Government of the People's Republic of Bangladesh

Operational Plan

Family Planning Field Services Delivery Program (FP-FSDP)

Health, Population and Nutrition Sector Development Program

(HPNSDP)

July 2011- June 2016

Directorate General of Family Planning
Ministry of Health and Family Welfare
July 2011

1.	**Name of the Operational Plan (OP) :**		Family Planning Field Services Delivery Program (FP- FSDP)
2.	**Name of the Sector of the Program**	**:**	Health,Population and Nutrition Sector Development Program (HPNSDP)
3.	**Sponsoring Ministry**	**:**	Ministry of Health and Family Welfare
4.	**Implementing Agency**	**:**	Directorate General of Family Planning.
5.	**Implementation Period**	**:**	
	a) Commencement	**:**	July '2011
	b) Completion	**:**	June '2016.

6. Objectives of OP:

General objectives*:*
To provide Family Planning & MCH-RH services for ensuring the healthy life & family welfare and to facilitate the decline in fertility, maternal, infant and child mortality and morbidity of the people of Bangladesh , specially the women , children and the poor.

Specific objectives:

1. To reduce Total Fertility Rate (TFR).
2. To increase Contraceptive Prevalence Rate (CPR).
3. To reduce discontinuation / drop-out rate of temporary contraceptive methods (Oral pill,Injectables & Condom).
4. To reduce unmet need of contraceptives to eligible couple.
5. To strengthen domiciliary services.
6. To provide adolescent reproductive health care services.
7. To reduce early marriage, adolescent pregnancy and unsafe abortion.
8. To provide health and family planning services through satellite and community clinics.
9. To improve the services status in the hard to reach and low performing areas.
10. To facilitate better MCH-FP services in the urban areas.

Ultimate target of the operational plan is to reach the goal of MDG-4 and 5 and to reach the goal of Vision 2021.

7. Estimated Cost:

7.1. PIP and OP Cost:

(Taka in lakh)

Description	Total	GOB	PA(RPA)	Source of PA
Approved cost of PIP (Development Budget)	2217666.00	860350.00	1357316.00 (869791.00)	JICA, USAID, SIDA, Others
Estimated Cost of the OP	161410.00	34399.00	127011.00 (88836.00)	IDA, KFW, USAID and Others
Cost as % of PIP	7.27%	1.55%	5.72%	

7.2. Estimated Cost of OP (According to Financing Pattern):

(Taka in lakh)

Source	Financing Pattern	2011-12	2012-13	2013-14	2014-16	Total	Source of the Fund
GOB	GOB Taka (ForeignExchange)	5345.92	6320.92	8379.42	14352.74	34399.00	GOB(Dev)
		0.00	0.00	0.00	0.00	0.00	
	CD-VAT	0.00	0.00	0.00	0.00	0.00	
	GOB Others (e.g.JDCF)	0.00	0.00	0.00	0.00	0.00	
	Total GOB=	5345.92	6320.92	8379.42	14352.74	34399.00	
PA	RPA (Through GOB)	16670.00	14791.08	14904.00	42470.92	88836.00	Pool fund
	RPA (Others)	0.00	0.00	0.00	0.00	0.00	
	DPA	4227.08	7100.00	7564.58	19283.34	38175.00	KFW, USAID & others
	Total PA=	20897.08	21891.08	22468.58	61754.26	127011.00	
Grand Total =		**26243.00**	**28212.00**	**30848.00**	**76107.00**	**161410.00**	

8. OP Management Structure and Operational Plan Components: Annexure I

8.1. Line Director : Director (Finance), DGFP.

8.2. Major Components of OP and their Program Manager / Deputy Program Managers:

Major Components	Program Manager (PM)	Deputy Program Manager (DPM)
Intensification of FP-FSD program	PM (Budget & Procurement)	DPM (Budget)
GO-NGO Co-ordination		
Ensuring availability of contraceptives and other supplies		DPM (Procurement &DDO)
Capacity Building	PM (Services & Monitoring)	DPM (Monitoring)
Monitoring& Supervision of the Program		
Family Planning Services in Urban Slums		DPM (Services)
Family Planning Services in Hard-to-Reach Areas		
Services for newly married couples and adolescents		

8.3. Proposed manpower in the development budget: Not applicable.

9. Description:

9.a. Background Information, Current situation and its relevance to National Policies, Sectoral policy, MDG, Vision 2021, Sixth five year plan, MTBF etc. :

9.a.(i) Background Information

Bangladesh is the most densely populated country in the World. It has a population of about 150 million, with a population density of more than 975 persons per square kilometer. One third of the Population is under 15 years of age and 63% are 15-64 years of age.

Family Planning was introduced in the country in early 1953s. Considering the importance of the program, the Government adopted Family Planning as a Government sector program in 1965. The policy to reduce fertility rates has been affirmed by the government of Bangladesh since 1971. Population control program have been identified as the top priority for Government action. In 1976 the govt. declared the rapid growth of population as the country's number one problem and adopted multisectoral Family Planning program. Population Planning became an integrated part of the total development process and was incorporated into five year plans. Policy guidelines and strategies for the population program are formulated by the National population council.

Since 1980 the program focused an integrated health and Family Planning program with a goal to provide an essential package of high qualities, client centered reproductive and child health care, family planning, communicable disease control and limited curative services in a one stop service centre. In 2003 Bangladesh government launched the Health Nutrition Population Sector Program (HNPSP).The government has also adopted Bangladesh population policy with its goal to improve the status of family planning and maternal child health including reproductive health services and to improve the living standard of the people of Bangladesh. Throughout the strategy changes, the family planning program has been functioning effectively and contraceptive usage has become more widespread. So far the success achieved in the family planning program is encouraging. To increase the current level of contraceptive use, the program effort has to be expanded because of rising number of young population along with the improvement of the quality of facilities and services. The male participation is also needed to be increased.

FP-MCH services delivery provision have been intensified and reorganized within broader perspective of Reproductive Health and decided to implement through 3(three) separate Operational Plans as mentioned below :

A. Clinical Contraception Services Delivery Programme (CCSDP) ,

B. Family Planning Field Services Delivery Programme (FP-FSDP) and

C. Maternal, Child and Reproductive Health Services Delivery Programme (MC&RH SDP).

As per above decisions, original operational Plan of FP-FSDP was prepared and got approval from the Steering Committee of HNPSP on 02 June 2004 for the period of 2003-2006 which was subsequently extended up to 2011 and currently as Health Population and Nutrition Sector Development Program (HPNSDP) for 2011-2016.

