Operational Plan

1.	**Name of the Operational Plan (OP)**	**:**	Clinical Contraception Services Delivery Programme (CCSDP)
2.	**Name of the Sector Programme**	**:**	Health, Population and Nutrition Sector Development Program (HPNSDP)
3.	**Sponsoring Ministry**	**:**	Ministry of Health and Family Welfare (MOH&FW)
4.	**Implementing Agency**	**:**	Directorate General of Family Planning (DGFP).
5.	**Implementation Period**	**:**	
	(a) Commencement	:	July 2011
	(b) Completion	:	June 2016

6. Objectives of the OP:

General Objective:

The main objective of the OP is to reduce Total fertility Rate (TFR) from 2.5 (2010) to 2.0/women by increasing CPR from 55.8 to 72% with 20% share of LAPM and thereby reducing Maternal Mortality Rate (MMR) by 2016.

Specific Objectives:

i. To promote a more effective method-mix CPR with increased share (20%) / proportion of longer acting and permanent family planning methods by performing VSC 2500000, IUD 2500000 and Implant 3500000 within 2016 which help in:
   a. Attaining replacement level fertility by 2016 at the earliest and its continuation;
   b. Shifting contraceptive use patterns towards more effective longer-acting and permanent methods;

ii. To increase male participation in family planning specially for No-scalpel Vasectomy (NSV);

iii. To provide skill development training of service provider and quality of care of family planning methods and services through Family Planning Clinical Supervision Team.

iv. To reduce unmet need from 17.6 to 09%.

v. To reduce discontinuation rate of FP method from 56% to 20%.

vi. To preventing early marriage, spacing of birth with establishing and popularizing the slogan "দুটি সন্তানের বেশী নয়, একটি হলে ভাল হয়" at the door step level (UH&FWC and community clinic) by the year 2016.

vii. To contribute in decreasing maternal mortality by preventing and spacing birth through LAPM services.

viii. To ensure contraceptive security of LAPM.

7.1. Estimated Cost **(Taka in lakh)**

7.1. PIP and OP cost

Description	Total	GOB	PA	(RPA)	Source of PA
Approved cost of the PIP (Development Budget)	2217666.00	860350.00	1357316.00	(869791.03)	**Pooled fund and other DPs.**
Estimated Cost of the OP (Development budget)	135814.30	68295.35	67518.95	(19005.00)	**Pooled fund, USAID, UNFPA and other DPs**
Cost of OP as % of PIP	**6.12%**	**7.94%**	**4.97%**	**(2.19%)**	

7.2 Estimated Cost (According to Financing Pattern): (Taka in lakh)

Source	Financing Pattern	2011-12	2012-13	2013-14	2014-16	Total	% of total cost	Source of fund
GOB	GOB Taka	18000.00	19000.00	19000.00	12295.35	68295.35	50.29%	GOB (Dev.),
	(Foreign Exchange)	(-)	(-)	(-)	(-)	(-)	(-)	
	CD-VAT							
	GOB Others (e.g. JDCF)							
	Total GOB=	18000.00	19000.00	19000.00	12295.35	68295.35	50.29%	
PA	RPA (Through GOB)	10780.00	5000	2945	280	19005.00	13.99%	Pooled fund
	RPA (Others)	0	0	0	0			
	DPA	850.00	4827.00	9561.50	33275.45	48513.95	35.72%	USAID, UNFPA and other DPs
	Total PA=	11630.00	9827.00	12506.50	33555.45	67518.95	49.71%	
Grand Total (Development)		**29630.00**	**28827.00**	**31506.50**	**45850.80**	**135814.30**	100.00%	

8. OP Management Structure and Operational Plan Components *(Attached management set up at Annexure-1(a) & 1(b)*

8.1. *Line Director: Director (CCSDP)/* Programme Manager, Clinical Services (Ex-PD post of FPCSP) of Directorate General of Family Planning.

8.2. Major OP Components of OP with their Programme Managers/ DPM:

Major Components	Program Managers	Deputy Program Managers
Strengthening LAPM Services:	Program Manager (Q A)	DPM-01 (L&S & Planning)
Ensuring availability of Contraceptives and MSR of LAPM.		
To provide quality of care of family planning LAPM services		DPM-02 (Monitoring & Evaluation)
Finance & Audit		DPM-03 (Finance & Audit)
To provide capacity development	Program Manager (S D)	DPM-04 (Capacity Development & Research)
To provide support to NGOs for LAPM services:		DPM-05 (NGO Support)

8.3. Proposed manpower in the development budget:

(Taka in lakh)

Sl. No.	Name of the Post	Number of post	Pay Scale	Grade	Consolidated Pay per person/ month	Total Month	Total Pay (Taka in Lakh) (Existing personnel)
1	Director /Ex. PD(Clinical Services)/ Program Manager (Clinical Services)	1	25750-33750	4	Deputation from DGFP revenue set-up		248.00
2	Dy. Director (Clinical Services)	1	22250-31250	5			
3	Program Manager/ Sr. Medical Officer	1	22250-31250	5			
4	Asstt. Director (QA)	3	18500-29700	6			
9	Night Guard	1	4100-7740	20			
10	Sweeper	1	4100-7740	20			
	Total CCSDP	8					

* Existing 8 (Eight) person receive pay & allowances as per national pay scale from development budget of this OP

9. Description

9.a) Background information, current situation and its relevance to National Policy, Sectoral Policy, MDG, Vision 2021,Sixth five year plan, MTBF etc.

9.a.i. Background information:

- Before starting of HPSP (July 1998) MCH-based Family Planning services (FP-MCH services) of DGFP were organized through 3 (three) separate services delivery related projects as,
  1. Family Planning Clinical Services Project (FPCSP),
  2. Family Planning Services Delivery Project, and
  3. Strengthening MCH Services Project.

- During HPSP (1998-2003), in the design of Family Planning was National MCH based Family Planning programme and during 2003-2011 of HNPSP the government decided to organize and provide "FP-MCH services" with a robust FP programme of DGFP through three separate services delivery related Operational Plans managed by three Line Directors under Population sub-sector. Accordingly, in HNPSP at first for the period of 2003-2006, then for 2003-10 and subsequently for 2003-2011 FP-MCH services delivery provision had been intensified and reorganized within broader perspective of Reproductive Health to implement through 3(three) separate Operational Plans as mentioned below :
  1) Clinical Contraception Services Delivery Programme (CCSDP),
  2) Family Planning Field Services Delivery Programme, and
  3) Maternal, Child and Reproductive Health (MC&RH) Services Delivery Programme.

9.a.ii. Current Situation:

- Bangladesh was well on the way in achieving replacement level fertility (Net Reproductive Rate NRR=1) by the target year of 2005 as TFR reduced rapidly from 6.3 children per woman in 1975 to 3.3 children per woman in early 1990s (1993-94). Accordingly corresponding CPR also increased from 7.7% in 1975 to 44.6% in 1993-1994. Since then, until 2004, TFR stalled at around 3.3 births per woman in spite of steady rising of CPR by 2% annually (from 44.6% in 1993-1994 to 53.8% in 1999-2000) which was a great concern.
- However, fertility plateau appears to be over, and in 2004 TFR reduced to 3 and in 2007 further reduced to 2.7 births per woman which is 10% fallen since 2004 (TFR 3) and 18% since 1999-2000, a similar rate of decline to those in the 1980s. This plateau of fertility has meant to re-fix the target of attainment of replacement level fertility (NRR=1) by 2015 at the earliest. Bangladesh National Population Policy of 2004 as a priority vision. Overall contraceptive use declined by 2% in the past 3 years from 58% in 2004 to 56% in 2007, but use of modern contraceptive methods remained unchanged. The decade-long decline in use of permanent and longer-term contraceptive methods stabilized in 2007. As in 2004 (7.2%), 7.3% couples are using sterilization, IUD and Implant in 2007 compared with 8.9% in 1999-2000, 10.6% in 1996-1997 and 11.4% in 1993-1994.
- TFR is still half a child above the replacement level, with wide divisional variation. In Khulna, fertility is now below replacement level i.e. TFR-2 with corresponding CPR of 63.1%, and in Rajshahi it is close to replacement level i.e. TFR-2.4 with corresponding CPR of 66%. This suggests that for attaining replacement level of fertility, increase of CPR by 72% is not obligatory, as it was believed earlier.
- CPR is not the only variable for reducing TFR. Fertility reduction is also influenced by some other social factors, like female: (1) age pattern of marriage, (2) education, (3) employment and (4) rate of abortion (specially MR).

- All of the above mentioned factors for reduction of fertility are positively available and trends of reducing fertility are gradually improving in Bangladesh. Therefore, it is very encouraging and suggests that greater efforts to bring national fertility to replacement level, then below, may be successful in the coming years.

9.a.iii. Achievements of LAPM

- ***Fertility Decline****:* Findings of the Table-1 below indicate that the very rapid fertility decline during 1980s and early 1990s was genuinely due to widespread adoption of modern contraceptive methods particularly LAPM services.

- To have any further decline in TFR for achieving replacement level fertility, the family planning use patterns would need to be shifted towards more effective longer-acting and permanent methods rather than short-acting modern and non-scientific traditional methods. But the major impact on fertility reduction could be achieved by raising the age of female at marriage, education and employment. This will push up 'age at first birth' and thereby again trigger a tempo effect to bring fertility down.

- Bangladesh has great scope to reduce early marriage, where at present about 50 percent of teenage girls (15-19 years) are married compared to other developing countries. Moreover, 17.6% couples have unmet-needs for FP services of which 6.7% for spacing purposes and 10.8% for limiting their births. They are the potential couples to adopt longer-acting and permanent 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 with major share of longer-acting and permanent methods as desired for achieving replacement level fertility. Keeping line with the national target of replacement level of fertility of 2.0 per woman, to be achieved by 2016, year-wise projection of CPR with method-mix proportion of all modern contraceptive methods has been set giving emphasis on LAPM services. It is expected that by performing of VSC 400–500 thousand, IUD 400 – 600 thousand and Implant 600-700 thousand per year, could result in a balanced method mix CPR and thereby could help to achieve target of Replacement level TFR of 2.0 per woman by mid 2016. Thereby, year-wise projection of VSC, IUD and Implants along with other FP methods has been made.

Table-1: Achievements of LAPM services, trends of CPR and translating into reduction of TFR.

Year of Survey	1975	1985	1993-94	1996-97	1999-00	2004	2007	2010	2016
CPR	7.7	25.3	44.6	49.2	53.8	58.1	55.8	59.0	72.0
TFR	6.3	5.1	3.4	3.3	3.3	3.0	2.7	2.5	2.0
Total number of VSC performed	21,009 (1972-75)	24,44,422 (1975-85)	17,10,344 (1985-93)	2,40,341 (1993-96)	1,81,681 (1996-99)	3,20,052 (1999-04)	460404 (2004-07)	997002 2007-11	2500000 (2011-16)
Total number of IUD & Implant provided	93,641 (1972-75)	12,01,072 (1975-85)	27,00,021 (1985-93)	7,75,842 (1993-96)	5,46,536 (1996-99)	1087066 (1999-04)	951960 (2004-07)	1899152 (2007-11)	6000000 (2011-16)
Yearly average VSC performed	7,000	2,44,000	2,13,000	80,000	60,000	64,000	153000	249000	500000
Yearly average IUD & Implant provided	31,000	1,20,000	3,37,000	2,58,000	1,82,000	217000	317000	474788	1050000

9.a.iv. Challenges & Future Direction:

- **Urban FP Services Delivery**: The urban local government laws assign direct responsibility for provision of family planning services along with other essential primary health care services to city corporations and municipalities. Whereas the MoH&FW responsible for defining health and population sector policies, strategies,

technical standards and providing health and family planning commodities including contraceptives. Since the launching of the UPHCP, the FP services have been delivered by the city corporations through contracted NGOs only in the project areas, leaving rest of the urban areas uncovered. Moreover, FP-MCH services provided by the contracted NGOs are clinic based and there are no provisions for domiciliary services. DGFP do not have adequate facilities or staff in urban areas especially in city corporation areas. Therefore, domiciliary services for distribution of FP commodities; counseling and motivational works for acceptance/use of contraception are not in place in urban areas specially in slums. Therefore, prevalence of contraceptive use have been consistently lower among urban slum dwellers which are now a major concern in reducing fertility rate. Moreover, eligible couples could not be brought under registration using FWA register in urban areas. More than 25% of total population are residing in City Corporation and Municipal area. Thereby, a large number of eligible couples remained uncovered/ unprotected for FP services in urban areas especially in slums.

