partnership/ contractual arrangement with NGOs and the private sector service providers	Partnership arrangements established	# of partnership arrangements in place	
	• Disseminate information and share lessons learned in existing forums at the national, district, sub-district and union level	Information disseminated and lessons shared Facilitated learning on effective FP approaches	Forum to support and facilitate learning on effective FP approaches formed and functional	
Strengthening research agenda	• Organize workshops/meetings to develop research plan based on identified gaps and priority areas	Research plan developed	# of research studies identified based on priorities	NIPORT
	• Implement research activities with NIPORT and with other partners	Research conducted	# of research reports and policy analyses	
	• Disseminate findings of the research studies	Findings disseminated in different forums (workshops at different levels, conferences)	Research presentations at workshops and conferences	

Strengthen reporting, monitoring and evaluation system	• Developed computerized data collection system	Accurate and timely data available to inform policy and service planning	Data quality process in place Data monitoring under taken regularly # of consistent computerized data collection system in place	DGFP NGOs Private sector
	• Develop M&E framework for collecting and reporting data at various levels	M&E framework agreed and operational	Documented framework for collection of M&E data	
	• Coordination and revision of implementation plan	Monitor and implementation of costed implementation plan	# of meetings for coordinating and implementing CIP	
	• Organize field visits		# of field visits	
Strengthen management capacity for service delivery, IEC activities, procurement and supply, and planning and management	Salary and allowance Operational activities Procurement of capital items to support management activities	Efficient management system to support service delivery, IEC activities, procurement and supply, and planning and management	# of staff who support management activities # of operational activities were supported on time # and type of capital items procured	DGFP

10.6. Key Focus Area 6: Policy and Advocacy

An effective policy environment and advocacy are important elements for the success of the NFPP. These create and maintain a supportive environment for improving the delivery and use of FP services. Political will and a supportive environment in Bangladesh are generally favorable for FP activities. Since 2003, the Bangladesh National Population Policy and National Population Council have been formed to oversee policy issues; however challenges remain in terms of coordination and collaboration among stakeholders at different levels. More political commitment is required to achieve FP targets. Inadequate funding, unavailability of skilled FP service providers, lack of sustainability for FP initiatives supported by development partners, weak mechanisms for monitoring and evaluation, inefficient procedures for the procurement of FP methods and absence of mechanisms for knowledge management and dissemination of data are major challenges. Commitment from decision-makers is essential for effective positive change and incorporating new policies. Turnover of decision-makers and loss of motivation and commitment adversely affect implementation, while approving and implementing policies is difficult and time-consuming.

There is a need for advocacy with policymakers, managers, senior officials and development partners to raise support for the NFPP. Advocacy tools based on research findings will be used to influence decision-makers, religious leaders, civil society leaders and media professionals to change FP policies. The reason for such advocacy is to mobilize the necessary support – funding, political commitment and visibility.

The implementation of the NFPP has policy implications that require timely decision-making. Policy decisions and advocacy are extremely important for motivating the FP providers, continuous availability of FP commodities, improving financing and efficiency in FP, conducting research and improving overall management and monitoring systems. The proposed strategies address these issues in recognition of their importance in effective implementation of the NFPP.

Objective: Strengthening policy and advocacy efforts

Strategies	Key Actions	Results: By 2020	Success Indicators	Key Role
Strengthen policy environment for implementation of the NFPP	• Undertake policy analyses to identify barriers and need for TA • Consultation meetings • Workshops • Policy dialogue	Policy agenda developed Policy dialogues held regularly Develop and implement policies supporting the NFPP including supporting documentation and appropriate monitoring processes Greater national-level commitment to implement the targets of FP2020	# of National Population Council meetings # of policy dialogues # of policy studies conducted to identify policy barriers Policy agenda documented Approved policies supporting activities of the NFPP (human resources, service delivery, procurement, research, management, monitoring and evaluation) Monitoring and evaluation of policy agenda	DGFP DGHS BCEWG Development Partners Private sector and NGOs Professional bodies/ associations NIPORT <u>Lead:</u> MOHFW
Advocacy campaign on key FP issues in partnership with key stakeholders	• Develop and revise advocacy tools based on policy analyses and research findings • Organize meetings, workshops, round-tables, seminars • Resource mobilization and allocation activities (meetings and workshops) targeting DPs and government	Advocacy tools in place Advocacy campaigns implemented Advocacy campaigns met objectives Funding from development partners and government for the NFPP increased	# of advocacy tools developed # of advocacy campaign activities implemented Evaluation of advocacy campaign processes Advocacy documents prepared Proportion of NFPP fund received from development partners and government over years	
Support NFPP activities through partnerships and collaborations	• Intersectoral activities (policy and advocacy meetings) • Intersectoral events (planning workshops, joint review)	Effective partnerships between government, NGOs and community stakeholders Public-private dialogue established	# of intersectional activities and events per year # of BCEWG meetings	

11. Future projections

Annual progression of CPR towards the target between the years 2014 and 2021 is depicted in Table 4. As mentioned earlier, the NFPP aims to increase the CPR to 75% and use of LAPMs to 20% by 2021. The annual percentage distribution of users of different FP methods was projected as per the annual changes in CPR and in use of LAPMs. Table 4 provides a basis for estimating number of users and acceptors of FP methods over 2016–2020.

Table 4 Annual projection of CPR and use of LAPMs

Methods (%)	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Pill	27.00	27.05	27.10	27.15	27.20	27.25	27.30	27.35
Injectable - three-month	12.40	12.42	12.45	12.47	12.49	12.51	12.54	12.56
Male Condom	6.40	6.41	6.42	6.44	6.45	6.46	6.47	6.48
Any Traditional	8.40	8.42	8.43	8.45	8.46	8.48	8.49	8.51
Implant - Implanon	1.70	2.06	2.41	2.77	3.13	3.48	3.84	4.20
IUD	0.60	0.73	0.85	0.98	1.10	1.23	1.36	1.48
Female Sterilization	4.60	5.57	6.53	7.50	8.46	9.43	10.39	11.36
Male Sterilization	1.20	1.45	1.70	1.96	2.21	2.46	2.71	2.96
Any Method	62.40	64.10	65.90	67.70	69.50	71.30	73.10	75.00
Any Modern Method	53.90	55.68	57.47	59.25	61.04	62.82	64.61	66.30
All LAPMs	8.10	9.80	11.50	13.20	14.90	16.60	18.30	20.00

Tables 5 presents number of users. To meet the incrementally increasing LAPMs and CPR targets each year, the number of FP users and acceptors will also increase.

Table 5 Number of contraception users by year (new + current users)

Method (numbers)	**2016**	**2017**	**2018**	**2019**	**2020**	**Total**
Pill	10,534,999	10,691,485	10,839,773	10,976,878	11,100,696	54,143,830
Injectable	4,838,296	4,910,163	4,978,266	5,041,233	5,098,098	24,866,056
Male Condom	2,497,185	2,534,278	2,569,428	2,601,927	2,631,276	12,834,094
Implant - Implanon	938,287	1,090,986	1,246,290	1,403,480	1,561,813	6,240,856
IUD	331,160	385,054	439,867	495,346	551,228	2,202,655
Female Sterilization	2,538,895	2,952,081	3,372,314	3,797,653	4,226,081	16,887,023
Male Sterilization	662,320	770,108	879,734	990,692	1,102,456	4,405,310
Total	**22,341,142**	**23,334,155**	**24,325,672**	**25,307,208**	**26,271,647**	**121,579,824**

Table 6 presents the number of LAPM acceptors estimated by the Reality Tool. LAPM acceptors have cost implications, and that is why they are presented separately in Table 6.

Table 6 Numbers of LAPM acceptors (new users) by year (Reality Tool estimated)

Method	**2016**	**2017**	**2018**	**2019**	**2020**	**Total**
Implant - Implanon	370,417	415,419	460,780	506,152	551,307	2,304,075
IUD	144,654	163,177	181,881	200,635	219,346	909,692
Female Sterilization	554,133	590,908	626,879	661,401	694,264	3,127,586
Male Sterilization	161,259	174,020	186,637	198,931	210,833	931,680
Total	**1,230,463**	**1,343,524**	**1,456,177**	**1,567,118**	**1,675,750**	**7,273,032**

12. Cost

Table 7 presents costs of different FP commodities per user per year. Commodities included temporary and long acting methods. These costs were estimated based on future projections of number of users (Pill, injectable and condoms, Table 5) and acceptors (Table 6). Unit costs of commodities were collected from DGFP and used to estimate cost per user for each method. DGFP purchases 150,000 progesterone-only pills and 100,000 emergency contraceptive pills every year. Annex 4 presents unit costs of FP commodities and other components. The exchange rate was fixed at Taka 77.58 = US$ 1.00 (11 September 2014). An inflation rate of 7% was applied in each year.