9.a.(ii). Current Situation:

Women of Bangladesh were having on an average 6.3 children in the period of 1971-1975. It took fifteen years to decline the fertility rate to 4.3 in early 90s. After a long stagnation, the fertility rate decline slightly to 3.0 children per women in 2004 (BDHS). BDHS report showed that the fertility rate decline continued and came down to 2.7 in 2007 and according to UESD 2010 it is 2.5. Accordingly corresponding CPR also increased from 7.7% in 1975 to 44.6% in 1993-1994, 55.8% in 2007 (BDHS). and 61.7 in 2010 (UESD).

Over the past three decade, use of any method of contraceptive by married women has been increased eight folds from 7.7 to 61.7 percent. Trends in the contraceptive method mix show that short term methods, especially oral pill are most popular. Injectables use has been increased from 7% in 2007 (BDHS 2007) to 12.5% in 2010 (UESD 2010). Permanent methods now accounts for 5.2% of all contraceptive use. Overall 61.7% of currently married women in Bangladesh are using a contraceptive method (UESD 2010). The oral pill is mostly used method (29.7%) followed by injectables (12.5%), condom (4.4%). Among long term methods IUD is (0.9%), Implant (1.3%), Female sterilization (4.6%) and male sterilization (0.6%).

Almost 3 in 5 (57%) contraceptive users in Bangladesh stop their method within twelve months of starting. Discontinuation rate is also high and varies by method, ranging from 76% for condom, 53.1% for injectables , 54.2% for oral pills and 56.5% for all methods. Discontinuation rates are highest for condom (76%) and lowest for IUD (33%). Discontinuation rate have been increased by 14% than in 2004 (BDHS 2007).

17.1% of married women have an unmet need for family planning of which 6.6 % for spacing and 10.5 % for limiting births. It was 11% in BDHS 2004. Despite a steady rise in contraceptive use, unwanted pregnancies are almost similar to the findings of BDHS 2004 (14% and 15%).

Overall knowledge of contraceptive methods was already high in 2004. Among ever married women, the most widely known method of family planning are the Oral pill (100%), injectables (99%), female sterilization (95%) and condom (90%) followed by IUD (84%), implants (81%), male sterilization (73%) BDHS 2007.

Reduction in population growth is the most important issue. The only option is to further reduce the fertility rate to replacement level within next five years. Total fertility rate reduced to 1.7 would help the population stabilizing at 210 million. For lowering fertility, the issues to be focused intensively in the next sector program are increasing age at marriage thereby delaying first birth, increasing use of contraceptive for spacing and limiting birth, targeting newly married couples, ensuring availability of FP methods. Another important activity for the next sector program is to strengthen BCC campaign to correct misperception and disbeliefs about FP methods. Approaches with targeting interpersonal communication by field workers on certain issues and community messaging for general information need to be enhanced. The larger GOB field work force of FP of 1980 and 1990s has been gradually reduced due to retirement of field workers and no recruitment for a long time. These newly recruited field workers need to be trained properly to provide goal oriented services effectively and efficiently. Targeting the poor, the young, low performing areas, urban slums and hard to reach areas are the prima-facie for the family planning program. The field services delivery program will focus more on hard to reach area, urban slums and low performing areas. The obstacles for adoption of permanent and long term clinical family planning methods will be tackled through innovative strategies and strengthening BCC campaign, quality services and ensuring easy and affordable access of clients to these services.

During the past years and also currently the major issue faced by the public sector FP Program is the scarcity of trained and skilled service providers at the service delivery points on regular basis, and this is more prominent in the low performing and hard to reach areas. This scarcity of trained and skilled service providers has been consistently hampering the performances of FP-MCH Services. Therefore, a huge shortfall of essential manpower both in service delivery and managerial level exists at the field level. Recently the government has started the recruitment process of manpower of different categories that will enhance the service delivery, monitoring and supervision in field.

Table: Relationship between shares of method-mix CPR with corresponding reducing trends of TFR in Bangladesh during the period of 1975-2010.

Methods/TFR	Sources										
	BFS 1975	**CPS 1983**	**CPS 1985**	**BFS 1989**	**CPS 1991**	**BDHS 1993-1994**	**BDHS 1996-1997**	**BDHS 1999-2000**	**BDHS 2004**	**BDHS 2007**	**UESD 2010**
TFR	6.3			5.1	4.3	3.4	3.3	3.3	3.0	2.7	2.5
CPR with any method	7.7	19.1	25.3	30.8	39.9	44.6	49.2	53.8	58.1	55.8	61.7
Any modern method	5.0	13.8	18.4	23.2	31.2	36.2	41.5	43.4	47.3	47.5	54.1
Pill	2.7	3.3	5.1	9.6	13.9	17.4	20.8	23.0	26.2	28.5	29.7
Injectables	0	0.2	0.5	0.6	2.6	4.5	6.2	7.2	9.7	7.0	12.5
Vaginal method	0	0.3	0.2	0.1	0	0	0	0	0	0	00
Condom	0.7	1.5	1.8	1.8	2.5	3.0	3.9	4.3	4.2	4.5	4.4
IUD	0.5	1.0	1.4	1.4	1.8	2.2	1.8	1.2	0.6	0.9	0.9
Implant	0	0	0	0	0		0.1	0.5	0.8	0.7	1.3
Male sterilization	0.5	1.2	1.5	1.2	1.2	1.1	1.1	0.5	0.6	0.7	0.6
Female sterilization	0.6	6.2	7.9	8.5	9.1	8.1	7.6	6.7	5.2	5.0	4.6
Any Traditional methods	2.7	5.4	6.9	7.6	8.7	8.4	7.7	10.3	10.8	8.3	7.6

Present CPR (in 2010) is 61.7% of which share of modern methods constitute 54.1% and that of non-scientific traditional methods 7.6%. Oral pill is by far the most widely used method (29.7%) followed by injectables (12.5%) , Female sterilization (4.6%) Condom, (4.4%) Implant (1.3%), male sterilization (0.6%) and IUD (0.9%) (UESD-2010).

Short acting methods are contributing 46.6% out of CPR-61.7% where as the long acting & permanent methods contribute only about 7.4% and other traditional methods contributing the rest. So till to date short acting methods e.g Oral pill, Condom, injectables are playing a major role to reduce the TFR. therefore, as a program of multi-sectoral and cafeteria approach. Field services activities should be more emphasized in conjunction with other activities.