- **Shortage of Service Providers and Managers in DGFP:** During the past years and also currently the major issues faced by the public sector FP programme are the scarcity of trained and skilled service providers, and this is more prominent in the low performing and hard-to-reach areas. This scarcity of trained and skilled service providers have been consistently hampering the performances of LAPM services along with other FP-MCH services. FWVs are playing vital role in delivering LAPM/ MCH Services. Furthermore, in every year a proportion of these posts are becoming lie vacant due to their retirement. Similarly nearly 500 posts of doctors are lying vacant, as because some doctors have joined to health cadre through BCS examination and some doctors belonging to health cadre returned back to their original health cadre. Although recruitment of some FWVs are done which will take another 2 years to come in to the job. Many managerial posts at different levels are lying vacant due to retirement. Therefore, a huge shortfall of essential manpower both in service delivery and managerial level are persistently existed. These vacancies of large number of vital posts have resulted in insufficient service delivery, monitoring and supervision in DGFP.

- **Regaining Demographic "Tempo Effect":**
  To have any further decline in TFR for achieving replacement level 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. But the major impact on fertility reduction will be achieved by raising 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, 17.6 percent couples have an unmet-need for FP services of which 6.8 percent for spacing purposes and 10.8 percent for limiting their births.

- **Addressing Population Momentum Effect:**
  The under 15 years population constitutes over 40% of the total population. This has serious implications for the continuing population growth due to " population momentum". The fact is that, due to the young age structure of the population, the population of Bangladesh is expected to increase for some time even after attainment of replacement level fertility. Thus even after attaining replacement level fertility, the number of women entering the reproductive age group (15-49 years) will be higher than the number of women leaving that age group. To minimize the impact of this age-structured mediated "population momentum effect" among other things, the following activities need to be done: (i) more effective enforcement of the minimum legal age at marriage for females,

(ii) further raising the female age at marriage, (iii) delaying the age at first birth, (iv) subsequent increasing the space between desired births, (v) meeting unmet need for contraception, (vi) minimizing unwanted fertility, (vii) reducing desired family size, complemented by more widespread voluntary acceptance of the " One child" family norm". These will be addressed through intensified IEC activities, high quality service delivery and inter sectoral collaboration for promoting female education (including female school/college stipend programme), employment of women. Those need cross-sectoral collaboration and efforts.

- **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 serving the urban slum dwellers and hard to reach areas.

9.a.v. Related policy issue:

- ***National Population Policy:***

The objectives of the Bangladesh Population Policy 2004 are to improve the status of family planning, maternal and child health including reproductive health services and also to improve the living standard of the people of Bangladesh through making a desirable balance between population and development in the context of MDGs and PRSP.

Main objectives are:

- Reduce Total Fertility Rate (TFR) and increase the use of family planning methods among eligible couples by raising awareness;
- Attain NRR equal to one by the year 2010 so as to stabilize population by 2060; and
- Ensure adequate availability and access of RH services, specially family planning services to all including information, counseling and services for adolescents.

Each year 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 fertility (i.e. NRR=1) is achieved by the year 2015. However if it is delayed up to 2020, the population will stabilize at 250 million in 2085 i.e. it would take another additional 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. The young people age 10-24 years constitute about 40 percent of the total population. Due to this higher young age structure; the population will increase even after reaching replacement level fertility, since a relatively larger proportion of girls will enter into child bearing age groups in every years. This will continue until the age structure stabilizes. In this context, government approved the Bangladesh Population Policy with a view to stabilize population growth through earliest possible achievement of NRR=1 i.e. replacement level fertility by 2015.

In line with this priority vision of GoB, OP of CCSDP has been prepared addressing those strategies as adopted in the National Population Policy.

- **Bangladesh National Strategy for Maternal Health-2001:**
  Family Planning helps in reducing MMR and IMR and also improves health and well being of the mothers through (1) birth spacing and limiting, (2) avoiding unsafe abortion and (3) limiting risk of pregnancy and childbirth by preventing pregnancy. Considering these aspects, CCSDP is a priority programme both in terms of demographic impact and health care of mothers and children. VSC if accepted earlier after desired number of children, will help in the development of good health of both the mothers and children. Such is true in case of IUD and Implant acceptors. Adoption of small family norm have direct benefit on health of mothers and children and well-being of the family. Therefore Maternal health Strategy emphasize on increasing CPR with larger proportion of permanent & longer-acting FP methods and reducing discontinuation rates

- **Relationship of HPNSDP with MDG, Sixth Five Year Plan and, Vision 2021:**
  - Since the millennium summit of 2000, Bangladesh, as a signatory of the Summit is pursuing attainment of the millennium development goals by 2015. The proposed plan will cover a period one-year beyond the targeted year of MDG, i.e., 2016, so the aim of HPNSDP is to attain these goals by at least 2016, if not possible by 2015. Bangladesh is on track to achieve the child related MDG 4. Achievement of MDG 5 however, remains a concern. Reduction of maternal mortality ratio to 143 per 100,000 live births will be difficult to reach until some dedicated efforts are taken. To this end this plan proposes for a separate operational plan exclusively for maternal, neonatal and child health, separated from essential service delivery package. Similarly maternal health has been given emphasis to one of the operational plans of DGFP. To achieve MDG 5 it has been suggested that FP department attend to maternal services at the union level exclusively, based on its relative strength at that level. Government has recently recruited and deployed medical officers for union level. It has therefore been suggested that these medical officers are given the responsibility of leading the union level workers towards attainment of MDG 5.

  - **Strategies plan of HPNSDP identifies the following priority action:**

    Priority interventions to improve Population and FP services will include:

    - 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 IEC activities.
    - Using different service delivery approaches for different geographical regions.
    - Ensuring uninterrupted availability of quality FP services closer to the people (at the CC level).
    - Registering eligible couples to establish effective communication and counseling.
    - Providing incentives for long acting contraceptive performance

9.a.vi. Description of OP Components and Implementation Arrangements:

A. Strengthening LAPM Services:

Keeping line with the national vision of achieving replacement level fertility of 2.2 children per woman, to be achieved by 2011-2016 at the earliest, year-wise projection of CPR with method-mix proportion of all modern contraceptive methods have been set giving emphasis on longer-term and permanent contraceptive methods in Table-2. It is

expected that by performing of 400–500 thousand permanent methods, 500 – 600 thousand IUD and 400-600 thousand Implants per year, could result a balanced method mix CPR and thereby could achieve target of TFR 2.0 children per woman by 2011-2016. To achieve the projection total fund required amounting taka 245700.83 lakh. But Govt. allocated to Development budget 135814.30 lakh only. So additional amount of taka 109886.53 lakh and required amount for procurement of (Vaccines & others drugs, Contraceptive, MSR, Equipment, Linen, printing and program related cost (sterilization, IUD and Implant etc.) will be expended from non-development budget. 350000 set of implant and 450000 sets of IUD are procured and 4500.00 lakh taka are disbursed for LAPM activities from non-development for the year 2011-2012 (economic code 4865 and 4876).

Table-2: *To provide 20% LAPM share/ proportion of modern FP methods in CPR by performing following projected LAPM services during the period of 2011-2016:*

Services to be provided	Performances achieved	Projection for LAPM services to be performed					
	2003-2011	2011-12	2012-13	2013-14	2014-15	2015-16	2011-16
Permanent methods (Tubectomy & NSV)	1551377	400000 (200000+ 200000)	450000 (215000+ 235000)	500000 (230000+ 270000)	550000 (250000+ 300000)	600000 280000+ 320000)	2500000
IUD	2042355	450000	475000	500000	525000	550000	2500000
Implant	855582	600000	650000	700000	750000	800000	3500000

- **Providing Financial Support for Permanent and Longer-acting Contraceptive Services through Imprest Mechanism:**

a. Since inception of permanent and longer-acting contraceptive services (such as, Tubectomy, Vasectomy-NSV, IUD and Implant) and Reversal operation of tubectomy and vasectomy (Recanalization of vas and tubes) in National FP programme of Bangladesh; some financial support are being provided and paid instantly on-spot through “Imprest Fund” system for meeting expenses of:

(1) Transportation cost, food charge and wage loss compensation for services recipients;

(2) Fees for surgeons and managers, surgeon’s assistants, service providers, OT in-charge and other supporting staff for performing clinical/ surgical procedures and related activities;

(3) Transportation cost for referrer bringing and accompanying the acceptors to the service centers;

(4) Contingency expenditures related to permanent, IUD and Implant procedures;

(5) Cost for management and treatment of complications/ side-effects/ ailment arise due to use of any modern contraceptive method;

(6) Burial cost for death of any acceptor due to complication/ side-effect of any FP method;

(7) Cost for reversal operation of NSV and tubectomy (Re-anastomosis operation of fallopian-tubes and spermatic-cords) for those acceptors who might have desire for child either due to death of all of their living children or re-marriage after death of the spouse or divorce; and

(8) Operational management cost for organizing special programme (camp) outside static centers for performing permanent and Implant services.

- All expenditures of the above mentioned fees/rate/charges are being paid instantly on-spot using GoB(Dev) & GoB (Non-Development) budget through 'Imprest Fund' system maintained at Upazila/Thana level through treasury function. This financial support is similar to the "Maternal Health Voucher Scheme" under Demand Side Financing. Differences are that all expenditures are being paid instantly on-spot using GoB (Dev.) & GoB (Non-Dev.) budget channeled through treasury mechanism at Upazila/Thana level. In this system a fixed amount of allocated fund is drawn as per fixed ceiling of Imprest fund in advance by the DDOs i.e. Medical Officers (MCH-FP) of the concerned Upazila/Thana through treasury mechanism & other officials of concerned service center. This advance fund are being used as a revolving fund by which reimbursement of fees/ charges/ costs are being paid instantly on-spot to the service recipients, service providers, referrers and associated staff with excess rate (minimum 33%) for hard to reach areas (Annexure XI). Contingency expenditures, special programme conducting cost, burial cost for death due to use of any contraceptive and complication/side effect management costs etc. are also being arranged instantly through this advance fund. Once the amount from the advance is spent, the same amount could be drawn from the local treasury by submitting bills & vouchers against allocated fund. Thereby, a revolving fund is always maintained. It is to be mentioned that once advance is drawn as per fixed ceiling (shown in Table-3 below) from Imprest Fund system, it does not require for adjusting the unspent money (amount equivalent to fixed ceiling) by 30th June of a Fiscal year. It will continue as revolving fund for the next fiscal years. Rates for different types of programme related fees/ costs/ charges are fixed and approved by the MOH&FW. Existing rates were fixed by the MOH&FW vide Memo. No নং-পকউ-১/সা-৫/ইমপ্রেষ্ট-এফ/২০০১/৪১, dated 28/08/2006.

  Currently, living cost as well as cost of food, wages, transport, essential commodities have been increased by about two fold than those were in mid-2006. VSC, IUD and Implants services have to be performed frequently beyond office time. CPR would need to be increased with the 20% share of prevalence of LAPM acceptors in the method-mix CPR as projected. To have a further positive impact in increasing the number of new acceptors for LAPM services, existing rates of different fees/charges need to be reviewed and increased in accordance with the present high rate of daily living costs as well as other expenses and which are much more in hard to reach areas. Therefore, for increasing the existing different fees/rates proposal have been made through this OP as shown in Table-3 below.