Table 7 Costs (US$) of commodities per user per year

Methods	Unit cost per user	**2016**	**2017**	**2018**	**2019**	**2020**	Total
Pill	1.94	23,578,775	25,723,692	28,036,503	30,520,447	33,179,586	141,039,002
Injectable	2.46	13,745,320	14,995,706	16,343,966	17,791,989	19,342,143	82,219,123
Male Condom	4.49	12,966,580	14,146,125	15,418,000	16,783,986	18,246,316	77,561,007
Implant (1 stick)	9.21	3,943,101	4,753,815	5,668,358	6,693,492	7,837,440	28,896,205
IUD	0.58	97,127	117,781	141,128	167,356	196,685	720,076
Progesterone only pill	6.58	1,141,450	1,227,059	1,319,088	1,418,020	1,524,372	6,629,989
Emergency contraceptive pill	0.77	89,526	96,240	103,458	111,217	119,559	519,999
Total		**55,561,879**	**61,060,417**	**67,030,501**	**73,486,505**	**80,446,100**	**337,585,402**

Estimated unit costs of services per user per year are shown in Table 8. The estimates for users by all modern methods are based on the formula: Average minutes the providers spend * average salary and benefit cost per minute + average cost of medical supplies) * number of visits of user per year * overhead cost (10% of the total cost).

FP providers (Medical Officer – Maternal and Child Health, Family Welfare Visitors and Family Planning Assistants) were asked about the average time they usually spend to provide different FP services including counseling. They also provided information about the average costs of drugs and medical supplies they use in providing services. Average monthly salaries and benefits of different providers were collected from DGFP. Cost of services varies (US$2.09-8.05) by method. Total costs of providing different FP methods, estimated based on number of projected users (Table 5) and unit costs (Table 8), are shown in Table 9.

Table 8 Unit costs (US$) of services (personnel cost + medical supplies) per user

Methods	**Total personnel cost**	**Medical supplies**	**OH%**	**Total cost per user**
Pill	2.48	0.00	10.00	2.73
Injectable	1.81	2.84	10.00	5.11
Condom	2.04	0.00	10.00	2.25
Implant	0.39	2.00	10.00	2.62
IUD	0.90	1.00	10.00	2.09
Female sterilization	3.10	4.22	10.00	8.05
Male sterilization	1.16	1.88	10.00	3.35

Table 9 Total costs (US$) of services (Personnel cost + medical supplies)

Methods	Cost per user	2016	2017	2018	2019	2020	Total
Pill	2.73	33,175,639	36,193,564	39,447,719	42,942,660	46,684,103	198,443,684
Injectable	5.11	28,568,775	31,167,622	33,969,895	36,979,519	40,201,415	170,887,226
Male Condom	2.25	6,482,406	7,072,099	7,707,949	8,390,849	9,121,914	38,775,217
Implant	2.62	1,122,365	1,353,127	1,613,443	1,905,237	2,230,851	8,225,024
IUD	2.09	350,122	424,577	508,737	603,284	709,012	2,595,731
Female sterilization	8.05	5,153,800	5,908,021	6,737,739	7,641,934	8,623,274	34,064,768
Male sterilization	3.35	623,703	723,539	834,199	955,836	1,089,001	4,226,278
Total		**75,476,811**	**82,842,548**	**90,819,681**	**99,419,319**	**108,659,570**	**457,217,928**

FP providers and their associates receive financial compensation (wage loss, food charge) and transportation costs to provide LAPM methods. These arrangements are in place to strengthen and promote LAPM services. Information on average cost per LAPM user was collected from DGHP and FP providers of Thakurgoan district. Average cost for sterilization is US$40.15. Table 10 shows costs by different LAPM methods.

Table 10 Costs (US$) for strengthening LAPM services

Methods	cost per user	2016	2017	2018	2019	2020	Total
Implant	6.71	2,874,021	3,464,928	4,131,514	4,878,707	5,712,500	21,061,669
IUD	6.46	1,079,184	1,308,675	1,568,084	1,859,506	2,185,392	8,000,841
Female sterilization	40.15	25,714,024	29,477,086	33,616,823	38,128,151	43,024,388	169,960,471
Male sterilization	40.15	7,483,049	8,680,857	10,008,533	11,467,911	13,065,584	50,705,934
Total		**37,150,277**	**42,931,546**	**49,324,954**	**56,334,275**	**63,987,864**	**249,728,915**

Costs of strategies by six focus areas are reported in Tables 11–16. Annex 5 provides information about costs of activities under each strategy by focus area, including time frame.

Costs of FP service delivery are presented in Table 11. Procurement of contraceptives, provision of FP services, strengthening LAPM service and domiciliary services were considered key activities to improve provision of FP services. These activities make up 91.36% of the total cost of the CIP. Costs of strategies in this focus area will increase over years due to the expected increase in demand and broadening of NFPP activities.

Table 11 Costs of ensuring equity-based quality FP services for the target population

#	Strategies	Costs (US$ million)					
		2016	2017	2018	2019	2020	Total
1	Improve provision of FP services for the clients	168.48	187.15	207.53	229.63	253.52	1,046.31
2	Strengthen systems and facilities to provide FP services	32.49	34.92	37.54	40.36	43.38	188.69
3	Improve QA mechanism for FP services	1.80	1.94	2.04	2.19	2.36	10.33
4	Strengthen Family Planning Services in HTR areas, low performing and urban slums	2.24	2.41	2.59	2.78	2.99	13.00
Total		205.00	226.42	249.70	274.96	302.26	1,258.34

Related information, education and communication (IEC) activities will be implemented during 2016–2020. Communication theme cost items include development of advocacy materials, and dissemination through radio, TV and other mass media. Only a few activities, such as mobile voice calls and electronic billboards, are not planned to occur in each year. More than 80% of the cost of this focus area is related to awareness campaigns, media campaigns and transmission (Table 12).

Table 12 Costs of Information, Education and Communication

#	Strategies	Costs (US$ million)					
		2016	2017	2018	2019	2020	Total
1	Increase awareness and motivation	0.77	0.83	0.89	0.96	0.74	4.20
2	Ensure production, distribution and dissemination	0.33	0.38	0.42	0.45	0.48	2.05
3	Conduct media campaign and transmission	0.70	0.76	0.81	0.87	0.94	4.09
Total		**1.80**	**1.97**	**2.12**	**2.28**	**2.16**	**10.34**

The high-performing staff focus area includes six strategies, and many training programs and workshops will be implemented under each strategy. Training activity will increase each year to ensure high-performing personnel are employed at community, facility and management level. The strategy for developing the knowledge and skills of the service providers, supervisors and managers will cost US$10.40 million out of US$12.07 million (Table 13). The remaining US$1.67 million will be spent on the other five strategies of this focus area.

Table 13 Costs of High-Performing Staff

#	Strategies	Costs (US$ million)					
		2016	2017	2018	2019	2020	Total
1	Knowledge and skill development of the service providers, supervisors and managers	1.87	2.00	2.04	2.16	2.32	10.40
2	Strengthening planning and management skills	0.12	0.13	0.14	0.15	0.16	0.71
3	Capacity strengthening for decentralised planning process	0.01	0.01	0.01	0.01	0.01	0.06
4	Capacity strengthening reporting, monitoring and evaluation system	0.12	0.13	0.14	0.16	0.17	0.72
5	Strengthen capacity of NIPORT, Specialized Centres and Regional Training Centres	0.04	0.04	0.04	0.03	0.00	0.15
6	Strengthen Technical Cooperation with development partners, including UN agencies	0.01	0.01	0.01	0.01	0.01	0.03
Total		**2.17**	**2.32**	**2.39**	**2.52**	**2.68**	**12.07**

Table 14 shows the estimated costs of implementing reliable and efficient systems for procurement and supply management of FP commodities. The cost of constructing a modern warehouse was included in 2016 and 2017. The cost of strengthening information and communications technologies (ICT) for detection of supply shortages at service delivery points covers the costs of a warehouse inventory management system, an Upazila inventory management system and eLMIS.

Table 14 Costs of procurement and supply management of FP commodities

#	Strategies						
		2016	2017	2018	2019	2020	Total
1	Streamline procurement and supply chain management system	11.32	12.17	13.08	14.05	15.12	65.74
2	Develop infrastructure for better storage condition	2.48	3.35	0.00	0.00	0.00	5.83
3	Strengthen product QA and material standardization	0.07	0.08	0.09	0.09	0.10	0.43
4	Strengthen ICT for detection of supply shortages at service delivery points	0.10	0.10	0.11	0.11	0.12	0.53
Total		**13.97**	**15.71**	**13.28**	**14.25**	**15.34**	**72.54**

The costs of several meetings and workshops in each year were estimated to derive the total cost of the decentralized planning process and strengthening exchange of information and coordination (Table 15). Implementation of research studies is scheduled for 2016 and 2018. A computerized data collection system, collecting and reporting data at various levels, coordination and revision of implementation plan and field visits are the approaches proposed for strengthening the reporting, monitoring and evaluation system, therefore the costs of these services were estimated (US$4.45 million). Strengthening management capacity for service delivery, IEC activities, procurement and supply, and planning and management accounts for 72.13% of the total cost of the planning and management focus area. This cost includes the salaries and allowances of some management staff, operational costs and the cost of procurement of capital items to support management activities.