To achieve Replacement Level of Fertility, discontinuation /dropout will be reduced through door to door service delivery, supportive supervision and motivational works with information on advantages-disadvantages, side-effect, complications and method of use with feedback. Service delivery will be enhanced to the hard to reach areas, urban slum-areas, hilly and riverine areas as well as low performing areas. Quality services delivery will be ensured to the target groups by segmenting the client on the basis of age, sex, parity, educational status, geographical location, socio-economic status particularly the poor and illiterate clients. Besides these, proper counseling and motivation will be continued to increase the age of marriage and child bearing and also to cover the unmet need's of the couples with GO-NGO collaboration along with strengthening of the activities of different Family Planning committees and regular orientation of service providers.

9.a.(iii). Bangladesh Population Policy:

Each year the population increases by additional two million people. It is likely to increase up to 172 million by the year 2020 and will stabilize at 210 million by the year 2060, even if replacement level of fertility (i.e. up to 2020, the population will stabilize at 250 million after 25 years. Although the population growth rate has slowed down, the population momentum still poses a threat. One important characteristic feature of Bangladesh population is its age structure. Adolescents constitute about 25 percent of the total population. Due to young age structure, the population will increase even after reaching replacement level of fertility, since a relatively larger proportion of girls will enter into child

bearing age group. This will continue until the age structure stabilizes. In this context, government approved the Bangladesh Population Policy,2004 with a view to reduce population growth through earliest possible achievement of NRR=1 i.e. replacement level fertility by 2010 which has now been moved to attain by the year 2016. But it is not yet achieved. So the government has already processed a draft copy of modified Bangladesh Population Policy for approval. In line with this priority vision of GOB, OP of FP-FSDP has been prepared addressing those strategies as adopted in the Bangladesh Population Policy.

9.a.(iv) United Nations Millennium Development Goals (MDGs):

Reproductive Health including Family Planning Services Program has been designed and will be monitored to contribute to the achievement of reproductive health relevant MDGs as adopted in the UN Millennium Declaration of September 2000. These include:

* Improving maternal health by lowering, maternal mortality rate by three fourth compared to 1990 levels by 2015.
* Reducing child mortality rate, by two-thirds compared to 1990 levels by 2015.

Family Planning helps in reducing MMR and IMR and also reducing the morbidity of both mother and children through –i) birth spacing, ii) birth control, iii) avoiding unwanted pregnancy and unsafe abortion, iv) limiting risk of pregnancy and childbirth. family Planning program, through reducing the population growth, contributes to better socioeconomic development and can assist in overall national development program.

9.a(v). Field Services Delivery Program in Relation to HPNSDP Strategy:

Operational Plan of Family Planning Field Services Delivery Program under the umbrella of Reproductive Health: FP-MCH Services Delivery Program of HPNSDP has been formulated in the context of Government commitments to health and population sector targets as outlined in the MOH&FW's for HPNSDP July 2011-June 2016, the United Nations Millennium Development Goals (MDG's), the Program of action of the International Conference on Population and Development (ICPD, Cairo, 1994). In this Operational Plan, RH:FP-MCH Services Program under Population sub-sector has been formulated and will emphasize on reducing high fertility and maternal and child mortality and promoting healthy life style. Through this operational plan special emphasis will be given to reduce early marriage and adolescent pregnancy and to maximize the coverage of unmet needs for family planning methods especially in hard to reach areas, urban slums etc. Bangladesh would achieve the following targets:

1. Reducing infant and under five mortality rates by 65%
2. Reducing the maternal mortality ratio by 75%
3. Eliminate gender disparity in child mortality
4. Ensure access to reproductive health services to all
5. Reduce the proportion of malnourished children aged under five by 50%
6. Reduce population growth through possible achievement of NRR 1.

9.b. Related Strategies in PIP :

The family planning (FP) Program has built a nationwide community based FP service delivery system, relying primarily on non-clinical methods such as oral pills and condoms. The emphasis on short- and long-acting clinical methods, which was relatively high in the 1980s, has faded. The current pattern of temporary contraceptive use, with oral pill users close to 30% of all married couples, is reaching saturation (only two other developing countries exceed this proportion), but other individual methods do not even account for 10% each except injectables. With persistent early marriage and highfertility, many women have completed their childbearing by the mid-late twenties, leaving them with two decades of reproductive life to avoid unwanted pregnancies. However, the proportions of couples relying on long-acting or permanent FP methods (IUD, implants, male or female sterilization) remains very low (less than

15%). Diversified and mass scale FP services will need to be undertaken to bring back the tempo of 1980s and achieve the target of fertility to replacement level.

Promote increased FP usage before and after the first birth: Efforts will be made to increase FP use before and after the first birth to bring fertility down further through mass media communication and BCC activities, creating and implementing collaborative multi-sectoral programs to bring about a change in the long standing culture of social pressure on the newly married couples to quickly demonstrate their capacity to reproduce and providing other counseling service.

Provide better support: The high rate of around 50% discontinuation in the first year by new adopters can be halved to 25%, and contraceptive prevalence could be doubled, with necessary interventions to reduce discontinuation including better counseling on side effects, especially in the first six months of use; recruitment of additional FWAs to bring the ratio of couples to workers back to a manageable level around 500 specially in the low performing areas; providing FP supplies and other support including provision of post abortion care (PAC) services from the static service point (CC); adopting region specific different service approach and emphasizing greater role of NGOs and private sector for servicing the urban slum dwellers and hard to reach areas.

Promote and facilitate use of LAPM: With the clearly demonstrable need for a shift from short-term methods like oral pills, condom & injectables to long acting and permanent methods (LAPM), the public sector will continue to play a major role in ensuring free or low cost provision of quality clinical services. In order that LAPM method plays a greater role in the FP program, security of commodity stocks will be ensured. Simplification of routine procurement procedures, training to upgrade the skills of community level workers, filling vacant positions and new recruitments, will be practiced for ensuring FP services and meeting the unmet needs. Various incentive packages will also be practiced to increase use of LAPM.

Priority interventions to improve Population and FP services will include:

- 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 family planning services closer to the people (at the CC 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 long acting and permanent method contraceptive performance.
- Strengthening FP services especially post-partum and post abortion family planning and demand generation through effective coordination of services with DGHS utilizing appropriate opportunities.