  Drop-out rate of IUD and implant is high within one year of insertion. To reduce the drop-out rate of IUD and implant, 3(three) follow-up visits are made (at the end of 1st, 6th and 12th month) after getting insertion. MO(MCH-FP), Upazila Family Planning Officers (UFPO), Asst. UFPOs, Asst. Family Welfare Officers (MCH-FP) and FPIs are playing important role in management, motivation and counseling of the performances of the LAPM services both in the field and service delivery centers. They were getting the fees or honorariums for those activities. Therefore, provision of fees for managerial, motivational and counseling activities have been proposed for MO(MCH-FP), UFPO, AUFPO, AFWO (MCH-FP) and FPI with equivalent post of other organizations has been proposed. For performing reversal operation (recanalization operation) of tubectomy and vasectomy, the fees for reversal operation has been proposed.
  Existing rates of financial support for different fees/costs/ charges for LAPM services are approved by Ministry of Health & Family Welfare vide memo no. স্বাপকম/পক-১/সা-৫-

Imprest-F/০১/১১৮, তারিখ ঃ ২০/০৩/২০১১ইং and proposed rate for the next sector program are given below in table 3:

Table-3 a. For Tubectomy and Vasectomy-NSV (per Acceptor): (Figure in Taka)

Sl No	Components	Existing rates	
		All over the country	For Hard to reach area
1	2	3	4
1.	Transportation cost, Food charge and Wage loss compensation for each acceptor:		
	(i) Wage loss compensation	1400	1800
	(ii) Food charge	300	600
	(iii) Transportation cost	300	600
	Sub-total cost for Acceptor	**2000**	**3000**
2.	Transportation cost for referrer accompanying the client to the service center	300	400
3.	Contingency expenditure for infection prevention & QOC per client (for cleaning & washing of linens/surgical apparels/ instrument, buying kerosene, soap/ cleaning OT, detergent, towel, photocopy etc).	80	100
4.	Surgeon fee	300	400
5	**Supporting Staff fees**		
	i. Surgeon's Assistant (with client's screening & laboratory test)	60	75
	ii. OT in-charge (with monitoring of client during operation procedure)	60	75
	iii. For stretcher carrying with client, autoclaving under supervision of FWV & night duty (for MLSS)	40	50
	iv. Shaving of operative area, cleaning of OT & post operative room, cleaning of instrument (for Aya)	15	25
	v. Sweeper for sweeping	20	25
	vi. Record Keeping & reporting (related staff of FP office)	20	25
	Sub-total (5)	**215**	**275**
6	For Management, Motivation and Counseling works of Managers :		
	(A) Government:		
	(i) Medical Officer (MCH-FP)	95	130
	(ii) For Upazila Family Planning Officers	95	130
	or		
	(iii) 1st class or equivalent officer of other related Govt. Organization (e.g. MCHTI, MFSTC, Model F.P. Clinic and Medical College Hospital), two officer engaged for such work as A.(i). & A.(ii)		
	or		
	(B) Non-Govt.:		
	(iv) 1st class or equivalent officer of other related Non-govt. Organization selected by related NGOs, two officer engaged for such work as A.(i). & A.(ii)		
	(C) For Asst. Upazila Family Planning Officers and other equivalent official of Non-govt. Organization (selected by related NGOs)	55	65
	(D) For Asst. Family Welfare Officer (MCH-FP) and other equivalent official of Non-govt. Organization (selected by related NGOs)	55	65
	(E) For Family Planning Inspector and other equivalent official of Non-govt. Organization (selected by related NGOs)	55	65
	Sub-total for managerial support :	355	455
	Total for Tubectomy and Vasectomy:	**3250**	**4630**

b. For IUD Services (Per acceptor): (Figure in Taka)

Sl No.	Components	Existing rates	
		All over the country	For Hard to reach area
1	Transportation cost for acceptor	150	200
2	Insertion fee for provider	60	80
3	Transportation cost for referrer accompanying the client to the service center	50	65
4	Contingency cost for infection prevention & QOC (buying kerosene, soap, detergent, towel and cleaning of linens, instrument, equipment, cleaning of OT, photocopy etc)	50	65
5	Follow up transport cost for client	240/- for 3 visits (at 1st, 6th & 12th months) @ Tk. 80/- per visit.	390/- for 3 visits (at 1st, 6th & 12th months) @ Tk. 130/- per visit.
	Total for IUD	550	800

(c) For Implant Services (Per acceptor): (Figure in Taka)

Sl. No.	Components	Existing Rate	
		All over the country	For Hard to reach area
1	Transportation cost for acceptor	150	200
2	Insertion fee for provider	60	70
3	Assistant Fee	30	40
4	Transportation cost for referrer accompanying the client to the service center	60	80
5	Contingency cost (both for insertion & removal) for infection prevention & QOC(buying kerosene, soap, towel, cleaning & washing of linens, instrument, equipment, cleaning of OT, photocopy etc.)	50	60
6	Follow up transport cost for client	210/- for 3 visits (at 1st 6th & 12th months) @ Tk. 70/- per visit.	300/- for 3 visits (at 1st 6th & 12th months) @ Tk. 100/- per visit.
7	Record keeping and reporting (related staff of FP office)	20	25
8	Sweeper for sweeping	20	25
	Total for Sub-dermal Implant	600	800

(d) For Recanalization Services (Per Client): (Figure in Taka)

Sl. No.	Components	Existing Rates
1	Food charge, wage loss compensation and transportation cost for client	3000/-
2	Seat rent (for private hospital/clinic)	3000/-
3	Surgeon's fee	6000/-
4	Anesthetist fee	2000/-
5	Surgeon's Assistants fee (Two person)	4000/-
6	OT Charge (for private hospital/clinic)	4000/-
7	Drugs and MSR	4000/-
	Total for recanalization services	26000/-

(e) For Organizing Special VSC Programme (Per programme): (Figure in Taka)

Sl. No.	Components	Existing Rate	
		All over the country	For Hard to reach area
1	Special VSC programme organizing cost	2000/-	3000

(f) Others: (Figure in Taka)

Sl. No.	Components	Existing Rate	
		All over the country	For Hard to reach area
1	Family Planning Acceptors side effect, complication and other related expenditure	Actual expenditure	
2	Burial fee	15000	20000

According to different fees/charges provision for necessary fund has been prepared and proposed through this OP as program related cost under GoB (Dev.)/ GoB (Non-Dev.) budget with different essential expenses, it is expected that service recipients, service providers, supporting staff, field staff, referrer and local level managers will further be encouraged, and FP programme will regain a momentum. Thereby, the acceptance rates of LAPM services will be increased and bring a balance in method-mix of CPR with increased share of prevalence of LAPM users. Thus, this financial support will help in achieving replacement level fertility by 2016.

- In addition to above mentioned fees/charges, costs for following expenditures as mentioned below, will also be provided as before through this system of spot-payment through imprest fund mechanism:

➢ a) **Burial Charges:** Though it is rare, but any acceptor may die at any time due to complications or side-effects from adopting or using any contraceptive method. Therefore, as humanitarian services, there is a provision for instant payment of Tk. 20000/- for meeting expenditure of burial costs for death of any acceptor due

to complications or side-effects of any modern contraceptive method provided from public or GoB approved NGOs services delivery centers. This payment will be made instantly to the spouse or legal successor(s) of the deceased.

b) Treatment and management of Side-effects/Complications: Family Planning services are provided to the healthy and happy eligible couple. Though all the process of providing Family Planning Services has less side effect and rare complication of surgical procedures; so any type of side effect or complication of the FP services should be handled with sophisticated care. Some complication/ side-effects like infection, abscess, hemorrhage/ bleeding, haematoma, PID, perforation of uterus (due to IUD insertion) etc may develop at any time for adopting any contraceptive methods. In this situation, proper treatment and management will be provided on emergency basis as back-up supportive and humanitarian services. During VSC procedure, intestine, urinary bladder, ovary or any other abdominal organs may get unintended injury. These type of unintended injuries need referral and emergency management. Therefore, for treatment & management of any side-effects/ complications for adopting any FP methods or unintended injuries to body organs during any procedures, any amount of money could be spent maintaining all existing financial rules. The main purpose will be to save the life of the ailing clients. All expenditures like purchase of drugs & MSR, costs for pathological/ imaging tests and costs for transport, food, lodging etc will be borne through this programme. All expenditures like transport, food, lodging etc for one relative of the ailing client staying at hospital during treatment period would also be borne. Provision of fund has been kept in this OP for managing complications/ side effects/ailments, if there be any for accepting any modern FP methods.

c) It is expected that with those above-mentioned financial supports, performances of clinical contraceptive services will increase maintaining high quality & high standard of services along with great satisfaction of the service recipients, providers, referrers and other associated managers and staff. Thereby, this system of financial support will facilitate in achieving the government vision of attaining replacement level fertility i.e. NRR=1 by 2016.

d) The Ministry of Finance is fixing Ceiling of Imprest fund, and MoH&FW endorsed it. Existing ceilings of Imprest Fund were fixed vide Finance Ministry's Memo No. অম/অবি(ব্যঃনিঃ-১)অগ্রিম-১/২০০২/২১০ তারিখ ২৮/১১/২০০৭খ্রিঃ, অম/অবি(ব্যঃনিঃ-১)অগ্রিম-১/ ২০০২/২২১ তারিখ ১৭/১২/২০০৭খ্রিঃ and endorsed by MOH&FW vide MOH&FW's memo নং-স্বাপকম/উন্নয়ন-১/সা-৫/ আইএফ/ ২০০১/৫৬ তারিখঃ ১২/১২/২০০৭খ্রিঃঃ ।

e) Existing ceilings of Imprest Fund were fixed based on expenditure incurred from programme related costs for performances of LAPM services performed in 2006-2007. During 2005-2007 there were stock-out of Implant and shortfall of IUD supply. So expenditure and performances of implant and IUD were low or nil. From 2007-2008 and on-wards steady supply of both Implants and IUD have been ensured and performances of permanent methods are increasing rapidly. But after 2008 due to the shortage in supply of IUD and Implant, the performance become decreased. Moreover existing rates of different fees/costs/charges for financial supports have been increased and also proposed to increase as mentioned in above Table-3. If existing rates are increased, consequently amount of expenditure would also be increased to about double than before. On the other hand, a certain amount of ready-cash are always kept as advance to FWVs for providing IUD services through UH&FWCs/RD/Urban Clinic/Union Clinic/Satellite clinics etc. By utilizing this ready-cash, FWVs could pay transportation cost for IUD acceptors and could meet contingency expenditures for IUD procedures instantly. In first week of every month FWVs submit bill & vouchers against incurred expenditures of the previous month and accordingly reimbursed from the Imprest fund. Thus a revolving fund is to be always maintained at all IUD services

delivery centers. Therefore, current rates of Ceiling for Imprest Fund would not be sufficient to meet both the existing and proposed new rates for different fees/charges/costs for instant payment on-spot. Thereby, existing rates of ceilings need to be further reviewed and increased as proposed below:

Upazila/Thana-wise existing and proposed new rates of Ceilings for Imprest Fund

S/L No.	Name of Upazila/Thana	Existing Ceiling (In Tk)	Proposed Ceiling (In Tk.)
1.	Mirpur, Dhaka	1,00,000/-	4,00,000
2.	Tejgaon, Dhaka	1,00,000/-	4,00,000
3.	Panchlaish, Chittagong	40,000/-	1,00,000
4.	Boalia, Rajshahi	40,000/-	1,50,000
5.	All Sadar Upazilla except Khulna, Barishal & Narayanganj	40,000/-	80,000
6.	Khulna Sadar	40,000/-	1,50,000
7.	Other Upazila/ Thana except those of Hilly Districts, Tongi, & Double Moring	30,000/-	80,000
8.	All Upazilas of Hilly Districts	20,000/-	80,000
9.	Tongi, Gazipur	40,000/-	1,50,000
10.	Sadar, Barishal	40,000/-	1,50,000
11.	Narayanganj, Sadar	40,000/-	1,50,000
12.	Double Moring, Chittagong	40,000/-	1,00,000
13.	Director (MFSTC)		1,50,000
14.	Superintendent (MCHTI)		1,50,000

f) DDOs/ Managers/Organization who will be able to spend such expenditures as described above in advance from any sources, will be allowed to do so and such bills/ vouchers could be paid through contingency bills from the treasury against allotted fund. Once advance is drawn as per fixed ceiling from Imprest Fund system, it does not require to adjusting the unspent amount by 30th June of the Fiscal year. It will continue as revolving fund for the next fiscal year.