Table 15 Costs of planning and management

#	Strategies	Costs (US$ million)					
		2016	2017	2018	2019	2020	Total
1	Strengthening decentralised planning process	0.10	0.11	0.15	0.12	0.17	0.65
2	Strengthening exchange of information and coordination	0.16	0.18	0.19	0.20	0.22	0.96
3	Strengthening research agenda	0.19	0.20	0.00	0.01	0.01	0.40
4	Strengthen reporting, monitoring and evaluation system	0.88	0.69	0.70	0.90	1.27	4.45
5	Strengthen management capacity for service delivery; IEC activities; procurement and supply; and planning and management	3.27	3.29	3.50	3.21	3.44	16.71
Total		**4.60**	**4.46**	**4.54**	**4.45**	**5.12**	**23.17**

The policy and advocacy area will have higher costs in 2017 and 2018 due to a policy study and development of advocacy tools. Costs of meetings, workshops, round tables, seminars and joint reviews were estimated under advocacy, partnerships and collaboration activities (Table 16).

Table 16 Costs of policy and advocacy

#	Strategies	Costs (US$ million)					
		2016	2017	2018	2019	2020	Total
1	Strengthen policy environment for implementation of the NFPP	0.08	0.12	0.13	0.06	0.06	0.46
2	Advocacy campaign on key FP issues in partnership with key stakeholders	0.07	0.08	0.09	0.03	0.04	0.31
3	Support NFPP activities through partnerships and collaborations	0.02	0.02	0.03	0.03	0.03	0.13
Total		**0.18**	**0.23**	**0.25**	**0.12**	**0.13**	**0.90**

12.1 Cost summary

The Costed Implementation Plan for the National Family Planning Program, Bangladesh has an estimated cost of US$1377.36 million over a five-year implementation period. The resource requirements for the six focus areas are summarized in Table 17.

Table 17 Cost summary :

#	Focus area	Costs (US$ million)					
		2016	2017	2018	2019	2020	Total
1	Ensuring equity based quality FP services for the target population	205.00	226.42	249.70	274.96	302.26	1258.34
2	Information, Education and Communication (IEC)	1.80	1.97	2.12	2.28	2.16	10.34
3	High-Performing Staff	2.17	2.32	2.39	2.52	2.68	12.07
4	Procurement and supply management of FP commodities	13.97	15.71	13.28	14.25	15.34	72.54
5	Planning and management	4.60	4.46	4.54	4.45	5.12	23.17
6	Policy and advocacy	0.18	0.23	0.25	0.12	0.13	0.90
Total		**227.73**	**251.11**	**272.27**	**298.58**	**327.67**	**1377.36**

Figure 7 presents percent distribution of total cost by FP commodities and six focus areas. The FP commodities account for 24.51% (US$337.59 million) of the total cost and the FP services delivery activities share 66.85% (US$920.75 million) of total cost. Cost of FP service delivery includes time cost of staff. These two costs are included in costs of activities under four strategies of focus area 1. More funding for these activities will be required, mainly due to the expected increase in demand for services, expansion of coverage and inflation. The procurement and supply management focus area (management related activities only) has the second-largest costs (5.27% of total). Policy and advocacy focus area requires less funding compare to other focus areas.

Figure 7: Percent distribution of total cost by six focus areas

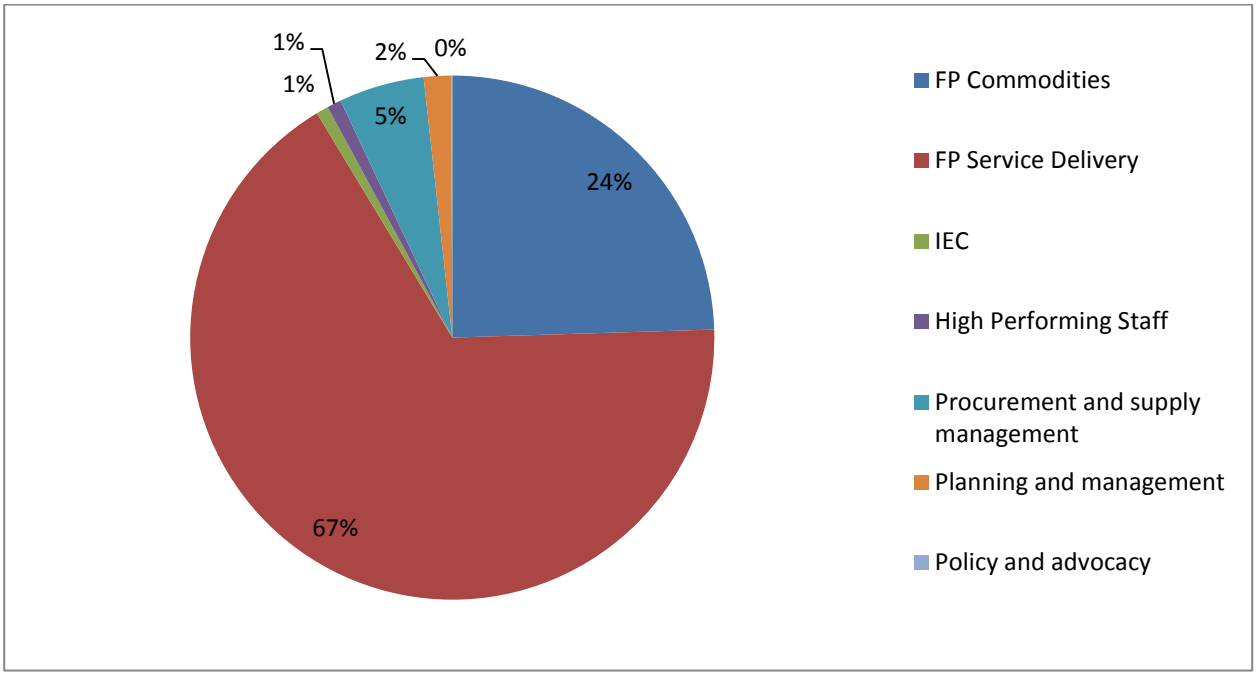


Table 18 compares the DGFP (2015-2016) budget with the cost of the CIP in 2016. Many activities that are supported by the revenue component of the DGFP budget were not included in the CIP. Stakeholders were advised to include multiple activities in the CIP to achieve the objectives of the six focus areas. These included training for enhancing staff, GO-NGO collaboration, expansion of services in urban areas, development of infrastructure for better storage condition, and strengthening reporting, monitoring and evaluation systems. The importance of ICT for detection of supply shortages at service delivery points was also reinforced. It should be noted that the CIP includes costs of commodities and services provided by both public and private sectors; costs were estimated from an institutional perspective, irrespective of source.

Administrative costs at the national, divisional, district, sub-district and community level were not considered in the CIP. Therefore, comparison between the DGFP (2015–2016) budget and the annual cost of the CIP will not be straightforward.

Table 18 DGFP budget (2015-2016) and 2016 cost of the CIP

DGFP Budget (2015-2016) US$ million				**CIP (2016) US$ million**
Development	Revenue	Total		
84.57	174.33	258.91		227.73

13. Impact of Family Planning services between 2016–2020

Broader health indicators were measured to assess the impact of FP services between 2016 and 2020 (Table 19). The broader demographic and health impacts of the FP services were analyzed using validated formulae and models in the MSI Impact Calculator (Corby N, Boler T and Hovig 2009). The coefficients generated from the MSI Impact Calculator were used to estimate the impact of family planning services in Bangladesh. These are: number of pregnancies averted 0.571429/CYP, number of births averted 0.375115/CYP, number of infant mortalities averted 0.017638/CYP, number of under-5 mortalities averted 0.022694/CYP, number of maternal mortalities averted 0.002138/CYP, number of abortions averted 0.164516/CYP, number of unsafe abortions averted 0.109677/CYP, Disability Adjusted Life Years (DALYs) 0.143114/CYP and Total Cost Savings US$90.31/CYP (2014 cost).