10. Priority activities of the OP:

10.a. Accomplish the components of Field service delivery Program-

Component -1: Intensification of FP-FSD program:

FP-FSD program is being implemented by skill manpower like FWAs, FPIs, FWVs, SACMOs, AUFPO, AFWO, UFPO, MO(FW)s and MO(MCH-FP) at field level through domiciliary visits and at service facilities like Satellite Clinics, Community Clinics, Union Health and Family Welfare Centres (UH&FWCs), Upazilla Health Complexes (UHC) & MCWCs. Field workers are distributing condom & oral pill and giving injectables to the acceptors at domiciliary and community clinic level. They also counsel, motivate and refer eligible couples for taking longer acting FP methods, care of safe motherhood

and child/adolescent health care services to the community clinics and other service centers. FWAs trained on SBA are providing safe delivery and Essential newborn care in the community. They provide health education among the target population on nutrition, food supplementation (Iron & vitamin A capsules) and give advice on personal hygiene. Ante-natal care, safe delivery, post natal care, essential newborn care providing by FWAs/ FWVs at domiciliary level and in service facilities like community & satellite clinics , UH&FWCs, Upazilla health complexes.

The future performance of the FP program will have major impact on the fertility rate and growth rate in next days. It will determine the stabilization of country's population. To achieve replacement level of fertility, use of contraceptive method has to be increased and the discontinuation rate or drop out rate will need to be reduced. Domiciliary services by FWAs will be ensured by increased supervision and monitoring. Hundred percent registrations of eligible couples can be done through door to door visit and thus supply of FP methods to all couples will be ensured. The service providers will be trained up properly and logistic supply to the field will be ensured to provide quality service. Government has taken initiative to fill up the vacant posts in the field which will certainly help to strengthen the FP services, especially in the low performing areas. To cover the hard to reach areas GO-NGO collaboration activities will be explored and the family planning committees at different levels will be activated. According to BDHS 2007, the awareness about oral pill, IUD, condom, injectables and sterilization have been well build up. But still the achievements of long acting methods are not satisfactory. Special BCC campaign i.e. workshop, forum, day observation, advocacy meeting etc. will be undertaken to counter the misperception and incorrect beliefs about long acting methods. The activities are-

1. Domiciliary services by FWAs will be ensured by increased supervision and monitoring.
2. Registrations of eligible couples and supply of FP methods to all couples will be ensured
3. The service providers will be trained up
4. Initiative will be taken to fill up the vacant posts
5. To cover the hard to reach areas GO-NGO collaboration activities will be explored
6. Family planning committees at different levels will be activated
7. Special BCC campaign i.e. workshop, forum, day observation, advocacy meeting etc. will be undertaken

Component -2: GO-NGO Co-ordination:

For field level family planning services multi-sectoral efforts and co-ordination to be reinforced. GO-NGO coordination and cooperation to be strengthen for field level family planning services. There are, throughout Bangladesh, about 400 national and local-level NGOs working in the field of family planning services delivery. NGOs are thus playing an increasing important role in the promotion and service delivery for RH:FP-MCH. This applies to domiciliary as well clinic-based services for family planning e.i. Safe Motherhood, adolescent health, EPI and community mobilization. During HNPSP, it is intended to record and "map" NGO services areas and the scope of MCH-FP services provided by NGO. This will make it possible in the longer-term to have NGOs work in clearly demarcated areas so that overlapping with GOB services may be avoided. GO- NGO Collaborative support will be strengthened NGOs like FPAB, MSCS, BRAC, NSDP funded NGOs UPHCP's for enhancing performance of short acting FP methods. GO-NGO activities will be made more effective through coordination meeting, Supervision, Monitoring, evaluation. Monthly meeting at upazilla level and bimonthly meeting at union level will reveal the scope of feedback, review the performances, and find the weak points and solutions of problems.

Multi-sectoral efforts and co-ordination with NGOs to be strengthened by -

1. GO-NGO co-ordination and co-operation for field level family planning services.
2. Including NGOs family planning services activities in Local Level Planning (LLP) of DGFP.
3. Ensuring coordinated efforts for effective supervision and monitoring by family planning field level managers with NGOs for providing FP services
4. Ensuring reporting and record keeping for family planning services by NGOs field level workers.
5. Monitoring and supervision of RH-MCH-Family Planning related NGO's Program activities by family planning field level managers under DGFP.

Component -3 Ensuring availability of contraceptives and other supplies:
Need assessment and procurement of required commodities, MSR (Cotton, povidone- Iodine solution) will be processed by LD (FP-FSDP) and done by the Logistic & Supply Unit of DGFP. Forecast of contraceptives (oral pill, condom, injectables), MSR and other commodities will be done for ensuring availability of contraceptives. Oral pills, Condoms and Injectables for the projected users of CPR method-mix will be procured through this OP. Projected target, present stock balance, quantity under pipe-line, stock-security etc will be taken into consideration in preparation of procurement plan. The activities will be-

1. Need assessment for required commodities, MSR
2. Procurement of Oral pills, Condoms and Injectables
3. Ensure timely supply of contraceptives to the field

Component -4: Monitoring & Supervision of the Program:
Line Director, FP-FSDP is responsible for monitoring the performances and take follow-up action of GO-NGO family planning activities. Divisional Directors (FP) and Deputy Directors (Family Planning), Asst.-Directors (CC)/ (FP), MO (CC) of Districts are monitoring and supervising the program. Upazila Family Planning Officer (UFPO), MO (MCH-FP)/MO (FW), AUFPO and AFWO(MCH) are also directly involved in management and implementation of the Program. RH-MCH-Family Planning related others NGO's Program activities are being monitored and supervised by family planning field service delivery program under the guidance of the Director General of Family Planning.

The monitoring and evaluation component of a program provide and important data to understand coverage and effectiveness of the program activities. MIS data will be used to monitor the progress in the program output. The M&E system will provide information that will be the base for keeping the project on track in relation to goal and objective. A good and effective MIS has already been established in DGFP. The MIS data will be used to assess the operational aspect of project implementation, particularly the delivery, coverage and use of project resources. Evaluation will be done to assess the effect and impact of the project intervention.

(i) MIS- an internal management information system will be formed to monitor the progress the activities of FSDP operational plan. The data generated from field will be analyzed, processed and synthesized to transform it into information, to provide management with appropriate information at right time for decision making needs. Coverage and effectiveness will also be monitored through national level survey done be NIPORT, BBS.

(ii) Evaluation- Midterm and end evaluation can be done to assess the development needs, enables modification or corrective action to program design, target or time. The external evaluation will be done by NIPORT.

(iii) Operation Research- Operation research and special studies will be under taken to reveal cost effectiveness and efficiency to current strategies and to explore new one. Operation research can be done through any lateral funding available. further technical and financial cooperation with other government and non-government organizations in terms of research, survey, special study etc. will be established.