Budget: Taka 48447.43 lakh under Economic code-4876 has been proposed through this OP for providing all of the above mentioned financial support and expenditures to be paid instantly on-spot through Imprest fund mechanism.

- **Strengthening Service Delivery Provision in Existing Static Centers:**

In addition to expanding new services facilities for rendering LAPM services, all existing static centers will be made more attractive as user's-friendly by improving quality of care, management of services and by improving provider attitude for ensuring increased accessibility and acceptance of LAPM services. VSC and Implant services are being and will be provided on regular basis by fixing at least 2/3 convenient "day" per week in each Upazila through fixed centers i.e. UHCs/MCWC and NGOs clinics. However, IUD services will be provided in all working days of a week. This will ensure in receiving VSC & Implant services by the willing acceptors and help the field workers (FWAs and NGO workers) and other referrers for referring and bringing the willing acceptors to service centers in fixed days, so that there would be no chance of failure in getting the services. It will also ensure about availability of services on a particular day(s) of a week. This system of fixed days need to be well informed within the catch-ment area through field staff as well by local management. It is observed that satisfied LAPM acceptors and other referrer are referring and bringing new acceptors from their community and it is gradually increasing and NSV acceptors are being much more than the tubectomy acceptors which reverses the previous ratio of tubectomy-vasectomy performance. On such regard, satisfied IUD clients may be able to improve the IUD acceptors. This referral system should be encouraged and further encouraged by improving quality care of services. Local level

managers and service providers will evaluate the performances by holding fortnightly/monthly meeting with field staff, NGOs and other stake-holders regularly and develop work plan locally for further improvement of services and performances.

- **Promoting Intra and Post-partum Contraception:**

At present EOC facilities expanded upto upazila level in public and private sector including limited NGO clinics. Through these EOC facilities/clinics, normal and assisted deliveries along with caesarian operation are rendering. Some mothers are being ligated for stopping their further births due to medical reasons or limiting their family size concurrent with their caesarian operation. These mothers are remained unnoticed as acceptors for tubal ligation. Some mothers are willing to adopt contraceptive methods during post-partum period for spacing or limiting their subsequent births. Due to lack of availability of those services in those EOC centers, they could not get the desired FP services. Moreover, it is the best time to counsel and motivate the mothers during antenatal, childbirth and post-partum period including husband and nearest relatives such as mother and father/mother-in-laws, sister-in-laws etc. So service providers and associated staff like SSN, paramedics etc can easily counsel and motivate the mothers having two or more children for adopting tubal ligation in concurrent with caesarian operation or in case of normal assisted delivery just after delivery or within first week of postpartum period. Clinic staff can also motivate mothers for adopting non-hormonal i.e. IUD and progesterone hormonal methods i.e. Implant and Injectable in post-partum period. These methods will not hamper breast-feeding also. Henceforth, necessary initiative will be taken to involve all Govt. and private hospitals, EOC centers both in public and private/NGOs sector for promoting post-partum contraceptive service delivery and will be equipped by providing essential logistics and financial supports. Intensive workshop for DGFP & DGHS staff. stakeholders will be done. Intensive hands on training will be provided for the service providers. Expenditure will be borne in relation to these activities from this OP.

Budget: Expenditure would be incurred from program related (Economic code 4876) cost under this OP.

- **Organizing Special VSC Programme (camp) outside static centers:**

VSC and Implant services are being provided on regular basis by fixing 2/3 convenient “day” per week in each Upazila through fixed centers i.e. UHCs/MCWCs. But due to difficult system of communication, clients cannot always have easy access to regular VSC static centers. Moreover, existing VSC static centers are far away from the client residences willing to adopt VSC services. Therefore, special programme approach is necessary and it has been proved to be very effective/useful provision of service delivery system. Therefore, at least two special programmes per month per Upazila for performing VSC procedures outside existing UHCs, MCWCs and other static VSC centers, will be organized preferably at UH&FWCs and NGO clinics ensuring optimum sterility, quality and standards. IUD and Implant services can also be performed in those special programmes. For selection of special programme sites, priority will be given to the UH&FWCs/ NGO clinics those located at remote/ hard-to-reach areas or far away from the existing fixed facilities. However, regular VSC programmes through existing static centers i.e. UHCs, MCWCs etc will continue as usual course. Special drive through this type of service delivery approach will be undertaken in low-performing and under-served areas. This type of service delivery provision will ensure availability of and increase access to VSC services close to the door-step of the couples and thereby, performances of VSC, Implant and IUD services will increase. This will also enhance in reducing unmet needs of contraception for those couples, who already completed their family or wish to longer spacing for next birth. Provision of Tk. 3000/- for organizing each special programme has been kept in this OP that will be borne from programme related cost.

Budget: Expenditure would be incurred from program related (Economic code 4876) cost.

- **Roving Team (RT) Initiative for Permanent and Implant services:**
  During the past years and also currently the major issues faced by Directorate General of Family Planning is the scarcity of trained and skilled service providers, and this is more prominent in the low performing and hard-to-reach areas. At present about 500 posts of Medical Officers are lying vacant. Recruitment against vacant posts of doctors have been stopped since long, and it is not clear when this recruitment would start.
  Therefore, those vacancies of doctors have consistently hampering the performances of LAPM services and have resulted insufficient service delivery.
  The problem may be solved by the active participation of the doctors working in DGHS and private registered physicians.
  To overcome this acute problem, 'Roving Team' approach has been initiated in collaboration with Marie Stopes Clinic Society (MSCS) Bangladesh financed by Marie Stopes International. Currently 10 VSC &16 IUD Roving Teams are placed in 7 divisions covering about 30 districts based on needs of the regions.

- **To increase male participation, popularizing LAPM services, encouraging satisfied LAPM acceptors, and multi sectoral GO-NGO field worker for motivating, referring and accompanying willing clients:**
  It has been observed that satisfied NSV and Implant acceptors are referring and bringing new acceptors from their community for adopting LAPM services and it is gradually increasing. If these satisfied acceptors are recognized as referral agents, they would feel honour and thereby, further encouraged. For this one-day orientation would be organized on motivation, primary selection and referral system for LAPM services in the respective upazilas with FPIs and FWAs. Orientation of satisfied LAPM acceptors and multi sectoral GO-NGO field worker will be organized at upazila level with the budget from this OP. After the orientation they felt honour that they are recognized as resource of the FP programme. With this feeling, number of new clients for LAPM services will increase and thus help in achieving projection of LAPM services. Transportation fee/cost for referring and accompanying the willing clients to the services delivery centers will be provided to those referrer instantly on the spot as per provision of the approved rate. Upazilla wise 30-35 satisfied NSV client, 30-35 Satisfied IUD clients, 30-35 multisectoral GO-NGO field worker will be oriented as referral agents during 2011-2016 in each upazila. Expenditure for orientation would be made following the provisions of office order of MOH&FW circulated vide স্মারক নং-স্বাপকম/সিসপ্র(স্বাস্থ্য-৪/(IST)/HNPSP/২০০৭/২০৭, তারিখ-২৮/১০/২০০৭খ্রিঃ এবং এতদ্সংক্রান্ত বিষয়ে বিভিন্ন সময়েজারীকৃত সরকারী আদেশ। Expenditure would be incurred from Economic code 4840 & 4842 cost.

  To popularize and publicize LAPM and male participation with increase awareness for benefit of small family size and incentive of LAPM are provided through the program. In addition to advertise and publicize the LAPM activities by IEM unit of the Directorate through electronic and print media the funds has been kept Taka 500.00 lakh/year for this purpose (Economic code 4832 & 4833).

(A) Training (Local):

1) Training for LAPM, RTI/STI and HIV AIDS case management: a) Basic training for doctors ১৮ দিন প্রতি ব্যাচে ৫ জন, b) Basic training for paramedics ১২ দিন প্রতি ব্যাচে ১০ জন, c)Refresher training for doctors ১২ দিন প্রতি ব্যাচে ৬ জন, and d)Refresher training for paramedics ০৬ দিন প্রতি ব্যাচে ১২ জন।

2) Training on Complication management of VSC Procedures (5 days, per batch 5 person):
   Participant : MO (MCH-FP), MO (Clinic), MO (FW) of DGFP, MO of NGO & Other organization. Resource Person : Skilled Personnel of DGFP, DGHS and other organization.
3) Post Pertum Family Planning (Three days training, per batch 6-8 person)
   Participants : MO (MCH-FP), MO (Clinic), MO (FW) of DGFP. Consultant (Gynae obs), MO & Nurses of DGHS, Medical Officer & Paramedics of NGO. Resource Person : Master Trainer of DGFP, DGHS & other institutional skilled Personnel.
4) Training (Foreign): Foreign Training cost for exchange of views with high Performing LAPM countries (one week, per batch 6-8 person):
   Participant: DGFP Technical personnel. Resource Person: Foreign trainer.
5) Observation & Study on update Technology regards LAPM Activities (two weeks, per batch 8-10 person):
   Participant : MO (MCH-FP), MO (Clinic), MO (FW), AD (CC), DPM of DGFP, DPM, PM, Line Director, CCSDP of DGFP. Resource Person : Foreign trainer.
6) **Training on recanalization (three weeks, per batch 6-8 person):**
   Resource Person : Foreign Trainer. Participant : PM. DPM of CCSDP, DD, Training co-ordinator & MO, MFSTC & MCHTI.
7) Training technical aspect of Hysteroscope use in IUD & Laparoscopie Tubectomy (three weeks, per batch **6-8** person)**:**

   Resource Person : Foreign Trainer. Participant : Central level Technical Personnel of CCSDP, DD, ATCO, Medical Officer of MFSTC & MCHTI.

(B) One Day- Seminar/Workshop (Local)**:**

a. Orientation Workshop of Satisfied NSV Clients (138 upazillas)
   Participants **:** 30 to 35 satisfied NSV Clients who refer LAPM clients with FPI (8), FWA (15) and NGO representative (3). ResourcePerson**:**DGFP Personnel, Upazilla Chairman, Deputy Commissioner, Civil Surgeon, District FP Officials, Regional Supervisor (FPCST-QAT) Vice Chairman, UH&FPO, UNO, Upazilla FP Managers and Press.
b. Orientation Workshop of Satisfied IUD Clients (484 upazillas)
   Participants **:** 30 satisfied IUD couple who refer LAPM clients especially IUD clients with FWV(8), FWA(15),Female UP member(3) and NGO representative(3) of each Upazilla. Resource Person: DGFP Personnel, Upazilla Chairman, Deputy Commissioner, Civil Surgeon, District FP Officials, Regional Supervisor(FPCST-QAT), Vice Chairman, UH&FPO, UNO, Female Medical Officer, Upazilla FP Managers and press.
c. Orientation Workshop of service providers for detection of FP projection utilizing client segmentation (485 upazillas, per batch 80-90 person)**:**
   -Participants All FWA, all FPI, all FWV and NGO representative(5)
   -Resource Person**:** DGFP Personnel, District FP Officials, Regional Supervisor (FPCST-QAT), UH&FPO and Upazilla FP Managers.
d. LAPM Orientation Workshop of Gynae & Obs Practitioners (21 workshop, per batch 80-90 person):

   -Participants: Gynae & Obs Practitioners (public, private & NGOs)
   -Resource Person: Principal Medical Colleges & Director Medical College Hospitals & DGFP Personnel.
e. Orientation workshop on LAPM field level service Provider, (485 upazillas, per batch 80-90 person)**:**

Participants : MO (MCH-FP), MO (Clinic), MO (FW) of DGFP. Consultant (Gynae obs), MO & Nurses of DGHS, Medical Officer & Paramedics of NGO. Resource Person : Master Trainer of DGFP, DGHS & other institutional skilled Personnel.