Table 19 Benefits and impact of FP services, 2016-2020

Indicator	2016	2017	2018	2019	2020	Total
CPR (%)	66	67.8	69.6	71.4	73.2	
CYP	28,762,021	29,869,151	30,951,779	31,992,651	32,983,595	154,559,198
No of pregnancies averted	16,435,453	17,068,099	17,686,744	18,281,529	18,847,783	88,319,608
No of births averted	10,789,066	11,204,367	11,610,477	12,000,923	12,372,641	57,977,474
No of infant mortalities averted	507,305	526,832	545,927	564,286	581,765	2,726,115
No of under 5 mortalities averted	652,725	677,851	702,420	726,041	748,530	3,507,566
No of maternal mortalities averted	61,493	63,860	66,175	68,400	70,519	330,448
No of abortions averted	4,731,813	4,913,953	5,092,063	5,263,303	5,426,329	25,427,461
No of unsafe abortions averted	3,154,532	3,275,959	3,394,698	3,508,858	3,617,542	16,951,589
Disability Adjusted Life Years	4,116,248	4,274,694	4,429,633	4,578,596	4,720,414	22,119,585
Cost Saving (US$)	3,003.35	3,351.07	3,732.97	4,147.90	4,597.10	18,832.41

These coefficients enabled estimation of the number of pregnancies and births averted, the number of infant and under-five mortalities averted, the number of abortions and unsafe abortions averted and number of disability adjusted life years (DALYs) averted.

Costs saved to individual households and national budgets as a result of the abortions and infant and maternal deaths averted by the NFPP (Corby et al., 2009) were estimated.

For estimation of CYPs, USAID conversion factors and estimated protection provided by contraceptive methods during a one-year period assumed all contraceptives were either sold or distributed free of charge to clients during that period.

14. Limitations

The CIP was based on an increase in the CPR to a target of 75 percent by the year 2021.

Changes in LAPM acceptors by year were based on projections of July 2013-June 2014 DGFP performance data.

The cost analysis was based on proposed activities in key six focus areas.

The time required to provide different FP services was estimated from data collected in qualitative interviews. No time-motion study was conducted.

Administrative costs at the national, divisional, district, sub-district and community level were not considered.

Postpartum tubal ligation occurring with cesarean section operations in the private sector has not been accounted for in cost analysis. These numbers are not reported in the DGFP MIS.

Costs of treating complications (implant, IUD and sterilization) were not included.

15. Institutional and partnership arrangements for implementation of the CIP

The implementation of the CIP is dependent on specific elements of institutional design (policies that prescribe the FP services) and organizational practice (the way the policies are implemented).

Key informants agree on the need for strong leadership and good governance. They agreed that existing governance infrastructures within the DGFP at all levels of health system can be used to implement the CIP. DGFP under the Ministry of Health and Family Welfare (MoHFW) will provide the leadership and the political support needed to implement the plan. DGFP will be responsible for developing and updating policies that will be required to accelerate implementation in efficient ways, resource mobilization, monitoring and evaluation.

Effective coordination between national, district and sub-district levels is critical to the successful implementation of the plan. The following five categories of partners will be involved in different stages and aspects of the project:

1. District Health management teams of MoHFW
2. District Family Planning management of MoHFW
3. NGOs involved in FP service delivery
4. NGOs involved in developing awareness of FP
5. Health departments of the City Corporations/Municipalities, where applicable.
6. Private sector agencies like SMC, private hospitals, private medical college hospitals
7. The organizations/institutions who are providing Technical Assistance to MOHFW, including UN agencies and International NGOs.

Implementation of the plan needs collaboration among stakeholders including departments of different ministries, development partners, national and international NGOs, private sector and civil society. BCEWG can play a key role in overall coordination of action and activities. A detailed plan within the framework of the CIP needs to be prepared each year. BCEWG will work with stakeholders to prepare an annual plan. This group will also initiate and coordinate revision of the CIP based on recommendations from stakeholders.

DGFP and BCEWG will strengthen GO-NGO collaboration in the areas of technical resource provision, capacity development, social and community mobilization and FP service provision to bring synergy and improve efficiency and effectiveness. The expertise of NGOs on the demand side of FP will be drawn institutionally into plan implementation.

Education, mass media, income generation activities, women's development and empowerment are linked to FP. They have opportunities to provide a greater number of resources and a wider variety of strategies to address FP issues. Institutional arrangements will be made to promote inter-sectoral collaborations between relevant ministries and institutions.

16. Resource mobilization

Since the implementation of the CIP will involve reasonably high costs, funds to cover these expenditures must be made available from both domestic and external sources. Unless sources of more funding are identified and resources mobilized, it will be impossible to implement all the planned activities of the NFPP from 2015.

The success of the CIP will depend on the acquisition of financial resources.

- BCEWG should collaborate with national stakeholders and development partners to generate financial resources to fully implement the CIP. They need to work together to prioritize interventions and resource allocation for efficient utilization of available funds.

- The MOHFW should allocate funds for FP from its budget.

- Involvement of the private sector and NGOs needs to be increased for resource mobilization and allocation.

- Private foundations and other innovative financing options for the CIP must be explored.

The DGFP should conduct regular periodic reviews of funding status. Reviews should focus on rigorous budgeting, tracking of funds, prioritization, alignment, efficient resource use and accountability.

17 Monitoring and evaluation framework

The CIP requires a well-defined monitoring and evaluation framework. The success of this CIP will depend on regular monitoring and evaluation to measure progress in implementation of planned activities and attaining the expected outputs. Data utilization, formal and informal feedback mechanisms, and overall data triangulation are key elements of the monitoring and evaluation framework.

Monitoring allows the identification of obstacles to the implementation of planned activities and the formulation of solutions for addressing them. DGFP will take the leadership role in monitoring the activities of the CIP. The BCEWG will be responsible for coordinating the activities of the CIP and monitoring progress.

The monitoring and evaluation framework will encompass the following two broad areas:

16.1 Monitoring implementation of activities in the CIP
16.2 Evaluation

17.1 Monitoring implementation of activities in the CIP

Monitoring through review meetings

CIP activities according to the approved annual work plan will be monitored and supervised at the central level at DGFP through existing monthly monitoring meetings, quarterly coordination meetings and by the BCEWG. The National Technical Committee, Civil Society and NGOs will conduct external monitoring at regular intervals.

Monitoring at district and upazila level

The District Family Planning Committee and Upazila Family Planning Committee will monitor implementation of NFPP activities at district and upazlia level.

Field Monitoring

Central, Divisional and District Officials will conduct regular field visits to monitor FP activities at field level.

Use of monitoring tool

A management monitoring tool for tracking the degree of implementation will be developed. This tool will also be used to collect data on the defined indicators for monitoring the plan. Data will be collected on expenditures, sources of funds, outputs and geographic coverage. This will be helpful to track implementation against expenditure. A feedback mechanism will also be in effect for all levels.

Data will be also collected on the following process indicators:

Quality: Service delivery according to protocols
System performance (training, supervision)

Sustainability: Supportive FP policies in place
Mobilization of resource for FP
Resource allocation for FP, including government budget
Existence of partnerships for FP

FP MIS

Family planning performance indicators are included in the routine data collection through the DGFP MIS. Steps are also being taken to report IUD and tubectomy performance from both public and private sector organizations in the DGMIS.

Semi-annual monitoring and financial reports

The BCEWG will prepare semi-annual monitoring and financial reports. These reports will present accurate expenditure information in accordance with the actual activities and progress made on site corresponding to the reporting period. The reports will be submitted to the FP-related meetings at national and district levels and disseminated at national level.

Mid-term and annual reviews

BCEWG will organize annual reviews and mid-term reviews of the CIP. Annual reviews will assess progress in resource mobilization, activities and results. Recommendations will be used to amend the CIP and revisit the activities if needed.

17.2 Evaluation

FP2020 forms the basis for the overall data collection system for evaluation.

Indicators that will be reported: (including Track20 Indicators: Track20 Project; Monitoring Progress in Family planning: www.track20.org).

- TFR
- CPR
- Share of LAPM
- Modern Methods (mCPR)
- Total number of contraceptive users by method
- Percent of women whose demand for modern contraception is satisfied
- Percentage of women with an unmet need
- Annual expenditure on FP commodities from government domestic budget
- CYP

Data sources of these indicators: Surveys such as the Demographic and Health Surveys (DHS), MICS and other nationally sponsored surveys and service statistics.

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Annex 1

Revised Family Planning 2020 Targets

Government of the People's Republic of Bangladesh
Ministry of Health and Family Welfare
FW-1 Branch.
dsfw1@mohfw.gov.bd

Memo no :45.169.005.00.00.005.2014- 323 Date:21-09-2015.

Sub: Revised Family Planning 2020 targets.

Ref : DGFP/MCRAH/FP2020/2015/800, Date :13-08-2015.

With reference to the above mention subject the undersigned is directed to inform you that the Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh has approved Revised Family Planning 2020 targets as given below :

- Reduce Total Fertility Rate (TFR) from 2.3 to 2.0 by 2021
- Increase Contraceptive Prevalence Rate(CPR) from 62% to 75% by 2021
- Increase share of LAPM from 8.1% to 20% by 2021
- Reduce unmet need from 12% to 10^ by 2021
- Reduce discontinuation rate of FP method from 30% to 20% by 2021

With best regards.