Activities for Monitoring & Supervision of the Program are -

1. Ensuring proper implementation of field activities.
2. Monitoring the field activities & progress through field visit, MIS report, LMIS report and other reports analysis as needed.
3. Regular monthly/bimonthly meeting with field managers with feedback and directions to the field level offices.
4. Regular field visit from central office
5. Ensure family planning committee meeting
6. Midterm and end evaluation
7. Operation research and special studies

Component- 5: Capacity Building:

Capacity building of the personnel involved in the Field Service Delivery Program implementation to be trained up through human resource development including regular and continued refresher training program. A capacity building strategy will be developed to enhance the capacity of FSDP personal as well as the Field level Service Providers for delivering quality services. Orientation training for Government non-government personal at district and upazila will help in increasing and updating the knowledge of Family Planning services and help them in motivating and coordinating Family Planning services. Orientation in Family Planning program for political leaders, religious leaders, policy maker, field level workers of health, agriculture, livestock, cooperative etc. volunteers and NGOs will be done to increase community involvement in the program. The Family Planning Committee Members will also be oriented about Family Planning Program and assigned for planning, monitoring and reviewing the reports of Family Planning activities. The activities include-

1. A capacity building strategy will be developed to enhance the capacity of FSDP personal as well as the Field Service Providers
2. Orientation training for Government non-government personal at district and upazila
3. Orientation in Family Planning program for political leaders, religious leaders, policy maker, field level workers of health, agriculture, livestock, cooperative etc. volunteers and NGOs
4. The Family Planning Committee Members will also be oriented about Family Planning Program

Component-6: Family Planning Services in Urban Slums:

Prevalence of contraceptives use has been consistently lower among urban slum dwellers than among the rural population which is now a major concern in reducing fertility rate. With gradual urbanization City Corporation and Pourashava area increased with population. Domiciliary and door to door services for distribution of FP commodities and counseling & motivational works for acceptance of contraception are negligible in City Corporation areas. Moreover eligible couples are out of registration because of clinic based service delivery system by NGO instead of domiciliary service. So, a large number of eligible couples remained uncovered/ unprotected for FP services in urban areas especially in slums. Therefore, package program for urban slums is proposed to launch in the next operational plan for starting domiciliary services and registration of eligible couples in urban slums.

Therefore, the following activities will be done for strengthening Family Planning Services in Urban Slums:

1. Registration of eligible couples in urban slums.
2. Domiciliary and door to door services for distribution of FP commodities
3. Counseling & motivational works for FP services
4. To establish referral linkage between urban slum and FP service centers within the City Corporation and Pourashava .
5. Arranging FP Package programs for eligible couples in urban slums.
6. Orientation and coordination meeting chaired by Family Planning Divisional Director will be conducted in respective City Corporation, Municipalities and Pourashava areas in consultation with City Corporation & MoLGRD. Appropriate guidelines with financial support will be provided from KFW and other donors.

   KFW (German) has proposed (annexed) 1.6 million Euro to provide consulting services for "Analytical Review of the Access to Family Planning Services for the urban poor in major cities of Bangladesh and develop proposal for a pilot project and pilot on diversification of service providers/PPP. Previously this component and budget of 1.5 million Euro was included in Policy Reform Operational plan of MoHFW and another 0.1 million Euros is added from the remaining fund of the Procurement Storage and Supply Management Operational Plan of DGFP. Now the total approx Taka 1600 lac (1.6 million Euro) is shifted to Field Services Delivery Program Operational Plan under DGFP.

Component- 7: Family Planning Services in Hard-to-Reach Areas:

Coordination with local NGOs, Family Planning services will be provided in remote hard to reach areas and where community clinic is not available. A package of services will be prepared and provided to the population of hard to reach areas through selected NGOs. Special camp for family planning methods,

MCH-RH services will be organized to increase the performance. Package Program for hard-to-reach areas especially in Sylhet and Chittagong regions has been proposed to launch for domiciliary family planning services. Bangladesh is a land of rivers. There are also hilly, Char and Haor area in different district. Program is hampering in these areas all time as the service providers are not able to reach FP method acceptors for this reasons. So propose a provision of transport hiring in this OP for those areas. Almost Chittagong Division 4665 and in Sylhet Division 6285 unions are affected. Package Program including recruitment of service providers for FP services for hard-to- reach areas especially in Sylhet and Chittagong regions on the basis of financing for performance will be explored. upazilas have hard to reach areas will be gradually brought under the performance based financing activity in a priority for the low performing areas among the hard to reach areas. Priority activities to be as follows:

1. Coordination with local NGOs, Family Planning services will be provided
2. A package of services will be prepared and provided to the population of hard to reach areas through selected NGOs.
3. Special camp for family planning methods, MCH-RH services will be organized to increase the performance
4. Package Program including recruitment of service providers for FP services for hard-to- reach areas especially in Sylhet and Chittagong regions on the basis of financing for performance will be explored. Volunteers/depo holder/community workers will be selected for providing family planning services in hard to reach areas.

Component- 8: Services for newly married couple:

Orientation and motivational program for newly married couple about family planning methods to be done. Hundred percent registrations of newly married couples will be ensured. Advocacy workshops, special campaign, forum, will be organized to motivate newlywed couples for adopting FP methods. One to one communication will also be enforced by ensuring home visit. Activities to be as follows:

1. Up-date listing of newly married couples.
2. Orientation and motivational workshops for newly married couples to adopt FP
3. Ensure family planning methods availability for newly married couples
4. Educational forum for adolescent

10.b. Other important activities to strengthening the FP services:

10.b.1. Awareness development Program:

Knowledge of family planning methods is widespread in Bangladesh. Almost all ever-married and currently married women know of at least one modern method and seven out of every ten women know at least one traditional method. On an average a currently married women has heard of 7.4 types of methods of family planning (BDHS 2007). Opposition to family planning and method related reasons are major reasons for nonuse of methods. 12% of non intenders do not intend to use family planning by themselves, their husband or others or because of religious prohibitions. 8% do not intend to use because of method related reasons, mainly fear of side effects.