- Providing Reversal Operation of Permanent methods (Recanalization Operation):

In Bangladesh national FP programme, it is mandatory for getting VSC services that willing clients should have at least two living children. But sometimes VSC clients lose their all living children after getting permanent methods (Tubectomy or Vasectomy-NSV). Moreover, sometime acceptors have remarried due to death of her/his spouse or divorced. Those acceptors of permanent methods might have right to desire for child. Although Tubectomy and Vasectomy are permanent methods of contraception, arrangement for reversal (re-canilization) of those procedures are available in Bangladesh. By reversal operation clients may have the opportunity for having children again. Recanalization is a micro-surgery by which specialized surgeons reanastomize the cut ends of fallopian tubes of female and Vas of the male clients. Recanalization services for both male and female are being provided as back-up supportive and humanitarian services free of costs borne from this OP. Costs of recanalization includes travel and food for client and one accompanying person; payment of service charges to the surgeon/surgical assistants/anesthetist; OT charges; Seat rent; cost of drugs and MSR. These recanalization operation were previously performed through six centers namely, Dhaka Medical College Hospital, BIRDEM, ICMH, BSMMU, Barishal Sher-e-Bangla Medical College Hospital and MFSTC. But at present expert surgeons are not always available in these hospitals/clinics. Therefore, in many occasions it needs to organize and manage this operation in private hospital/clinics in consultation with available expert surgeons near to client address. All expenditure for reversal operation for clients of permanent methods are being borne through provision of this OP and expenditure are made locally using budget of programme related cost through imprest mechanism.

Budget: Expenditure would be incurred from program related (Economic code 4876) cost.

- **Expanding service delivery facilities close-to-users by upgrading UH&FWCs as User's Friendly for clinical contraception and Safe Motherhood services delivery:**

At present out of 3725 constructed UH&FWCs there are about 1500 constructed UH&FWCs of all Upazila have been upgraded through equipping, furnishing and minor renovation including provision of skill-mixed manpower in phases to convert these center as **"User's Friendly"** for providing VSC and Implant services along with other safe motherhood services by year 2003-11 and rest 2225 constructed UH&FWCs will be made **"User's Friendly"** providing relevant above support by the year 2011-16 through this OP. For this, required extension/ renovation works with two additional rooms (delivery and recovery rooms with two beds capacity and toilet facilities) in each UH&FWCs have been undertaken by CMMU. For this essential equipment, furniture, MSR have been procured & supplied and necessary renovation has also been arranged by allocating fund to local level managers as mentioned below:

(1) ***Equipment/ Instrument*****:** Autoclave -1, OT Table -1, Oxygen Cylinder -2, Oxygen Therapy set with Flow Meter -1, Ambu-Bag -1, Dressing Drum -2, Instrument Trolley -1, NSV-set -4, Tubectomy-set -6, OT Light -1, four Burner Stove -1 etc.

(2) ***Clinic furniture*:** Iron-cot - 2, Wooden bench with arms -4, and Steel Chair with arms – 10.

(3) ***Linen*:** Mattress – 2, Bed sheet -4, Mosquito nets –2, Pillow with cover –2 and screen for doors and windows -10 sets.

(4) ***Surgical Apparels*:** Required quantity of Blanket, Surgical Apparels like tubectomy/ vasectomy/ Implant sheet, trolley sheet, gown, cap, mask, gloves-sheet, draw sheet etc will be supplied from provision of regular program activities for 20 VSC and 10 Implant procedures per UH&FWC to be upgraded.

(5) ***Minor renovation*:** Netting of door & windows of OT, making provision for running water (hand washing basin/water drum -1, repair/ installation of tube well), repair and installation of electrical appliances, improvement of toilet-facilities etc in each UH&FWCs.

(6) ***Supply and installation of*:** Generator -1, Water filter for safe drinking water - 1, Water motor pump -1, electric appliances (ceiling fan – 2) etc.

With this improved services delivery provision available close to the doorsteps rendered by FP-MCH staff, there will be impact on the reduction of stagnated TFR with increased contribution of long-acting & permanent FP methods in CPR, decreases IMR and MMR. So all UH&FWCs will be upgraded in HPNSDP period.

Expenditure will be incurred from this OP.

- **To provide reward by lottery for permanent method clients:**

CCSDP of DGFP will introduce reward by lottery for permanent method recipients in all divisions twice in a year to popularize the permanent method especially for NSV to rural and urban areas of the country.

B. Ensuring availabilities of LAPM contraceptives & MSR

- Availability and steady supply of essential commodities is a paramount pre-requisite for rendering clinical contraceptive services through out the country. To assure availability and maintaining steady supply, sufficient quantities of essential commodities are being and will be procured through provision of this OP for meeting the requirements of performances of projected VSC, IUD and Implant services. Commitment of Project Aid and long procedure of procurement process hampered contraceptive security. The required quantities of contraceptives are not procured from available project aid. For smooth running of long acting method IUD and Implant and essential drugs and MSR would be procured from GOB Development and Non-Development budget. Requirement list for essential commodities and other logistics support has been prepared based on year-wise projection of VSC, IUD and Implant services to be provided to newly acceptors. Currently, it is observed that among all VSC performances about 60% are NSV, and it is gradually increasing. Thereby, commodities requirement for VSC procedures has been prepared on this recent trend of VSC performances i.e. 60% for NSV and 40% for Tubectomy.

- Total projected number of services, present stock balance, quantity under pipe line, quantity to be replaced for old items and stock-security has been taken into consideration in preparation of need assessment for individual items.

Some essential daily consumable commodities like contraceptives (Implant & IUD), MSR etc could not be procured as per expected schedule and time. So, the proposed quantities and budget for those essential commodities need to be revised based on actual requirement and consumption for the next years. Therefore, previously prepared requirement list of those essential commodities has been revised for the next period of OP with budget estimation. The estimated unit price of Goods are unstable due to fluctuation of money.

This OP will continue upto June 2016. Therefore, 12-18 months buffer-stock for essential commodities has been proposed and would be procured in last year (2015-2016) of HPNSDP, so that programme would not suffer due to any delay for starting a new programme after 2016.

- Preparation of need assessments and determination of specifications for essential commodities are the responsibility of LD (CCSD) through a committee. Logistic & Supply Unit of DGFP will do all offshore procurement. Both LD (CCSD) and Logistic & Supply Unit of DGFP will do national procurement. Storage and distribution of essential commodities to service facilities will be maintained through existing supply system of DGFP as per instruction/ direction of LD (CCSD). Procurement of essential items of LAPM activities would be procured by Director (Logistic & Supply) and Line Director (CCSD). Procurement of office equipment, furniture, stationeries, consumable items etc will be the responsibility of LD (CCSD).

- Local level managers will be allowed to procure some locally available essential & emergency drugs, MSR, commodities for infection prevention procedures, LAPM activities and clinic/ office furniture as per needs and fund will be placed to them. This will help easy availability of emergency and essential drugs, MSR and other commodities as per local needs. This will also save lives & prevent unnecessary wastage due to expiry & non-use.
- During VSC procedures, sometimes emergency conditions like allergic reaction, breathing difficulty, rapid pulse, both hypo & hypertension, acidosis, even shock arises. There may be injury of intestine, urinary bladder, ovary or other abdominal organs during VSC procedures. To combat these type of unwanted emergency medical and surgical situation, some essential drugs and MSR are urgently needed on the spot and to be reserved in OT. Therefore, some emergency drugs like, Inj. Naloxone, Inj. Hydrocortisone, Inj. Aminophylline, Inj. Sodi-bi-carb, Inj. Adrenaline, I/V Saline, Inj. Calcium-gluconate etc. and some MSR like Atraumatic Cat-gut/PGA, Catheter, Ryle's tube etc. are to be bought and stored in OT for saving lives. These drugs are not generally used but it is mandatory that these items be kept in OT for safety of the clients and to combat unwanted emergency. The less it is used, the more is the quality of services provided. As such once the expiry date of these drugs & MSR is over, these items are to be destroyed and none should be liable for this type of expiry. But if possible these emergency drugs and MSR should be utilized in health unit locally.

- The Family Planning acceptors for receiving VSC services usually come to the VSC service center with dirty clothes in Bangladesh, which is a potential danger to maintain asepsis in the OT. To avoid any untoward situation related to aseptic procedure, one Saree or one Lungee are being provided to each Tubectomy and Vasectomy client respectively as surgical apparels. Instead of Saree/ Lungee the VSC clients may be provided during surgical procedure by wearing the sterile client gown. As financial reimbursement of traveling, wages loss, food charge cost become increased, Saree/ Lungee may be dropped gradually. The planning for procurement of saree and lungee are planned in the OP for the year 2011-12. Required quantities of client gown are being and will be procured for the projected number of VSC clients. Local managers or DDOs can procure client gown when needed with prior approval of competent authority.

- **Disbursement for accelerated achievement of result (DAAR):** To provide LAPM services with all activities in two UHCs in five low performing districts with high rate of maternal and child mortality for achieving the Disbursement for accelerated achievement of result (DAAR) indicator. Fund will be disbursed for mapping, payment for volunteers for specific catchments area, orientation for special LAPM crash program, monitoring, supervision, evaluation and report writing.

- Detailed Lists of essential commodities (Contraceptives, Drugs, MSR, Surgical apparels and other commodities) to be procured are given as Annexure-VIII
- Proposed Budget for procurement of different essential commodities are Contraceptives: Total Tk. 51300.03 lakh; Drugs: Total Tk. 4046.76 lakh; MSR: Tk. 14088.24 lakh
- **Printing and Supply of Forms, Cards, Registers etc:**

  Different types of Forms, Cards, Registers, Screening forms, Client's informed consent forms etc for VSC, IUD and Implant services are essential for appropriate registration, record-keeping, scrutiny, proper follow up, programme monitoring, reporting, establishing accountability and quality of care of services provided. Different types of Registers & Forms for keeping records of spot-payment are also essential separately for VSC, IUD & Implant services. Therefore, adequate quantities of different types of printing materials will be printed and distributed keeping in line with projected number of VSC, IUD and Implant services to be performed during HPNSDP period.

  Some items those could not be procured in scheduled FY would be printed in next FY.

  Printing items will be procured both by Logistic & Supply unit of DGFP and LD (CCSDP).

  Budget: Total Tk. 740.54 lakh (under GoB-Dev.) has been proposed for printing of required quantities of printing items.

  Details list of different types of Forms, Cards and Registers with required quantity and budget estimation is attached as Annexure-VIII.

- **Management Costs of H/Q Office:** For meeting expenditure of day to day management costs of H/Q office: (i) office stationeries, computer & other consumable items, postage, copying charges, telephone installation, miscellaneous costs etc; (ii) utility costs (T&T, WASA, electricity, gas etc); (iii) procurement of computers with accessories, office equipment & furniture, electrical equipment etc. on replacement basis when necessary and (iv) repair & maintenance of existing (also those will be procured in upcoming years) office equipment, furniture etc has been proposed in this OP. An Email/Internet connection has been established and LAN system within the office will also be established. One Computer with accessories, one Photocopier and one Multi-media projector will be provided to FWVTI, Dhaka.

  A PABX-system (auto system) was established within the H/Q office for maintaining internal communication with officers and supporting staff including officers & supporting staff of 'Maternal, Child and RH Services Delivery Programme'. One Fax-machine has also been procured and connected to H/Q office. All the expenses were made through the previous OPs.