21.09.2015

(A. Gaffar Khan)
Joint Secretary
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Copy for information and necessary action to :

1. Alisa Wong,Country Engagement Working Group Manager, Family Planning 2020, e-mail : alisawong@familyplanning2020.org, Fax:+ 1 202 887 9021
2. Argentina Matavel Piccin, Representative, UNFPA, Bangladesh, IDB Bhaban, E/8, Begum Rokeya Sharani, Agragaon, Dhaka-1207.
3. P.O to Additional Secretary (FW & Prog), Ministry of Health & Family Welfare

PPD LETTER-2015

Annex 2

Bangladesh Commitments for the London Summit on Family Planning (FP2020)

Goal: Ensure quality and equitable Family Planning services for all Eligible Couple (ELCO) by improving access to and utilization of population and family planning services, particularly by the poor.

Targets:

- Reduce Total Fertility Rate (TFR) to 2.0 by 2016 and further reduction to 1.7 by 2021*
- Increase Contraceptive Prevalence Rate (CPR) from 61% to 80% by 2021.
- Increase share of LAPM from 7% to 20% by 2016 and to 30% by 2021.
- Reduce unmet need from 12% to 7% by 2021.
- Reduce discontinuation rate of FP method from 36% to 20% by 2021.

* Year 2021 corresponds to the 50th year of independence of Bangladesh

Source: Results framework, Health Population Nutrition Sector Development Programme: 2011-16 ,
BDHS 2011,
Perspective Plan of Bangladesh: 2010-2021:Making Vision 2021 A Reality, General Economics Division, Planning Commission, GOB

Political or policy commitments	Finance commitments	Delivery or programming commitments
Reaching replacement level fertility (TFR 2) by 2016, and further reduction to 1.7 by 2021 through ensuring supply of contraceptives, education, employment and health services targeting women. Adopting the policy of expansion and provision of clinical contraceptive methods by trained/ skilled nurses, midwives and paramedics by 2016. Attention to eliminating the geographical disparity, inequity between urban & rural, rich & poor and ensuring rights through innovative service delivery and BCC approaches including the use of ICT. Policy to address the high rate of adolescent pregnancy through ensuring improved access to family planning services by the adolescent population and through ensuring diversified and mass scale FP services.	Minimizing the financing gap by 50% from current levels by 2021 by re-allocating development budget and mobilizing more resources for family Planning. Approx. $ 400 is committed from the public sector to cover 39.4 million Eligible Couple by 2021 with a resource gap of $380 mil (i.e.approx. 40 mill/year) **A total of $ 380 additional resource will be required to cover 39.4 million ELCO by 2021.**	In order to achieve the TFR target of 1.7 and to reduce unmet need of family planning from 12% to 7% by 2021, the country is committed to increasing the CPR from 61% to 80% by 2021 and reaching 39.4 million ELCO. Addressing skewed method mix toward pills and injectables by increasing access to long acting and permanent methods (LAPM) aiming to increase 30% share of LAPM by 2021. Increasing the CPR for modern methods up to 60% in the two low-performing geographical areas (eastern part of the country) and urban slums by 2021, through innovative service delivery and BCC approaches including the use of ICT. Reduce discontinuation of rate of contraceptive from 36% to 20% by 2021. Reduce the adolescent pregnancies through social mobilization, implementation of the minimum legal age for marriage and upgrading one third of the MNCH centres to provide adolescent friendly SRH services including Family Planning.

Source: Bangladesh's Announcement at the London Summit on Family Planning , Bill & Melinda Gates Foundation [https://www.youtube.com/watch?v=1UeTlnxi8uo]

Annex 3

Key informants and other officials interviewed

#	Name	Position / Department
1	Ms. Rina Parveen	Director Planning, DGFP
2	Dr. Md. Mainuddin Ahmed	LD, CCSD, DGFP
3	Md. Kafil Uddin	Director, L&S, DGFP
4	Dr. Mohammed Sharif	Director, MCH-Services, DGFP
5	Dr. S. A. Fida Hasan	DD (Account) and PM (FSDP)
6	Dr. Tapash Ranjan Das	Deputy Director, MCH, MCH Services Unit, DGFP
7	Dr. Fahmida Sultana	Deputy Director, Services, MCH Services Unit, DGFP
8	Dr. Shamsul Alam Bhuyan	PM, FSDP, DGFP
9	Mr. Ajoy Ratan Barua	Assistant Director, Personnel, DGFP
10	Mr. Noor Nobi	Finance Officer and DPM, CCSDP, DGFP
11	Mr. Shafiul Haque	Assistant Director, MIS, DGFP
12	Mr. Khandaker Mahbubur Rahman	DPM, IEM, DGFP
13	Mr. Md. Bozlul Haque	Accountant, CWH, L&S, DGFP
14	Md. Humayun Kabir	Assistant Chief (Planning) and PM (PM&E), DGFP
15	Ms. Irin Akhter	Research Officer, Planning, DGFP
16	Dr. Bushra Binte Alam	Senior Health Specialist, The World Bank
17	Ms. Brenda A. Doe	Senior Family Planning Advisor, USAID
18	Dr. Sukumar Sarker	Senior Technical and Policy Advisor, USAID
19	Dr. A. J. Faisel	Country Representative, EngenderHealth
20	Mr. Liaquat Ali	MER, EngenderHealth
21	Mr. Saiful Hasn	Program Officer, EngenderHealth
22	Dr. Ubaidur Rob	Country Representative, Population Council
23	Mr. Mahabub Anwar	Population Council
24	Dr. Zubyer Hussain	Country Director, MSH
25	Mr. Mohammad Golam Kibria	Senior Technical Advisor, MSH
26	Dr. Rafiqus Sultan	UPHCSDP
27	Mr. Zaman Farid	UPHCSDP
28	Dr. Loshan Moonesinghe	Family Planning Specialist, UNFPA
29	Dr. Abu Sayed Mohammad Hasan	Technical Officer , UNFPA
30	Mr. Md. Bashir Ullah	Finance and Admin. Officer, UNFPA

Annex 4

Unit costs per user per year

(1 US$ = 77.45 taka)

Methods	US$
Pill	0.13*15 cycle
Injectable-three month	0.61*4 cycle
Progesterone Only Pill (POP)	0.44*15 cycle
Male condom	0.04*120 pieces
Implant	9.21
IUD	0.58
Emergency Contraceptive Pill	0.77 per dose
Female sterilization	8.05 / case
Male sterilization	3.35 / case

System strengthening	US$
Safety box	1.03
Carrying bag	8.61
Injectable client card	0.02
Registrar book	4.52
Still trunk	10.33
Umbrella	3.87
Uniform	6.46
Computer / laptop	1,107

Training	US$
Medical Officer Basic training	3,600.00 / course
Medical Officer Refresher training	1,800.00 / course
FWV Basic Training	140,500.00 / year
FWV Refresher Training	35,400.00 / year
Knowledge sharing on FP BCC issues for officials and service providers	30,000.00 / year
Orientation workshop (FPA/FPI/FWA)	774.69 / workshop
Satisfied NSV & IUD clients workshop (workshop for satisfied clients)	1,032.92 / workshop
One day orientation workshop for FWV	581.02 / workshop
Orientation workshop for committee members (district level)	3,873.47 / workshop
Orientation workshop / meeting for newlywed couple	581.02 / workshop
Medical Officer Basic training	21,000.00 / year
Medical Officer Refresher training	8,100.00 / year
Nurses/Paramedics Basic Training	15,000.00 / year
Refresher training of FWA register and formats	387.35 / course
Computer basic training (7 days)	3,873.47 / course
Advance training on computer	3,873.47 / course
Seminar/workshop/conference	77,469.34 / year
LAPM user tracking and bottom up projection	5,500.32 / year

Training	US$
Train service providers, supervisors, managers on Clients Charter of Rights, quality of care including counseling	387.35 / course
Training of Audio-visual zone Manager and technical staff	6,455.78 / course
Improvement of communication on skills on BCC within country	6,455.78 / course
Design and material development	18,592.64 / year
Awareness rising on emergency preparedness	12,911.56 / year
Training on plan and development	51,646.22 / year
Provide skills development training for the service providers from NGO/private sector	70,000.00 / year
Develop management skills of supervisors and managers on decentralized planning, implementation, monitoring and evaluation of the NFPP	1800 / course
Conduct external and internal study tours to learn best practices	10000 / person
Provide training at district and sub-district levels in decentralized planning using data to set goals, plan and monitor NFPP activities	1800 / course
Training of personnel on M&E including computerized MIS	18000 / course
Develop/ expand master trainers' pool on FP with special focus on counseling, quality of care and different FP methods including LAPM	1200 / course
Faculty development and improve training facilities with adequate supply of training materials and logistics	10000 / course
Joint planning workshops, meetings and reviews to develop plan to provide technical and financial support for capacity strengthening activities	5000 / event

Strengthening Information & communication technology	US$
Warehouse inventory management system	21,240 / year
Upazila inventory management system	24,596 / year
eLMIS	45,836 / year