In past days, the negative impressions and misinformation about some of the methods have not been properly addressed. BCC campaign in next sector program will be carried out attempting to correct misperception or misbelieves about methods. Fear of displacement of IUD, inability to work after vasectomy, religious prohibition of sterilization etc. will be the main focus of discussion in BCC campaign. Efforts will be given to enroll and retain girls in school to delay early marriage and thus delay early pregnancy. Information and services will be enhanced and will target specifically to adolescent and newly married groups. Targeting information and motivations in the health facilities can be effective for post natal women. As facility deliveries increase, post natal period will be on important time to promote post partum contraception. BCC activities will be more focused on hard to reach, urban slum and low performing areas. Obstacles to the adoption of long acting methods will also be overcome through proper messaging, correct information and motivation of people. The approaches for distributing knowledge among clients will be explored to make BCC activities more effectives. Family Planning workers will be trained to increase their communication skill, so that they will be able to communicate with the clients personally or in groups. Gender perspective will also be taken in to accounts. Intensive public information and motivations through workshop, seminar, day observation will be organized to bring

about changes in attitude and awareness at all level of the community. Orientation of the Family Planning Committee Members will be done, so that the members can direct, guide and monitor the program.

10.b.2. Referral linkage:

A good referral linkage will be established between domiciliary services, community clinics and other health centers for permanent and long acting Family Planning methods, safe mother hood, child/adolescent health care services and management of complication of Family Planning method. The achievement of using permanent and long acting methods involves training of service providers, close supervision and supply of logistics.

10.b.3. Intersectoral Coordination:

In Collaboration with Ministry of Information, Key messages of Family Planning will be disseminated through all possible channels of information. Orientation and motivation will be provided to the field workers of Agriculture, social welfare, cooperative, etc. in collaboration with relevant ministries. LGED is responsive for Urban health project in City in Municipality area. Liaison with LGED, the Family Planning services in Urban slum will be ensure by providing technical and logistics support and supportive supervision.

10.b.4. Reducing Unmet Need:

Women who are currently married and do not want children or want to wait two or more years, but do not use any contraceptives method, are considered to have an unmet need for Family Planning services. Unmet need has increased from 11% in 2004 to 17% in 2007 (BDHS 2007). The increase in unmet need may be due to problems in supply of Family Planning logistics or increase in demand for Family Planning services. There will need to make scope to meet the existing demand for Family Planning and assist couples to achieve their ideal number of children. Services to couples having unmet need for family planning especially longer-acting and permanent methods to be ensured by frequent visits, regular follow-up, ensuring switchover from one method to another and providing full information regarding use and side-effects and promoting more male participation. To have any further decline in TFR for achieving replacement level of fertility, the family planning use patterns would need to be shifted towards more effective longer-lasting and permanent methods rather than short-acting modern and non-scientific traditional methods.

10.b.5. Multi-sectoral efforts for increasing female age at marriage and first birth.

The major impact on fertility reduction will be achieved by increasing age at marriage and by bringing the couples into contraceptive uses those have unmet need for family planning services. These will push up both' age at first birth' and 'CPR', and thereby again trigger a tempo effect to bring fertility down. Bangladesh has great scope to reduce early marriage, where at present 50 percent of teenage girls (15-19 years) are married compared to other developing countries. Moreover, 17 percent couples have an unmet-need for FP services of which 6.6 percent for spacing purposes and 11 percent for limiting their births. They are the potential couples to adopt modern longer-acting FP methods. If all of those women having unmet need to space or limit their births, are to use FP methods, the CPR would rise to 72 percent with major share of modern longer acting and permanent methods which is about to the desired level of CPR for achieving replacement Level. Orientation and co-ordination programs and meetings among other ministries and non-government organizations would be conducted to ensure multi-sectoral efforts to bring a general consensus for increasing female age at marriage and first birth. Collaboration program with education ministries, efforts will be given to enroll and retain girls in school and continue their education at least up to higher secondary level. Appropriate employment of women, specially the young one, can help to delay early pregnancy. Income Generating Activities (IGA) provided by ministry of Women & Children Affairs or NGOs having such program will be arranged for adolescent girls and newly married women.

10.b.6. Up-dating of FWA registers:

FWA register is the key-tool for monitoring the day-to-day works of FWAs and keeping records of use of contraceptives & FP-MCH services, demographic events of households/eligible couples including birth and death. FWA Registers has already been introduced. FWA register and MIS forms are procured

and supplied by MIS Unit, DGFP. Up-date of FWA registers including list of eligible couples, method-wise contraceptive acceptors, list of new-born and deaths, contraceptive drop-outs & switch over from one method to another will be ensured on need based in the next operational plan.

10.b.7. Intensifying organization of satellite clinics:

Conduction of 8 satellite clinics per union per month was organized as per previous schedule. To cover the hard to reach areas extra two or more satellite clinics need to be organized. This will help to provide services to the population of the remote areas from where people are unable to come due to financial or physical inability or time constraints. So two more satellite clinics, along with 8 satellite clinics per union per month will be organized for hard-to-reach-areas. Where community clinics are available will be utilized for this purpose. On an average 36,000 satellite clinics will be conducted per month throughout the country. Through these Satellite Clinics, ANC, PNC, Family Planning Services including follow-up and complication management, EPI, Child Health care, Adolescent Health care etc. will be provided. In addition, Health education/counseling on nutrition, sanitation, birth spacing, delayed marriage, identification of risk pregnancy and motivation for longer and permanent FP methods with appropriate referral, communicable & non-communicable diseases, tree plantation,, use of rain water etc. will be done through the satellite clinics program. The Satellite Clinic is pro poor, designed to reach the poor and stands close to the rural poor with services rendered by local grass-root level FP workers (FPIs & FWAs). FWVs are responsible for delivering FP & MCH services. Considering the increasing rate, carrying cost and conveyance has been increased to 200/- (Two hundred) for FWV instead of Tk.100/- (one hundred) taka alloted for each satellite clinic.

10.b.8. Discontinuation/drop out rate of different contraceptives.

Discontinuation/drop out rate would be reduced by shifting contraceptive use patterns towards more effective longer-acting and permanent methods from short-acting hormonal and traditional methods and by promoting more male participation. This activity to be done by encouraging gradual transition of short acting family planning acceptors to long acting and permanent methods by frequent visits, regular follow-up, by ensuring switchover from one method to another method and providing full information regarding use and side-effects.

10.b.9. Upgrading of UH&FWC:

Government has decided to up-grade all UH&FWCs to make the centers as "User Friendly". Periodically all the UH&FWC's will be Upgraded with essential instruments, equipment, medicine and logistics The unusable, broken furniture will be replaced in UH&FWCs .The UH&FWC remain unprotected at night. Services of security of UH&FWC's will be maintained through contracting private agencies/firm or no-work no-pay basis or appointment of Ansar & VDP members. Fencing of the institutions boundary is necessary for the protection and security. So fencing of the UH&FWCs will be completed in this OP period. The maintenance cost of UH&FWC wil be 500/- (Five hundred) taka instead of previous allocation of taka 400/- due high market price.