  At present there are 5 telephone lines for H/Q office of which 2 for LD-CCSDP (one for office & one for residence) and 2 lines for two Programme Managers (for office use) and 1 for FPCST-QAT, Dhaka. Additional 8 new telephone lines are essential as:

  1. Residences Programme Managers - 2,
  2. Residences of Deputy Programme Managers – 4,
  3. Residence for Finance Officer – 1, and
  4. Fax-connection – 1

  To maintain continuous supply of electricity, 4 (four) IPS have been procured and installed in computer room, planning & finance section and another one in conference room.

  Budget: Provision has been kept for central level management costs including 8 regional FPCST-QAT offices and 3 Mohanagar Satellite clinics.

  List of office equipment, instrument, furniture etc to be procured through this OP is attached as Annexure-VIII.

- **Strengthening Service Delivery of Mohanagar Satellite Clinics:** Existing 3 Mohanagar Satellite Clinics (Mirpur, Basabo and Narayanganj) will continue in HPNSDP with all existing staff and facilities. Clinic operational and management costs (utility costs, office stationeries, rental cost, other miscellaneous costs etc) will be borne through this OP. Budget provision for 3 Mohanagar Satellite Clinics will be met from this OP. Budget estimation includes management and maintenance cost of H/Q office.

- **Procurement of New Vehicles and Maintenance of existing vehicles:** Maintenance costs (for POL, repair, registration etc) for existing 17 vehicles (4 Mobile Clinic-cum-Ambulances, 10 vehicles for 10 regional FPCST-QAT, 4 vehicles for H/Q and 1 motor cycle for office messenger) are being and will be met through this OP. Vehicles bearing registration number Dhaka-Metro-Gha-11-0792 was procured about 20 years ago and now it is not economically viable. So, this vehicle needs to be replaced.

  Budget: Meeting maintenance and POL costs has been proposed through this OP. A list of Vehicles is attached in Annexure-VI.

- **Manpower requirement and providing Pay & Allowances:** 8 posts have not been recommended for transferring to revenue set-up. Reason is that, since inception of the project those 8 posts are being filled up by personnel posted from revenue set-up. Therefore, provision of Pay & Allowances for 8 personnel has been proposed through this OP for the FY 2011-2016 under development budget. 8 personnel will be retained upto June 2016 under development budget and will be transfer to revenue budget through the OP. For qualitative and quantitative supervision and monitoring the FPCST-QAT increased from 10-29 and the supporting staff should be provided for smooth running of the team. So 102 personnel will work under FPCST-QAT activities are proposed in development budget of HPNSDP (2011-16) of CCSDP operational plan.

- **Maintenance costs for Electrical Generators:** To maintain continuous supply of electricity during emergency like delivery, VSC procedures or any other emergency procedures, one Electrical Generator has been supplied in all upgraded UH&FWCs .To run these Generators smoothly, fuel and maintenance costs will be borne through this OP of CCSDP.

- **Functional Coordination:** Functional coordination will be established with DGHS for delivering post partum clinical FP services through UHCs, Districts Hospitals, Model FP Clinics attached to Medical College Hospitals and other specialized hospitals.

- **Maintenance costs for office equipment, computers, furniture etc. and procurement of accessories:** To run office equipment, computers, photocopiers, furniture etc smoothly, required repair and maintenance cost would be borne through this OP. Similarly necessary accessories and spare-parts would also be procured through this OP.

C. To provide quality of care Family Planning Services:

- Clinical Contraceptive services under DGFP are guided by defined clinical & management standard protocols like: Contraceptive Manual (জন্মনিয়ন্ত্রণ ম্যানুয়াল), MCWC Operation Manual, UH&FWC Operation Management Manual (ইউনিয়ন স্বাস্থ্য ও পরিবার কল্যান কেন্দ্র পরিচালনা সহায়িকা), বন্ধ্যাকরণ কার্যক্রমে আচরণ পরিবর্তনে যোগাযোগ, etc since long. MCWC Operation Manual has been updated in 2004, and পরিবার **পরিকল্পনা ম্যানুয়াল** (Family Planning Manual) has been revised and updated printed in 2008. Another updating of

the FP manual is under going. Medical Eligibility Criteria for Contraceptive use has been developed in perspective of national FP programme of Bangladesh based on WHO guidelines. This criteria has been included in the FP manual. These will help in proper client screening in reducing drop-outs, side-effects/ complications and unnecessary method-switching. At the same time every effort will be made to increase the accessibility of FP users in facilities by making those more attractive and user-friendly by improving provider attitude and management of FP services through proper counseling and screening.

- Infection prevention is one of the most important components of quality of care. Strict infection prevention procedures are always maintained at optimal level at all service centers of DGFP and NGO clinics for delivering VSC, Implant and IUD services. Universal infection prevention procedures through decontamination and autoclaving are always followed, and no boiling of any item is allowed. All re-useable surgical requisites required for VSC, Implant and IUD procedures are being decontaminated, properly cleaned and followed by autoclaving. As part of maintenance of sterility, disposable & sterile surgical gloves, BP blades and syringes are also being used. Sterile dressing matrixes are also used for post-operative dressing, which are water proof, so that client can take his/her bath as usual. Decontamination by 0.5% chlorine solution is also mandatory for re-useable surgical requisites immediately after use. For autoclaving, one or more autoclave with 4-burner stove and dressing-drum are always available in all VSC and Implant static centers under DGFP. For IUD insertion, one portable mini-autoclave (like EPI sterilizer) with timer and three special compartment racks has been supplied in all services centers upto UH&FWCs/ union level. To assess the status of autoclaving, use of autoclave-test tapes are mandatory. Each center should have minimum 12 Tubectomy-kit sets, 8 NSV-kit sets, 3 IUD insertion kit sets and Implant insertion trocar-canula- 20 sets in useable condition. Once any kit become out of order, new kits should replace those. Cost for purchase of kerosene is being met from budget allocation of programme related costs as contingency expenditure.
- Since long, no antibiotics are using routinely during post-operative or post-procedure period for VSC, IUD and Implant services, as because, of strictly maintaining sterility procedures. This has been established as a routine system for non-medication by antibiotics during post-operative/procedure period in DGFP for clinical contraceptive services delivery. Till now incidences of infection or sepsis during post-operative/procedure period are insignificant. FPCST-QAT supervisors in 10 regions and AD/MO(CC)s in district level are directly involved in assuring and monitoring quality of care and infection prevention procedures. They also monitor morbidity & mortality cases related to all modern contraceptive methods.
- For decontamination procedures: Plastic bucket (20L) – 2 pieces, Plastic Mug (1L) - 1 piece, Plastic Stirrer- 1 piece once in every 2 years, and Utility Gloves- 2 pairs for every year are being managed for all service facilities upto UH&FWCs. Bleaching powder @ 3kg per month per UH&FWCs/union and 6kg for VSC static centers are also being provided. For purchase of those items and bleaching powder fund are being and will be placed to local DDOs i.e. MO (MCH-FP) of all upazilas for local purchase. Storage of bleaching powder is difficult, so chlorine tablet or liquid Chlorine (bleach) can be used for decontamination. Both Chlorine tablet and liquid bleach are more potent, safe, easily storable but slightly expensive. Local level managers can purchase chlorine tablet or liquid bleach instead of bleaching powder if available in local market.
    - **Budget:** For Infection Prevention procedures, Provision for Tk. 508.50 lakh has been proposed through OP.

D. To provide capacity development and research:

➢ Organizing orientation Workshop/ Seminar/ Training :

Orientation Workshop/ seminar/ Training will be organized regularly to build up awareness, Skill, & update knowledge to service provider & community by which LAPM activities / Performance will be increased. Several workshop and training will be organized in upcoming yeas (2011-2016) within the country and abroad. One day Orientation Workshop with satisfied NSV & IUD acceptors is an ongoing program & it will be continued. Orientation workshop & training will held on Post Pertum LAPM for DGFP & DGHS Doctors, Nurses, Paramedics & Field workers. Basic & Refresher training on VSC for doctors & Paramedics for DGFP & NGOs Personnel will be held to develop technical skill & knowledge. Recanalization & Complication management training for doctors & paramedics of DGFP and NGOs, Bottom-up projection making by utilizing client segmentation will be held. To gain update knowledge & skill, strategy implied by high Performing LAMP Countries and exchange of views, Personnel from CCSDP of DGFP will go for foreign training (NSV, IUD, Laparoscopic tubectomy, Hysteroscope, Recanalization Etc). Expenditure for workshop/ seminar/ Training would be made following the provisions of office order of MOH&FW circulated vide স্মারক নং-স্বাপকম/সিসপ্র (স্বাস্থ্য-৪/ (IST)/ HNPSP/২০০৭/২০৭, তারিখ-২৮/১০/২০০৭খ্রিঃ and Govt. order issued or to be issued to followed.

Budget: For cost related with organizing workshop/seminar and training has been proposed through this OP.

➢ Strengthening Regional FPCST-QAT:

In order to reduce VSC related morbidity and to eliminate preventable mortality by providing technical support and conducting on-spot training on various aspects of VSC services; four Sterilization Surveillance Teams (SST) with 4 Foreigner and 4 Local Medical Consultants was formed in 1982. Later on temporary clinical methods such as IUD and Injectables were included in the scope of work of the SST and renamed as Family Planning Clinical Supervision Team (FPCST) to reflect the added dimensions of clinical contraception services. Since 1992 eight regional supervisor (FPCST-QAT) have been working to supervise and monitor the quality care of MCH and Family Planning Clinical Methods, service providing centers, service providers and clients of 3725 UH&FWC, 91 MCWC and 427 UHC. Assistant Director (CC) are working as Regional supervisor (FPCST-QAT) in addition to their duties of respective district. According to the HPNSDP (2011-16) result frame work OP out put indicator (pregnancy registration, ANC, Delivery, PNC, NBC, verification of achieved FP-MCH performance of service center and field workers, follow-up, drop out or discontinuation rate of FP method, LAPM performance at Hard to reach and tribal area, verification of performance achieved by Roving team and NGO service provider) of CCSDP is to collect, cumulate and evaluate. It is very difficult to do the job of all indicators by existing ten regional supervisor FPCST-QAT, as working area of each FPCST-QAT is so large and existing huge no of ELCO (8-11 district/ FPCST-QAT). To achieve all the indicators properly it is very essential to upgrade, strengthen and modification of the FPCST-QAT. The districts of ten region for Regional Supervisor FPCST-QAT are given below:

1. Dhaka :

Existing District	1.Dhaka, 2.Gazipur, 3.Narayangong, 4.Manikjong, 5.Munsijog, 6.Norshindi, 7.Tangail = 7(Seven)
Proposed District:	1.Dhaka, 2.Gazipur, 3.Narayangong, 4.Manikjong, 5.Munsijog, 6.Norshindi, 7.Tangail= 7(Seven)

2. Mymensing:

Existing District: 1.Mymensing, 2.Kishorjong, 3.Netrokona, 4.Jamalpur, 5.Sherpur= 5(Five)

Proposed District: 1.Mymensing, 2.Kishorjong, 3.Netrokona, 4.Jamalpur, 5.Sherpur= 5(Five)

3. Chittagong:

Existing District: 1.Chittagong, 2.Cox,s Bazar, 3.Rangamati, 4.Bandarban, 5.Khagrachori, 6.Feni, 7.Noakhali, 8.Laxmipur 9.Chandpur, 10.Comilla= 10(Ten)

Proposed District: 1.Chittagong, 2.Cox,s Bazar, 3.Rangamati, 4.Bandarban, 5.Khagrachori= 5(Five)

4. Comilla (New):

1.Comilla, 2. Chandpur, 3. Feni, 4. Noakhali, 5. Laxmipur, 6.B-Baria= 6(Six)

5. Sylhet:

Existing District: 1.Sylhet, 2.Sunamjong, 3.Moulovibazar, 4.Hobijong, 5.B-Baria= 5(Five),

Proposed District: 1.Sylhet, 2.Sunamjong, 3.Moulovibazar, 4.Hobijong= 4(Four)

6. Rongpur:

Existing District: 1.Panchoghor, 2.Thakurgoan, 3.Dinajpur, 4.Nilphamary, 5.Lalmonirhat, 6.Rongpur, 7.Kurigram, 8.Gaibanda= 8(eight)