Policy and management	US$
Workshops to develop decentralized plans	24532
Plan review and finalization meeting	323
Monitoring and supervision decentralized plan	27876
Prepare monitoring reports on implementation of the NFPP	2582
Workshop at community clinic	116088
Community level meeting	3783 / year
Ward level meeting	18593 / year
Workshop on coordination	2582
Dissemination	1291 / workshop
Organize workshops/ meetings to develop research plan based on identified gaps and priority areas	5000 / year
Implement research studies in collaboration with other partners	80000 / year
Dissemination	5000 / year
Developed computerized data collection system	1000 / individual
Develop M&E framework for collecting and reporting data at various levels	20000 / year
Printing and publications	6,456 / year
Technical assistant	12,912 / year
Develop GIS, Tele com equipment	290,510
Establishment of data center	129,116
Coordination and revision of implementation plan	750 / year
Organize field visits	6000 / year

Annex 5

Implementation time frame and cost

Key Focus Area 1: Family Planning Service Delivery

Activity	Activity Group	Time Frame	2016	2017	2018	2019	2020	Total
			Costs	Costs	Costs	Costs	Costs	
Improve provision of FP services for the FP clients								
Procurement of contraceptives	Service delivery	2015(Q1) - 2020 (Q4)	55,561,879	61,060,417	67,030,501	73,486,505	80,446,100	337,585,402
Provision of contraceptives	Service delivery	2015(Q1) - 2020 (Q4)	75,476,811	82,842,548	90,819,681	99,419,319	108,659,570	457,217,928
Removal of IUD & implant	Service delivery	2015(Q1) - 2020 (Q4)	65,182	78,806	94,190	111,453	130,737	480,367
Strengthening LAPM services	Service delivery	2015(Q1) - 2020 (Q4)	37,150,277	42,931,546	49,324,954	56,334,275	63,987,864	249,728,915
Domiciliary services	Service delivery	2015(Q1) - 2020 (Q4)	223,814	240,600	258,645	278,043	298,896	1,299,998
Total			168,477,962	187,153,917	207,527,970	229,629,594	253,523,166	1,046,312,610
Strengthen systems and facilities to provide FP services at different levels								
Organization of satellite clinics	Service delivery	2015(Q1) - 2020 (Q4)	1,119,069	1,202,999	1,293,224	1,390,215	1,494,482	6,499,989
UHFWC's furniture	Furniture	Q3 (2015-2020)	298,418	320,800	344,860	370,724	398,529	1,733,330
Tubewell installation	Infrastructure	Q3 (2015-2020)	29,842	32,080	34,486	37,072	39,853	173,333
UHFWC electrical equipment	Equipment	Q1 (2015-2020)	29,842	32,080	34,486	37,072	39,853	173,333
Security guard	Infrastructure	2015(Q1) - 2020 (Q4)	1,790,510	1,924,798	2,069,158	2,224,344	2,391,172	10,399,982
MSR, instrument and surgical	Equipment	Q3 (2015-2020)	28,349,742	30,475,975	32,761,667	35,218,788	37,860,217	164,666,389
Registers, forms, cards	Printing materials	Q3 (2015-2020)	223,814	240,600	258,645	278,043	298,896	1,299,998
Safety box	Materials	Q3 (2015-2020)	119,367	128,320	137,944	148,290	159,411	693,332
Carrying bag	Printing materials	Q3 (2015-2020)	119,337	128,288	137,909	148,253	159,372	693,159
Injectable client card	Printing materials	Q3 (2015-2020)	12,683	13,634	14,657	15,756	16,937	73,667
Registrar book	Printing materials	Q3 (2015-2020)	78,335	84,210	90,526	97,315	104,614	454,999
Still trunk	Materials	Q3 (2015-2020)	131,304	141,152	151,738	163,119	175,353	762,665
Umbrella	Materials	Q3 (2015-2020)	67,144	72,180	77,593	83,413	89,669	389,999

Activity	Activity Group	Time Frame	2016	2017	2018	2019	2020	Total
			Costs	Costs	Costs	Costs	Costs	
Uniform	Materials	Q3 (2015-2020)	111,907	120,300	129,322	139,022	149,448	649,999
Computer / laptop	Materials	Q3 (2015-2020)	5,116	5,499	5,912	6,355	6,832	29,714
Sub-total			32,486,430	34,922,915	37,542,126	40,357,781	43,384,637	188,693,889
Improve quality assurance (QA) mechanism for FP services								
Guideline	Guideline development	Q3 (2015-2016)	34,669	37,269	0	0	0	71,938
Monitor and supervision visit	Quality assurance	2015(Q1) - 2020 (Q4)	235,748	253,429	272,436	292,868	314,834	1,369,314
Quality assurance and management	Quality assurance	Q3 (2015-2020)	73,960	79,507	85,470	91,880	98,771	429,589
Infection prevention materials	Materials	Q3 (2015-2020)	231,274	248,620	267,266	287,311	308,860	1,343,331
Linen & bedding	Materials	Q3 (2015-2020)	339,093	364,525	391,864	421,254	452,848	1,969,583
Hospital equipment	Equipment	Q3 (2015-2020)	655,700	704,877	757,743	814,573	875,667	3,808,560
Office equipment & others	Equipment	Q3 (2015-2020)	141,241	151,835	163,222	175,464	188,624	820,385
Hospital/medical furniture	Furniture	Q3 (2015-2020)	88,944	95,614	102,785	110,494	118,781	516,619
Sub-total			1,800,628	1,935,675	2,040,786	2,193,845	2,358,385	10,329,319
Strengthen FP services in HTR areas, low performing and urban slums								
Registration, mapping, referral linkage	Urban FP	Q1 (2015-2020)	1,790,510	1,924,798	2,069,158	2,224,344	2,391,172	10,399,982
Outsourcing, supply system, mobile team	Service delivery	2015(Q1) - 2020 (Q4)	447,628	481,200	517,289	556,086	597,793	2,599,996
Sub-total			2,238,138	2,405,998	2,586,447	2,780,431	2,988,964	12,999,978
Total			**205.00**	**226.42**	**249.70**	**274.96**	**302.26**	**1,258.34**

Key Focus Area 2: Information, Education and Communication (IEC)

Activity	Activity Group	Time Frame	2016 Costs	2017 Costs	2018 Costs	2019 Costs	2020 Costs	Total
Increase awareness and motivation								
Country wide awareness for female representatives	Campaign	2015(Q1) - 2020 (Q4)	10,445	11,228	12,070	12,975	13,949	60,667
Country wide awareness for campaign for couple (1 child & 2 child) on LAPM	Campaign	2015(Q1) - 2020 (Q4)	52,223	56,140	60,350	64,877	69,743	303,333
Awareness building campaign for print and electronic media	Campaign	2015(Q1) - 2020 (Q4)	20,889	22,456	24,140	25,951	27,897	121,333
FP campaign throughout the country	Campaign	2015(Q1) - 2020 (Q4)	41,779	44,912	48,280	51,901	55,794	242,666
Campaign through road show across the country	Campaign	2015(Q1) - 2020 (Q4)	29,842	32,080	34,486	37,072	39,853	173,333
Orientation workshop for UP chairman/members, teachers, religious leaders	Workshop	2015(Q1) - 2020 (Q4)	29,842	32,080	34,486	37,072	39,853	173,333
Orientation workshop for school students/ youth forum/ adolescent health (Sylhet & CTG division)	Workshop	2015(Q1) - 2020 (Q4)	19,860	21,349	22,950	24,672	26,522	115,353
Orientation workshop for UZ family planning committee members and social workers	Workshop	2015(Q1) - 2020 (Q4)	14,921	16,040	17,243	18,536	19,926	86,667
Motivational meetings for newlywed and low parity couples (low performing and hard to reach areas)	Meetings	2015(Q1) - 2020 (Q4)	18,457	19,841	21,330	22,929	24,649	107,206
Observation of World Population Day	Observation of days/ week	2015(Q1) - 2020 (Q4)	141,749	152,380	163,808	176,094	189,301	823,332
Observation of campaign and service week	Observation of days	2015(Q1) - 2020 (Q4)	171,591	184,460	198,294	213,166	229,154	996,665
Mobile voice call from Honourable PM	Campaign	Q 3 (2015, 2017, 2019)	222,773	240,600	257,442	278,043	0	998,858
Sub-total			774,369	833,566	894,881	963,289	736,640	4,202,746