10.b.10. Procurement:

Contraceptives have been procured through DPA source like KfW Germany. In HNPSP (2003-11) 32 million cycles of Low dose oral pill and 7.2 million vials Injectables and 7.92 million AD syringe had been purchased from a grant provided by KfW under German Financial Co-operation with Bangladesh BMZ No. 2003 66 237, 2005 70 424. From a total of 5.5 million Euros approx 4.1 million Euros was spent for the aforementioned items. As per the letter of KfW (annexed) the remaining fund of approx 1,466,649 million Euro are proposed to be utilized to procure additional contraceptives during 2011-12. MoHFW also given permission to utilize the money during this sector programme. About 3.8 million vials (approx) of Injectables and 4 million pcs of AD syringe could be purchased from that fund. For purchasing of Contraceptives a total of 130441.00 lakhs taka (GOB-9000.00 lakh and PA- 121441.00 lakh including RPA- 88766.00 lakh and DPA- 32675.00 taka.) has been proposed in this OP.

To ensure record keeping, quality, scrutiny, follow-up, referral, Performance monitoring, registration etc. adequate number of different types of Forms, Cards, and Registers etc will be provided in all service facilities. To facilitate the service delivery and convenience during home visit bags for carrying registers, commodities and umbrella will be procured to provide to the field workers (FWA,FPI,FWV). The

provision for supply of special uniforms for all FWA's and FWV's has been proposed in this OP. Two set of uniform (Apron) will be provided to each of 23500 FWA's and 5674 FWV's and SACMOs.

For smooth implementation of FP-MCH Program and revitalizing FP activities, extensive field visit to supervise and monitor are essential. Therefore to strengthen and facilitate supervision and monitoring of field activities, 2(two) Jeeps for FSDP headquarter, 44 (forty four) Jeeps for Districts level managers, 500 (five hundred) Motor Cycles for Upazila level managers and 2100 (two thousand & one hundred) Bicycles for field supervisors are needed. Total list has been given in annexure VI.

50 Ambulances, 5 Speed-boats and 1 Jeep had been received from closed project (ABN-008). Maintenance costs (converting into CNG, for POL, repair, registration etc) of these existing vehicles & 2(two) vehicles of FP Field Services Delivery Unit will be met up from the available provision in POL, repair & registration etc. as proposed.

10.b.11. Review Meeting:

Meeting at Union and Upazilla level will be ensured to hold regularly in presence of Upazilla Managers. Regular meeting with staff is necessary for effective program implementation and establishing accountability and responsibility of the service providers as well as the community. Elected public representative especially female representative and Chairman of Upazilla & Union family planning committee monitor the program through review meeting. These meetings will ensure the accountability and responsibility of committee members to monitor the program implementation. There will be an entertainment allowance for each meeting.

11. Relevant Result Frame Work (RFW) and OP level Indicator

11.(i) Relevant RFW Indicators :

Indicators	Unit of Measurement	Base line (with Year and Data Source)	Mid- 2016
Total Fertility Rate (TFR)	% of women	2.7 (BDHS 2007)	2.0
Contraceptives Prevalence Rate (CPR)	% of user	55.8% (BDHS 2007) 61.7% (UESD 2010)	72%
Unmet need for family planning	% of user	17.1% (BDHS, 2007)	9.0%
Use of modern contraceptives in low performing areas	% of user	Syl. 35.7%, Ctg. 46.8% (UESD,2010) Syl. 24.7%, Ctg. 38.2% (BDHS 2007)	Syl. & Ctg. 50%
% of facilities without stock-outs of contraceptives at a given point of time	% of service center	58.1%, BHFS 2009	70%

11.(ii) OP level indicators (Output/Process) :

Indicators	Unit of Measurement	Base line (with Year and Data Source)	Projected Target	
			Mid-2014	Mid-2016
Percentage of Injectable acceptors (method mix)	%	7.0% (BDHS 2007)	11%	12%
Percentage of Oral Pill users (method mix)	%	28.5% (BDHS 2007)	33%	34%
Percentage of Condom users (method mix)	%	4.5% (BDHS 2007)	5%	6%
Percentage of Satellite Clinic conducted	%	360,000 / year	1080000	1800000
Lowest performing (FP) districts monitored	Number	Monthly Report	10/month	10/month
% of UFP Committee meeting held	Number	MIS Report	75	125
Discontinuation rates reduced: a. Oral pill b. Injectables c. Condom	%	 54.2 (BDHS 2007) 53.0 (BDHS 2007) 75.7 (BDHS 2007)	 25 25 45	 15 15 30
Unmet need for FP reduced	%	17.1%(BDHS,2007)	12 %	9.0%

11(iii). Source and methodology of data collection to measure/preparation of annual progress report:

The source of information will be collected from Management Information System (MIS) of Directorate General of Family Planning and also from Bangladesh Demographic Health Survey (BDHS), Utilization of Essential Services Delivery (UESD) report published from NIPORT.