Proposed District: 1.Panchoghor, 2.Thakurgoan, 3.Dinajpur, 4.Nilphamary, 5.Lalmonirhat, 6.Rongpur, 7.Kurigram, 8.Gaibanda= 8(eight)

7. Rajshahi:

Existing District: 1.Nator, 2.Rajshahi, 3.ChapaiNobabjong, 4.Joypurhat, 5.Nowgoan, 6.Bogra, 7.Pabna, 8.Sirajgong= 8(Eight)

Proposed District: 1.Nator, 2.Rajshahi, 3.ChapaiNobabjong, 4.Joypurhat, 5.Nowgoan, 6.Bogra, 7.Pabna, 8.Sirajgong= 8(Eight)

8. Faridpur (New):

1.Faridpur, 2.Gopaljong, 3.Bagerhat, 4.Shariatpur, 5.Madaripur, 6.Rajbari, 7.Kustia= 7(Seven)

9. Jessore:

Existing District: 1.Jessor, 2.Narail, 3.Jenaidah, 4.Chuadanga, 5.Meherpur, 6.Magura, 7.Khulna, 8.Satkhera, 9.Kustia, 10.Bagerhat, 11.Rajbari= 11(Eleven)

Proposed District: 1.Jessor, 2.Jenaidah, 3.Narail, 4.Chuadanga, 5.Magura, 6.Khulna, 7.Satkhera, 8.Meherpur= 8(Eight)

10. Barisal:

Existing District: 1.Barisal, 2.Bhola, 3.Pirojpur, 4.Patuakhali, 5.Jhalokati, 6.Barguna, 7.Madaripur, 8.Shariatpur, 9.Faridpur, 10.Gopalgong= 10(Ten)

Proposed District: 1.Barisal, 2.Bhola, 3.Pirojpur, 4.Patuakhali, 5.Jhalokati, 6.Barguna= 6(Six)

The additional 19 (nineteen) FPCST-QAT Zone will be selected during implementation of the OP

- **Charter of duties of FPCST-QAT:** In HPNSDP the operational plan of CCSDP and MC&RAH are solely accountable and responsible for the improvement of LAPM services and EOC services in rural area up to grass root level respectively. The duties and responsibilities of FPCST-QAT is:
  i. Regional supervisors work under the guidance of Line Director (CCSDP) and report to LD(CCSDP) on administrative and technical matters related to clinical family planning services and also report to Director (MCH-Services) and LD (MC&RAH) on technical matters related to EOC-RH services.

ii. To monitor the outlets of Clinical FP Services along with EOC-RH services of MCWCs and to identify measures for improving and maintaining the quality of clinical contraceptive services at all level and EOC services.
iii. To organize & supervise the work of administrative staff in the regional office and also maintaining office discipline according to GoB rules.
iv. They help the LD (CCSDP) to implement, supervise and monitor the clinical FP services.
v. FPCST-QAT work for improvement of MCH services including EOC at all MCWCs with rural areas and recommend to Director (MCH-Services) and LD (MC&RAH).
vi. FPCST-QAT ensure quality of care, infection prevention (sterility and decontamination procedures), OT management, clinic management etc in services delivery facilities.
vii. FPCST-QAT provide and/or manage Clinical contraceptive services regularly through local level planning where there is no skilled service provider. They are acting as a trainer for NSV, Tubectomy, Implant and IUD for developing skill of the untrained or unskilled service providers within their region.
viii. They maintain close liaisons with ongoing "Strengthening Delivery of LAPM in Bangladesh" programme of Engender Health and Marie Stopes Clinic Society for proper implementation within the region as resource persons and service providers.
ix. FPCST-QAT helps Line Directors (CCSDP/ MC&RAH/FPFSDP) in timely collecting financial Statement of Expenditure (SOE) from the cost-centers.
x. To collect monthly clinic based total performances report on clinical contraceptive services and send it to LD (CCSDP) regularly.
xi. To monitor all clinical contraceptives related morbidity and mortality cases as well as those of safe motherhood services.
xii. To supervise and monitor for result frame work OP output indicator of CCSDP and MC&RAH
xiii. To verify pregnancy registration, ANC, Delivery, PNC and NBC at grass root level.
xiv. To verify the achievement of FP-MCH performance of service center and field workers,
xv. To verify follow-up, drop out or discontinuation rate of FP methods,
xvi. To verity and justify LAPM performance at Hard to reach and tribal areas,
xvii. To verify the performance achieved by Roving team and NGO service provider
xviii. To collect cumulate and evaluate the LAPM and EOC performance
xix. They also provide services as per requirement and as desired by Divisional Directors and Deputy Directors of the respective region and District.

- Operational and office management costs of 10 regional FPCST-QAT offices are being borne through this OP. DSA cost of regional supervisors and drivers would be borne from the budget provision of UNFPA's 8th Country Programme "Strengthening Delivery of RH Services". DSA for FPCST-QAT supervisors would be @ of Tk. 2000.00 and Tk. 1000.00 per night-hault and per day without night-hault respectively for maximum 10 and 12 visits respectively per month with effect from July 2011. Similarly DSA for field trips of FPCST-QAT Drivers would be @ of Tk. 500.00 and Tk. 250.00 per night-hault and day without night-hault respectively for maximum 10 and 12 trips per month with effect from July 2011. Budget estimation includes management cost of H/Q office. Computer with accessories and one photocopier for all FPCST-QAT offices should be provided for local purchase.
  Budget: DSA cost of FPCST-QAT has been proposed under UNFPA funding through this OP.

- **Introducing new variety of Sub-dermal Implant in national FP programme:**

Norplant a six-rod implant device is being used in national Family Planning programme of Bangladesh since 1995 followed by piloting and acceptability trial. Bayer Schering Pharma, Germany the only manufacturer of 'Norplant' has decided to phase out from existing six-rod device 'Norplant' to two-rod device 'Jadelle' Currently, 3(three) other devices of implant are available which are:

(i) Implanon, a single-rod device implant available in preloaded condition in a disposable sterile applicator. It contains 68mg Etonogestrel (active metabolite of Desogestrel), a synthetic progestogen hormone and the rod is 40mm in length and 2mm in diameter. It is effective for three years and manufactured by Schering Plough/Organon Oss, the Netherlands. No surgical incision and trocar-canula are required for insertion.

(ii) Jadelle, two-rod device implant containing Levonorgestrel hormone manufactured by Bayer Schering AG, Germany. Each rod is 43 mm in length, 2.5 mm in diameter and contains 75 mg Levonorgestrel hormone as active ingredient. It is effective for five years. 'Jadelle' requires minor surgical incision for implantation and therefore, Trocar & Canula are required for implantation like Norplant.

(iii) Sino Implant-II, a two rod implant device.

(iv) Sayana-a subcutaneous injectable device.

For introducing any new device of contraceptives in national FP programme, it requires acceptability/clinical trial in national perspective and also require approval from the National Technical Committee (NTC).The implant device Implanon is in the FP program and the trial of Jadelle is completed but the trial of Sino implant-II is on process. After completion of trial and approval of NTC the implant will be introduced in FP program. The new variety of contraceptive injectable SAYANA will be introduce in the program after completion of legal procedure of trial and approval.

E. To provide support to NGOs for LAPM services:

- **Multi-Sectoral Approach:**

As population problem is first priority national problem in the country, only the ministry of health and family welfare will not able to mitigate the problem. Collaborative support of all other ministry especially LGRDC, Law, Education, Agriculture, Women & Social Welfare, Ministry of Youth, Ministry of Home etc. should involve to solve the population problem. Previously the member of Ansar, VDP and social welfare play pivotal role to motivate and bring the LAPM clients. So orientation program of LAPM is necessary to arrange in all upazillas with greater involvement of public representatives and multi-sectoral personnel

- ***Provide support to NGO's for LAPM Services :-***

  - Bangladesh Association for Voluntary Sterilization (BAVS) is a national NGO being administered by the MOH&FW. BAVS is providing LAPM services of family planning clinical services since 1975. BAVS was giving support to Directorate General of Family Planning by providing LAPM Services through 18 clinics in different districts and thus providing share of LAPM in CPR.
  - The fund is disbursed as per self-containing programme proposal submitted by BAVS to DGFP & DGFP forwarded it to MOH&FW for approval. The salaries and other allowances will be as per circular of MoF for the consolidated pay and allowances from development budget as vide memo no. MoF/FD/Budget-11/Misc-52/2003/(part-2)/35, dated: 26/01/2010. More over BAVS's role to provide LAPM will be reviewed. BAVS will generate their own fund gradually and will be sustainable. BAVS services will be made cost-effective in comparison to the GOB services.

- ***Collaboration with NGOs for providing FP-MCH services in Char and Costal areas:***

  i. DFID and USAID supported NGOs are working in char, hard to reach, coastal, hilly and reverine areas to promote and popularize LAPM services.

  ii. GO-NGO collaboration will made through the decision of PIP of HPNSDP are given below:

  a For CCSDP of HPNSDP for 2011-16 Tk. 2100.00 lac provided to NGO for LAPM Services. Seven lac VSC client can get services by the allotted budget of the period by govt. service provider. It will be cost effective and cost benefit by utilizing total amount of budget by outsourcing to NGO with proper establishment to provide LAPM Services. Outsourcing the services for LAPM services as part of PPP or GO-NGO collaboration in hard to reach and low performing areas

  b NGOs, both national and international, will be selected on the GOB existing financial and procurement rules and regulations. National and locally acting NGOs with experience of similar works will be given priority. Support for service delivery will be considered under this collaboration. However, BAVS will continue to deliver LAPM services as a government administered NGO until further decision of GOB. The allocated budget of CCSDP of HPNSDP for period 2011-16 of Taka 2100.00 lakh will be expended for BAVS and other NGOs.

- **Collaborative Support:**

Mohammadpur Fertility Services & Training Center (MFSTC), FWVTI and MCHTI, Azimpur work in close collaboration with LD (CCSD) for providing services and training on clinical contraception. Collaborative support are being maintained and strengthened with NGOs like Marie Stopes Clinic Society, BAVS, FPAB, Lifebuoy Friendship, UPHCP's NGOs, USAID funded SSFP's NGOs, and other private sector clinics/hospitals for enhancing performances of LAPM services. Other interested and competent NGOs may be involved in programme implementation of CCSDP. Technical and collaborative supports will be taken from Engender Health and UNFPA. Collaborative support will also be taken from CIDA, WHO, DfID, KfW involved in programme implementation of CCSDP. Coordination with DGHS will be maintained for providing clinical contraception services through UHCs, District and Specialized hospitals and EOC-centers.

F. **Support from UNFPA Country Programme**: Under the UNFPA country programme, following support will be provided for strengthening clinical contraception services delivery programme:

a. Human resource development: skill based basic and refresher trainings on NSV, Tubectomy, Implant and IUD services including infection prevention procedures for service providers and other trainings;
b. Logistic support by supplying Contraceptives, NSV-kits and MSR;
c. Field/ clinic staff orientation and organizing monitoring meeting;
d. Strengthening 10 FPCST-QAT Regional Supervisors Office and proposed additional 29 FPCST-QAT (3 HQ, 7 Divisional, 19 Regional), providing DSA of supervisors & drivers for field visits/trip and providing other technical logistic support;

9.b. Related HPNSDP Strategies:

9.b.i. The HPNSDP sets out the sector's strategic priorities and explains how these will be addressed to a certain extent, taking into account the strengths, lessons learned and challenges of implementing the last two sector programs, the HPSP and HNPSP.

Sector specific strategies HPNSDP include:

Streamline, expand the access and quality of MNCH and family planning services, in particular supervised deliveries and family planning methods (MDG 4 and MDG 5).

Revitalize various family planning interventions to attain replacement levels.
Improve and strengthen nutritional services by mainstreaming nutrition within the regular DGHS and DGFP services (MDG 1).
Strengthen the various support systems by increasing the health and family planning workforce at Upazila and CC levels, including enhanced focus on planning of OPs, MIS and M&E functions.
Strengthen contraceptive security and additional staff to improve procurement and distribution.
Increase coverage and quality of services by strengthening coordination with other intra and inter-sectoral and private sector service providers.
Pursue priority institutional and policy reforms, such as decentralization and LLP, incentives for service providers in hard to reach areas, PPP, single annual work plan, etc.

9.b.ii. Key Strategies for reducing TFR to replacement level by 2016 will be:

A. Strategies:

- Shifting contraceptive use patterns towards more effective longer-acting and permanent methods from short-term hormonal and traditional methods; and promoting increased male participation specially for No-scalpel Vasectomy (NSV) with 20% share of LAPM in CPR;
- Multi-sectoral efforts for raising female age at marriage and first birth through promoting female education (including female school/college stipend programme) and employment, and more effective enforcement of the legal age of marriage;
- Intensifying Public information and motivation campaigns to bring about overall changes in attitude and awareness creation among all stake-holders (beneficiaries, service providers, community people etc.) campaign on: enhancing longer acting and permanent methods, delayed marriage, popularizing preferring one child with maximum-two-child family norm, minimizing dropout & unwanted fertility, encourage male involvement in NSV, availability of FP services, female education etc.
- Reinvigorating domiciliary visit specially in hard-to-reach, far-flung, low-performing areas by well informed field staff i.e. FWAs, NGO field workers/depot holders etc. who can effectively counsel couples to maximize continuation of temporary FP methods, minimize unnecessary method switching; motivating, selecting and bringing clients to nearby service centers for adopting permanent & longer-acting FP methods;
- Sustaining quality of care of service delivery center, FP clients and service providers by regular supervision and monitoring through FPCST-QAT team.
- Establishing strong coordination with MoLG&RDC especially with city corporations and municipalities for starting domiciliary services and registration of eligible couples especially in urban slums, thickly populated peri-urban & industrial areas through NGOs.
- Introducing new variety of medically safe & easily applicable hormonal and non-hormonal longer-acting contraceptives methods in national FP programme for meeting wide range of choices and minimizing method-switching, side-effects/complications and drop-outs;
- Bringing couples having unmet need for FP (17.6% of which 6.8% for spacing and 10.8% for limiting births) into FP methods use particularly for longer-acting and permanent methods;
- Expanding new service delivery facilities close to door-step of the users and organizing special programs on clinical contraception, and converting all facilities more attractive and user's friendly by improving the management of services and by improving provider attitude;

- Ensuring availability and steady supply of Contraceptives and other essential commodities required for procedures/operation of LAPM services up to service delivery centers by contraceptive security;
- Developing skill of the service providers through skill-based training and improving appropriate and adequate counseling, screening, follow-up, side-effects management and treatment of complications and ensuring availability of the skilled service providers through local level planning within the district/region.
- Deployment of skilled doctors and paramedics through 'Roving Team initiative' for performing Tubectomy, Vasectomy (NSV) and Implant in upazilas where there are no trained doctor or post of doctors are lying vacant and remote, hard-to-reach areas in collaboration with NGOs.
- Engaging local paid volunteer in hard to reach areas (chor, haor-baor,hilly and coastal), slums of city corporation and thickly populated industrial area and areas with scattered house-hold for 50-70 house-holds for FP commodities supply and continuation of use of the commodities with financial incentive for each LAPM services.
- LAPM strategies made to improve LAPM activities in 56th and 57th NTC meeting vide memo no. DGFP/MCH-S/NTC-4/138/95(Part-4)/499 and 74, date: 17/05/2010 & 26/01/2011 respectively in which the following decisions were taken:
  a) Tubectomy or Vasectomy can be done if the client has two living children and the age of the youngest child is at least one year.
  b) Tubectomy can be done during cesarean section delivery of the second child for clients requesting such service;
  c) Tubectomy or Vasectomy can be done in a couple of two children if both husband and wife jointly give consent after knowing and understanding the implications of permanent method.
  d) Acceptance of Implant as long acting family planning method by the newly married women and married women with no child is allowed.

B. Implementation responsibilities of these strategies are not only mandate for DGFP or MOH&FW, but also require multi-sectoral efforts and involvement (like female education and employment, urban FP-MCH services etc). Under population sub-sector of HPNSDP these strategies will be addressed and materialized through three direct FP-MCH services delivery related Operational Plans of DGFP i.e. OP's of Clinical Contraception, FP Field Services and MC&RAH Services Delivery Programmes. Some important cross-cutting issues those play pivotal role i.e. public information, motivation and counseling campaigns; human resource development; MIS; procurement & supply system etc are also required to be reinvigorated for accelerating the FP-MCH services delivery through related OPs of DGFP. Therefore, three services delivery OPs will need to be supplemented and supported by other OPs of DGFP.

Operational Plan of Clinical Contraception Services Delivery has been formulated by reflecting the objectives, targets and strategies as outlined in Strategic document of HPNSDP; Sixth Five Year Plan, Bangladesh Population Policy-2004 and Bangladesh National Strategy for Maternal Health. It also reflected the Government commitments, vision and targets to health and population sectors as set out in PRS, MDGs and vision 2021.

10. Priority activities of the OP:

- Ensuring availability of LAPM services close-to users
- Reinvigorating domiciliary visit specially in hard-to-reach, far-flung, low-performing areas slums of urban areas by well informed field staff i.e. FWAs
- Ensure availability of contraceptives (implants and IUD) and other essential commodities like Drugs, MSR, Instrument, Equipment, Surgical apparels, printing

materials etc at all service delivery centers, so that steady supply are always maintained whenever and wherever needed.

- Shifting contraceptive use patterns towards more effective longer-acting and permanent methods from short-term hormonal and traditional methods;
- Promoting increased male participation specially for No-scalpel Vasectomy (NSV) with 20% share of LAPM in CPR
- Sustaining quality of care of service delivery center, FP clients and service providers by regular supervision and monitoring through FPCST-QAT team.
- Increasing male participation and popularize LAPM services orientation program of satisfied Long Acting and Permanent Method (LAPM) clients are prepared.
- Reducing drop out of long acting method; monthly, quarterly, half yearly and yearly follow up of the LAPM clients has been introduced in the program.
- Introduce reward through lottery among the permanent methods recipients at divisional level twice in a year.
- Delivery of LAPM services to ELCOs, upazila wise children based client segmentation done and projection for contraceptive distribution and service delivery policy prepared by the grass root level service provider for achieving projected CPR & TFR.
- Simplification of routine procurement procedures, training for upgrading the skills of community level workers, filling vacant positions and new recruitments, will be practiced for ensuring FP services and meeting the unmet needs.
- Quality of care of LAPM services of FP clients, service provider and service centers provided by FPCST-QAT team.
- FPCST-QAT Supervise, monitor the morbidity and mortality of LAPM services and ensure the quality of care. This service will cover all UH&FWC, UHC, MCWC & other GO & NGO service centers providing LAMP & EOC services. They also monitor the dropout and discontinuation of these services.
- Skill based training to the VSC, IUD and Implant service provider's through different training centers to improve their skill.
- 21 days basic 14 days refresher for doctors VSC training; 15 days basic and 7 days refresher training of FWV/SACMO/Staff nurse/Paramedics and 2 days Implant training of the doctors to ensure quality services all over the country.
- Outsourcing the services for LAPM services as part of PPP or GO-NGO collaboration in hard to reach and low performing areas
- BAVS's role to provide LAPM will be reviewed. BAVS will generate their own fund gradually and will be sustainable. BAVS services will be made cost-effective compared to the GOB services.

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

11.1. Relevant RFW Indicators

Indicators(s)	Unit of Measurement	Base line (with Year and Data Source)	Projected Target (Mid-2016)
(1)	(2)	(3)	(4)
1. Total fertility Rate (TFR)	Rate	2.7, BDHS 2007	2.00
2. Contraceptive Prevalence Rate- CPR	%	55.8%, BDHS 2007 61.7% UESD 2010	72%
3. Unmet need for family planning	%	17.1%, BDHS 2007	9.0%
4. Maternal Mortality Rate (MMR)	Ratio (per 100,000 live births)	194, BMMS-2010	143

11.2. OP level Indicators:

Indicators	Unit of Measurement	Base line (with Year and Data Source) – Update data sources?	Projected Target	
			Mid-2014	Mid-2016
Number of VSC performed	Number	253799 (FPCST/QAT report, 2008-2010/year), DGFP MIS	450,000	600,000
Number of IUDs inserted	Number	278562 (FPCST/QAT report, 2008-2010/year), DGFP MIS	550,000	750,000

Indicators	Unit of Measurement	Base line (with Year and Data Source) – Update data sources?	Projected Target	
			Mid-2014	Mid-2016
Number of Implants inserted	Number	101572 (FPCST/QAT report, 2007-2010/per), DGFP MIS	600,000	800,000
Number of UH&FWCs upgraded to perform VSC,IUDs, Implants	Number	1500, MIS-DGFP	1000	2225
% of Eligible couples using LAPM services.	%	7.3 %, BDHS, 2007	15%	20%
Discontinuation rate of LAPM contraceptives reduced	%	56.5%, BDHS 2007	30%	20%
Number of VSCs performed by Roving teams (e.g. Tribal areas)	Number	29120 (FPCST/QAT 2010)	135000	250000
Number of personnel trained in clinical contraception	Number	332 (2009-10 & FPCST/MIS)	1996	3560
Number of couples referred by FWAs for LAPM	Number	FWA-278981 (2009-10 & FPCST/MIS)	FWA-2177500	FWA-3875000
Number of NSV and IUD acceptors trained as referral agents – as per "Total 15000 satisfied NSV & IUD acceptors	Number	81215 (2009-10 & FPCST/MIS)	225833	1250000
Use of modern contraceptives (LAPM) in low-performing areas	%	7.3%	14%	20%
Availability of semi-permanent FP methods in Upazila Health Complexes (UHC) in low performing districts with high maternal and child mortality rates (**DAAR Indicator)**	Number	NA, CCSDP	2 UHC in each of 5 low performing districts	2 UHC in each of 25 low performing districts

11.3. Source and methodology of data collection to measure/ preparation of annual progress report:

Data generated from the OP implementation, monitoring & evaluation at Line Director's Office will be the primary source. The routine data originated from different cost centers monthly, quarterly, yearly recorded in registrars, formats will be useful for oversecing the progress. The FWA register filled by field workers as MIS report and data provided by the regional supervisor FPCST/QAT will be the source of FP services data.

The secondary data sources such as surveys & studies findings of different agencies or organization (even NGO) will be used for progress monitoring BMMS, BDHS, UESD etc. also will be the secondary sources of data.

Proposed/surveys or research findings or client interviewing under this OP will be important methodology of data collection.

12. Estimated Budget:

12.1. Estimated summary of development budget: (Taka in lakh)

Name of the Components	Economic Code	GOB	Project Aid			Total	% of the total cost
			RPA		DPA		
			Through GOB	Others			
1	2	3	4	5	6	7	8
a) Revenue Component							
Pay of Officers	4500	100.00	-	-	-	100.00	0.07%
Pay of Establishment	4600	25.00	-	-	-	25.00	0.02%
Allowances	4700	123.00	-	-	-	123.00	0.09%
Supplies and Services	4800	62778.82	18524.46	-	46637.41	127940.69	94.20%
Repairs and maintenance	4900	332.50	-	-	-	332.50	0.24%
Grant in Aid	5900	2100.00	-	-	-	2,100.00	1.55%
Total recurrent exp.		65459.32	18524.46	-	46637.41	130621.19	96.18%
B. Capital expenditure :							
Acquisition of Assets	6800	2836.03	480.54	-	1,876.54	5,193.11	3.82%
Total capital		2836.03	480.54	-	1,876.54	5,193.11	3.82%
Grand total		68295.35	19005.00	-	48513.95	135814.30	100.00%