Ensure production, distribution and dissemination								
Message dissemination through bill board hoardings/bill board at uz and union level in low performing areas	Dissemination	2015(Q1) - 2020 (Q4)	119,367	128,320	137,944	148,290	159,411	804,372
Short film production and telecasting	Dissemination	2015(Q1) - 2020 (Q4)	37,302	40,100	43,107	46,341	49,816	216,666
TV drama production and telecasting	Dissemination	2015(Q1) - 2020 (Q4)	114,891	123,508	132,771	142,729	153,434	667,332
TV spot production on LAPM	Dissemination	2015(Q1) - 2020 (Q4)	96,986	104,260	112,079	120,485	129,522	563,332
Advertise through newspaper	Dissemination	2015(Q1) - 2020 (Q4)	29,842	32,080	34,486	37,072	39,853	173,333
Electronic bill-board	Dissemination	2015(Q1) - 2020 (Q4)		30,335	0	0	0	30,335
Posters/leaflets/booklets/brochures	Printing	2015(Q1) - 2020 (Q4)	20,889	22,456	24,140	25,951	27,897	121,333
Bill boards maintenance	Dissemination	2015(Q1) - 2020 (Q4)	14,921	16,040	17,243	18,536	19,926	86,667
Best practice documentary film	Dissemination	2015(Q1) - 2020 (Q4)	11,191	12,030	51,729	55,609	59,779	190,338
Sub-total			326,022	380,808	415,556	446,723	480,227	2,049,336

Conduct media campaign and transmission								
Radio program	Media campaign and transmission	2015(Q1) - 2020 (Q4)	179,051	192,480	206,916	222,434	239,117	1,039,998
Radio program (private radio channel)	Media campaign and transmission	2015(Q1) - 2020 (Q4)	74,605	80,200	86,215	92,681	99,632	433,333
BTV program	Media campaign and transmission	2015(Q1) - 2020 (Q4)	59,684	64,160	68,972	74,145	79,706	346,666
Private TV program	Media campaign and transmission	2015(Q1) - 2020 (Q4)	179,051	192,480	206,916	222,434	239,117	1,039,998
Motivational program through private TV channels	Media campaign and transmission	2015(Q1) - 2020 (Q4)	111,907	120,300	129,322	139,022	149,448	649,999
Country wide film show by audio-visual plan	Media campaign and transmission	2015(Q1) - 2020 (Q4)	22,381	24,060	25,864	27,804	29,890	130,000
Folk song, jarigan and pot sharing	Media campaign and transmission	2015(Q1) - 2020 (Q4)	17,905	19,248	20,692	22,243	23,912	104,000
Motivational program in 3 hill districts and uzs of CHT & SYL division	Media campaign and transmission	2015(Q1) - 2020 (Q4)	59,684	64,160	68,972	74,145	79,706	346,666
Sub-total			704,267	757,087	813,869	874,909	940,527	4,090,660

Total	**1,804,659**	**1,971,462**	**2,124,305**	**2,284,921**	**2,157,395**	**10,342,741**

Key Focus Area 3: High-Performing Staff

Activity	Activity Group	Time Frame	2016	2017	2018	2019	2020	Total
			Costs	Costs	Costs	Costs	Costs	
Knowledge and skill development of the service providers, supervisors and managers								
Develop/upgrade FP course curriculum for different cadre of service providers	Capacity development	2015(Q1)-2017(Q4)	28756	61,826	33,231	0	0	123,813
Training on procurement and supply management (Medium course)	Capacity development	2015(Q1) - 2020 (Q4)	10,445	11,228	12,070	12,975	13,949	60,667
Training on procurement and supply management (Long course)	Capacity development	2015(Q1) - 2020 (Q4)	7,460	8,020	8,621	9,268	9,963	43,333
Training (3wkks-3 months)	Capacity development	2015(Q1) - 2020 (Q4)	7,460	8,020	8,621	9,268	9,963	43,333
Workshop for procurement, supply and logistic management	Capacity development	2015(Q1) - 2020 (Q4)	7,460	8,020	8,621	9,268	9,963	43,333
Study tour abroad (courses and exchange visits)	Capacity development	2015(Q1) - 2020 (Q4)	22,381	24,060	25,864	27,804	29,890	130,000
Medical Officer Basic training	Capacity development	2015(Q1) - 2020 (Q4)	4,160	4,472	4,808	5,168	5,556	24,164
Medical Officer Refresher training	Capacity development	2015(Q1) - 2020 (Q4)	2,080	2,236	2,404	2,584	2,778	12,082
FWV Basic Training	Capacity development	2015(Q1) - 2020 (Q4)	162,365	174,543	187,633	201,706	216,834	943,081
FWV Refresher Training	Capacity development	2015(Q1) - 2020 (Q4)	40,909	43,977	47,276	50,821	54,633	237,616
Knowledge sharing on FP BCC issues for officials and service providers	Capacity development	2015(Q1) - 2020 (Q4)	34,669	37,269	40,064	43,069	46,299	201,370
Orientation workshop (FPA/FPI/FWA)	Capacity development	2015(Q1) - 2020 (Q4)	62,668	67,368	72,421	77,852	83,691	363,999
Satisfied NSV & IUD clients workshop (workshop for satisfied clients)	Capacity development	2015(Q1) - 2020 (Q4)	23,873	25,664	27,589	29,658	31,882	138,666
One day orientation workshop for FWV	Capacity development	2015(Q1) - 2020 (Q4)	80,573	86,616	93,112	100,096	107,603	467,999
Orientation workshop for committee members (district level)	Capacity development	2015(Q1) - 2020 (Q4)	67,144	72,180	77,593	83,413	89,669	389,999
Orientation workshop / meeting for newlywed couple	Capacity development	2015(Q1) - 2020 (Q4)	40,286	43,308	46,556	50,048	53,801	234,000
Medical Officer Basic training	Capacity development	2015(Q1) - 2020 (Q4)	24,268	26,088	28,045	30,148	32,409	140,959
Medical Officer Refresher training	Capacity development	2015(Q1) - 2020 (Q4)	9,361	10,063	10,817	11,629	12,501	54,370
Nurses/Paramedics Basic Training	Capacity development	2015(Q1) - 2020 (Q4)	17,334	18,634	20,032	21,534	23,150	100,685
Refresher training of FWA register and formats	Capacity development	2015(Q1) - 2020 (Q4)	358,102	384,960	413,832	444,869	478,234	2,079,996
Computer basic training (7 days)	Capacity development	2015(Q1) - 2020 (Q4)	156,670	168,420	181,051	194,630	209,228	909,998
Advance training on computer	Capacity development	2015(Q1) - 2020 (Q4)	8,953	9,624	10,346	11,122	11,956	52,000
Seminar/workshop/conference	Capacity development	2015(Q1) - 2020 (Q4)	89,526	96,240	103,458	111,217	119,559	519,999
LAPM user tracking and bottom up projection	Capacity development	2015(Q1) - 2020 (Q4)	6,356	6,833	7,346	7,896	8,489	36,920
Train service providers, supervisors, managers on Clients Charter of Rights, quality of care including counselling	Capacity development	2015(Q1) - 2020 (Q4)	358,102	384,960	413,832	444,869	478,234	2,079,996
Training of Audio-visual zone Manager and technical staff	Capacity development	2015(Q1) - 2020 (Q4)	7,460	8,020	8,621	9,268	9,963	43,333
Improvement of communication on skills on BCC within country	Capacity development	2015(Q1) - 2020 (Q4)	7,460	8,020	8,621	9,268	9,963	43,333
Design and material development	Capacity development	2015(Q1) - 2020 (Q4)	21,486	23,098	24,830	26,692	28,694	124,800
Awareness rising on emergency preparedness	Capacity development	2015(Q1) - 2020 (Q4)	14,921	16,040	17,243	18,536	19,926	86,667
Training on plan and development	Capacity development	2015(Q1) - 2020 (Q4)	59,684	64,160	0	0	0	123,844

Activity	Activity Group	Time Frame	2016 Costs	2017 Costs	2018 Costs	2019 Costs	2020 Costs	Total
Provide skills development training for the service providers from NGO/private sector	Capacity development	2015(Q4) - 2020 (Q4)	80,894	86,961	93,483	100,494	108,031	469,863
Strengthen staff performance appraisal system	Capacity development	2014 (Q2-Q4)	23,005	0	0	0	0	23,005
Develop comprehensive training follow up mechanisms	Capacity development	2015 (Q2-Q4)	17,254	0	0	0	0	17,254
Sub-total			1,869,305	1,997,138	2,044,719	2,162,350	2,324,527	10,398,040

Strengthening planning and management skills								
Develop management skills of supervisors and managers on decentralised planning, implementation, monitoring and evaluation of the NFPP	Capacity development	2015(Q3) - 2020 (Q4)	6,240	6,708	7,212	7,752	8,334	36,247
Conduct external and internal study tours to learn best practices	Capacity development	2015(Q3) - 2020 (Q4)	115,563	124,230	133,547	143,563	154,330	671,232
Sub-total			121,803	130,938	140,758	151,315	162,664	707,479

Capacity strengthening for decentralised planning process								
Provide training at district and sub-district levels in decentralised planning using data to set goals, plan and monitor NFPP activities	Capacity development	2015(Q3) - 2020 (Q4)	10,401	11,181	12,019	12,921	13,890	60,411

Capacity strengthening reporting, monitoring and evaluation system								
Training of personnel on M&E including computerised MIS	Capacity development	2015(Q3) - 2020 (Q4)	124,808	134,168	144,231	155,048	166,677	724,931

Strengthen capacity of NIPORT, Specialized Centers and Regional Training Centers								
Develop/ expand master trainers' pool on FP with special focus on counselling, quality of care and different FP methods including LAPM	Capacity development	2015(Q3) - 2018 (Q4)	13,868	14,908	16,026	0	0	44,801
Faculty development and improve training facilities with adequate supply of training materials and logistics	Capacity development	2015(Q3) - 2019 (Q4)	23,113	24,846	26,709	28,713	0	103,380
Sub-total			36,980	39,754	42,735	28,713	0	148,181

Activity	Activity Group	Time Frame	2016	2017	2018	2019	2020	Total
			Costs	Costs	Costs	Costs	Costs	
Strengthen Technical Cooperation with development partners, including UN agencies								
Joint planning workshops, meetings and reviews to develop plan to provide technical and financial support for capacity strengthening activities	Capacity development	2015(Q1) - 2020 (Q4)	5,778	6,211	6,677	7,178	7,717	33,562

Total	**2.17**	**2.32**	**2.39**	**2.52**	**2.68**	**12.07**

Key Focus Area 4: Procurement and supply management of FP commodities

Activity	Activity Group	Time Frame	2016 Costs	2017 Costs	2018 Costs	2019 Costs	2020 Costs	Total
Streamline procurement and supply chain management system								
Procurement planning, M&E	PME	Q1 (2015-2020)	45,106	48,489	52,126	55,954	60,238	261,912
Shipment, clearing and delivery	Procurement	2015(Q1) - 2020 (Q4)	343,181	368,920	396,589	425,719	458,308	1,992,716
Supply chain management	Service delivery	2015(Q1) - 2020 (Q4)	7,478,363	8,039,242	8,642,183	9,276,975	9,987,127	43,423,890
Record keeping & feedback	MIS	2015(Q1) - 2020 (Q4)	3,455,684	3,714,861	3,993,475	4,286,807	4,614,961	20,065,788
Sub-total			11,322,335	12,171,511	13,084,372	14,045,455	15,120,633	65,744,306
Develop infrastructure for better storage condition								
Infrastructure development	Infrastructure	2015(Q1)-2016(Q4)	2,476,819	3,352,731	0	0	0	5,829,549
Strengthen product QA and material standardization								
Appropriate testing and surveillance of the goods	Quality assurance	2015(Q1) - 2020 (Q4)	74,605	80,200	86,215	92,548	99,632	433,199
Strengthen ICT for detection of supply shortages at service delivery points								
Warehouse inventory management system	PME	2016(Q1)-2020(Q4)	22,302	23,417	24,588	25,818	27,108	123,233
Upazila inventory management system	PME	2016(Q1)-2020(Q4)	25,826	27,117	28,473	29,897	31,392	142,705
eLMIS	PME	2016(Q1)-2020(Q4)	48,128	50,535	53,061	55,174	58,500	265,398
Sub-total			96,256	101,069	106,122	110,889	117,000	531,336
Total			**13,970,014**	**15,705,511**	**13,276,709**	**14,248,892**	**15,337,266**	**72,538,391**

Key Focus Area 5: Planning and management

Activity	Activity Group	Time Frame	2016 Costs	2017 Costs	2018 Costs	2019 Costs	2020 Costs	Total
Strengthening decentralised planning process								
Workshops to develop decentralized plans	workshop	Q2(2015-2020)	28,218		32,609	35,055	37,860	133,743
Plan review and finalization meeting	Meeting	Q2(2015-2020)	373	401	431	463	498	2,167
Monitoring and supervision decentralised plan	Monitoring	2015(Q1) - 2020 (Q4)	32,214	34,630	37,228	40,020	43,021	187,113
Prepare monitoring reports on implementation of the NFPP	Monitoring	Q2(2015-2020)	2,984	3,208	3,449	3,707	3,985	17,333
Sub-total			99,361	106,955	147,586	123,436	170,730	648,067
Strengthening exchange of information and coordination								
Workshop at community clinic	workshop	Q1(2015-2020)	134,154	144,216	155,032	166,659	179,159	779,219
Community level meeting	meeting	Q2(2015-2020)	4,372	4,700	5,052	5,431	5,838	25,393
Ward level meeting	meeting	Q3(2015-2020)	21,486	23,098	24,830	26,692	28,694	124,800
Workshop on coordination	workshop	Q4(2015-2020)	2,984	3,208	3,449	3,707	3,985	17,333
Dissemination	workshop	Q3(2015-2020)	1,492	1,604	1,724	1,854	1,993	8,667
Sub-total			164,488	176,825	190,087	204,343	219,669	955,412
Strengthening research agenda								
Organize workshops/ meetings to develop research plan based on identified gaps and priority areas	workshop	Q2(2015)	5,751	0	0	0	0	5,751
Implement research studies in collaboration with other partners	research study	2016(Q1) - 2017 (Q4)	184,900	198,768	0	0	0	383,668
Dissemination	workshop	2019(Q1) - 2020 (Q4)	0	0	0	7,178	7,717	14,895
Sub-total			190,651	198,768	0	7,178	7,717	404,313

Activity	Activity Group	Time Frame	2016 Costs	2017 Costs	2018 Costs	2019 Costs	2020 Costs	Total
Strengthen reporting, monitoring and evaluation system								
Developed computerised data collection system	Equipment	2015(Q3) - 2020 (Q2)	346,688	496,919	667,735	861,377	1234642	3,607,360
Develop M&E framework for collecting and reporting data at various levels	Monitoring	Q2 (2015)	23,005	0	0	0	0	23,005
Printing and publications	Printing	2015(Q1) - 2020 (Q4)	7,460	8,020	8,621	9,268	9963	43,333
Technical assistant	TA	2015(Q1) - 2020 (Q4)	14,921	16,040	17,243	18,536	19926	86,667
Develop GIS, Tele com equipment	Equipment	Q2 (2015)	334,159	0	0	0	0	334,159
Establishment of data center	Equipment	2015 (Q2-Q4)	148,515	160,400	0	0	0	308,915
Coordination and revision of implementation plan	Coordination	2015(Q1) - 2020 (Q4)	867	932	1,002	1,077	1,157	5,034
Organize field visits	Monitoring	2015(Q1) - 2020 (Q4)	6,934	7,454	8,013	8,614	9,260	40,274
Sub-total			882,548	689,764	702,613	898,872	1,274,949	4,448,746

Strengthen management capacity for service delivery, IEC activities, procurement and supply, and planning and management								
Salary and allowance	Salary & allow	2015(Q1) - 2020 (Q4)	261,146	280,732	301,787	324,354	348,752	1,516,771
Operational activities	Operational	2015(Q1) - 2020 (Q4)	2,153,954	2,315,500	2,489,162	2,673,256	2,876,540	12,508,413
Procurement of capital items to support management activities	Capital items	2015(Q1) - 2020 (Q4)	850,392	695,644	706,952	213,985	217,295	2,684,267
Total			3,265,492	3,291,876	3,497,901	3,211,595	3,442,587	16,709,451

Total	**4,602,540**	**4,464,187**	**4,538,186**	**4,445,425**	**5,115,650**	**23,165,989**

Key Focus Area 6: Policy and advocacy

Activity	Activity Group	Time Frame	2016 Costs	2017 Costs	2018 Costs	2019 Costs	2020 Costs	Total
Strengthen policy environment for implementation of the NFPP								
Undertake policy analyses to identify barriers and need for Technical Assistance	Policy strengthening	2015(Q1) - 2017 (Q4)	34,508	74,192	79,756	0	0	188,455
Policy Dialogue	Meetings	2015(Q1) - 2020 (Q4)	46,225	49,692	53,419	57,425	61,732	268,493
Sub-total			80,733	123,884	133,174	57,425	61,732	456,948

Advocacy campaign on key FP issues in partnership with key stakeholders								
Develop and revise advocacy tools based on policy analyses and research findings	Advocacy	2015(Q1) - 2017 (Q4)	46,010	49,461	53,170	0	0	148,641
Organize Meetings, workshops, round-tables, seminars	Advocacy	2015(Q1) - 2020 (Q4)	23,113	24,846	26,709	28,713	30,866	134,246
Resource mobilization and allocation activities (meetings and workshops) targeting development partners and government	Advocacy	2015(Q1) - 2020 (Q4)	4,623	4,969	5,342	5,743	6,173	26,849
Sub-total			73,745	79,276	85,222	34,455	37,039	309,737

Support NFPP activities through partnerships and collaborations								
Intersectional activities (policy and advocacy meetings)	Partnerships	2015(Q1) - 2020 (Q4)	11,556	12,423	13,355	14,356	15,433	67,123
Intersectional events (planning workshops, joint review)	Partnerships	2015(Q1) - 2020 (Q4)	11,556	12,423	13,355	14,356	15,433	67,123
Sub-total			23,113	24,846	26,709	28,713	30,866	134,246

Total	**177,590**	**228,005**	**245,105**	**120,593**	**129,637**	**900,931**