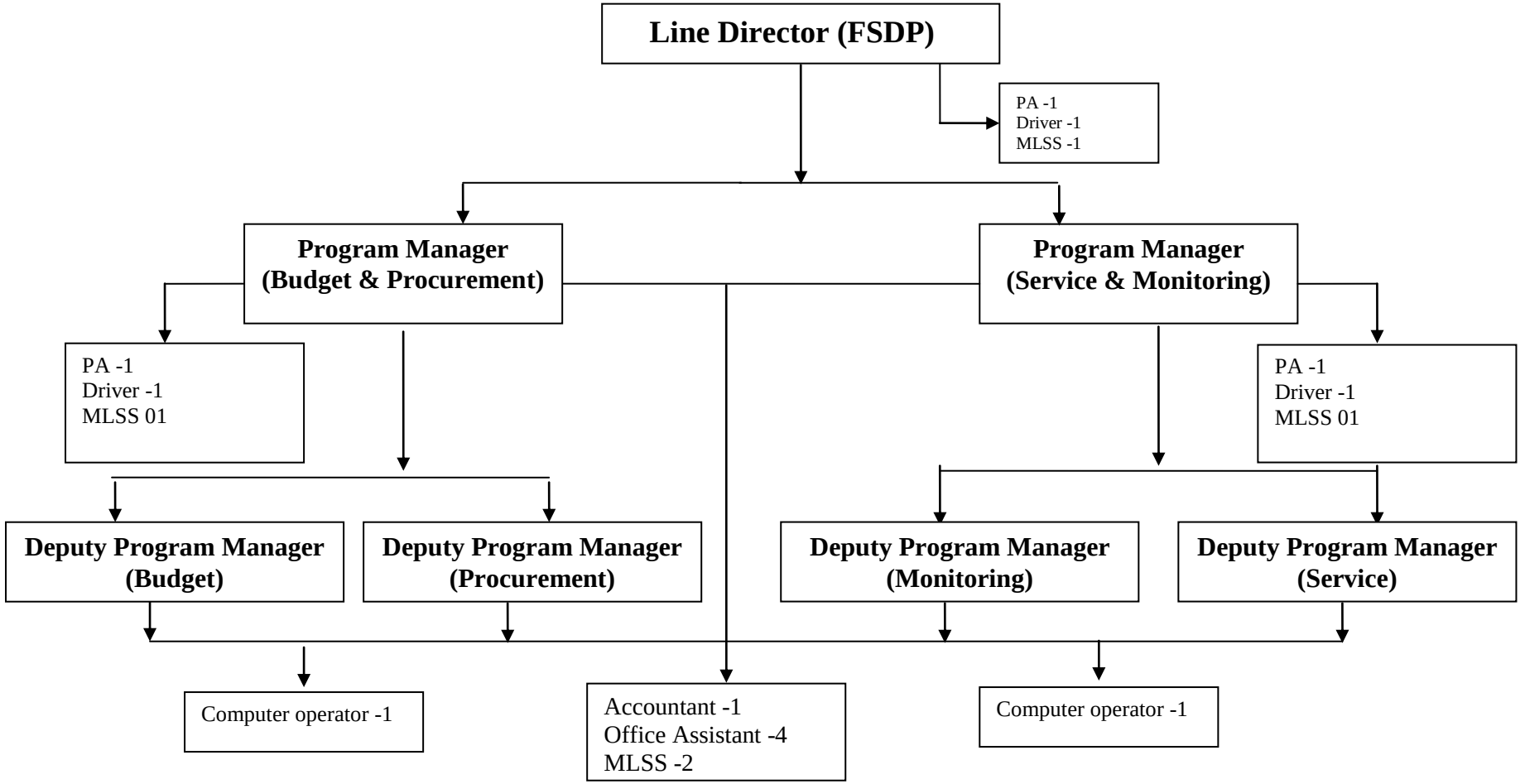
12. Estimated Budget:

12.1. Estimated summary of development budget:

Name of the Components	Economic Code	GOB	Project Aid			Total	% of the total Cost
			RPA				
			Through GOB	Others	DPA		
1	2	3	4	5	6	7	8
a) Revenue Component							
Pay of Officer	4500	0.00	0.00	0.00	0.00	0.00	0
Pay of Staff	4600	0.00	0.00	0.00	0.00	0.00	0
Allowances	4700	0.00	0.00	0.00	0.00	0.00	0
Supplies & Services	4800	28974.80	88766.00	0.00	38175.00	155915.80	96.6
Repair & Maintenance	4900	185.00	0.00	0.00	0.00	185.00	0.11
Sub total=		**29159.80**	**88766.00**	**0.00**	**38175.00**	**156100.80**	96.71
b) Ca;ital Component							
Acquisition of Assets	6800	5239.20	70.00	0.00	0.00	5309.20	3.29
Sub total=		**5239.20**	**70.00**	**0.00**	**0.00**	**5309.20**	**3.29**
Grand Total (a+b)		**34399.00**	**88836.00**	**0.00**	**38175.00**	**161410.00**	**100**

Annexure I

Organogram of Field Services Delivery Program



Annexure

	Organogram is for OP management	(Annexure-I)
15.	Logical Framework of Field Service Delivery Program, DGFP.	(Annexure-II)
16.	Annual procurement Plan for Goods, Services (Separate table for a. Goods, b. Works c. Services	(Annexure-III a.1, Annexure- III a.2)
17.	List of Machinery & Equipments	(Annexure-IV)
18.	List of Furniture-Fixture	(Annexure-V)
19.	List of Vehicles	(Annexure-VI)
20.	List of Training and Estimated cost	(Annexure-VII)
21.	Related Supporting Documents (if any)	
	21.1. List of Equipments, Machineries, Furniture and Other Related Materials Procured under HNPSP (2003-11)	(Annexure-VIII)
	21.2. Implementation mechanism of FP activities at different level	(Annexure-IX)
	21.3. RH: FP-MCH Service delivery structure	(Annexure-X)
	21.4. Letter from KFW to MoHFW	(Annexure-XI)
	21.5. Program management in reverine area	(Annexure-XII)
	21.6. List of workshop/orientation and estimated cost	(Annexure-XIII)
	21.7. Minutes of HPNSDP Steering committee, dated 17.10.2011	(Annexure-XIV)
	21.8. Activities taken by the decision of Steering committee	(Annexure-XV)

22. Name & Designation of officers responsible for the preparation of this OP.

1. Faikuzzaman Chowdhury, Director (Finance) and Line Director (FP-FSDP)
2. Dr. S A Fida Hasan, Deputy Director (Accounts) & Program Manager (FP-FSDP).
3. Dr. Tahmina Hossain Talukder, Deputy Program Manager (FP-FSDP)
4. Dr. Jaynal Haque, Ex-Deputy Program Manager (FP-FSDP)
5. Ms Amita Dey, Deputy Program Manager (FP-FSDP)

The undersigned PM, FSDP of DGFP has prepared this OP with active co-operation and support of DPMs, FSDP under the guidelines of LD-FSDP. It was also enriched with the valuable advice and suggestions of AD, DD (Procurement & Supply) , PM (Planning), LD (L&S), LD (Planning), LD (MIS), LD(IEC), LD(MCH), LD(CC) and Director General of DGFP.

(Dr. S A Fida Hasan)
Program Manager (FP-FSDP).

(Faikuzzaman Chowdhury)
Director (Finance) and Line
Director (FP-FSDP)

23. Recommendation and Signature of the Head of the Implementing Agency with seal and date:

(M M Neazuddin)
Director General
Directorate General of Family Planning
6, Kawran Bazar, Dhaka- 1215.
Date: .....

24. Recommendation and Signature of the Secretary of the Sponsoring Ministry with seal and date: