গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়
স্বাস্থ্য শিক্ষা ও পরিবার কল্যাণ বিভাগ
জনসংখ্যা -১ শাখা
বাংলাদেশ সচিবালয়, ঢাকা
www.mefwd.gov.bd

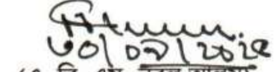
স্মারক নং- ৫৯.০০.০০০০.১১৪.৯৯.০০২.২৪.১৭০ তারিখ: ৩০/০৯/২০২৫

বিষয়: 'Bangladesh National Family Planning Strategy (2025-30)' মন্ত্রণালয়ের ওয়েবসাইটে প্রকাশ সংক্রান্ত।

সূত্র: পরিবার পরিকল্পনা অধিদপ্তরের স্মারক নং-৫৯.১১.০০০০.৫৫০.৯৯.০২৪.২২-৩৭৭, তারিখ: ১১/০৯/২০২৫;

উপর্যুক্ত বিষয় ও সূত্রের পরিপ্রেক্ষিতে পরিবার পরিকল্পনা অধিদপ্তরাধীন ক্লিনিক্যাল কন্ট্রাসেপশন সার্ভিসেস ডেলিভারী প্রোগ্রামের উদ্যোগে এবং ইউএনএফপি এর সার্বিক সহযোগীতায় প্রণয়নকৃত **'Bangladesh National Family Planning Strategy (2025-30)'** স্বাস্থ্য শিক্ষা ও পরিবার কল্যাণ বিভাগ, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়ের ওয়েবসাইটে প্রকাশ করার জন্য নির্দেশক্রমে অনুরোধ করা হলো।

সংযুক্তি: বর্ণনামতে।



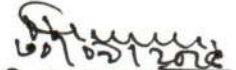
(এ. বি. এম. নুরুল আলম)
সহ. সচিব (জনসংখ্যা-১)
টেলিফোন : ৯৫৪৬০৪৬
Email:population1@mefwd.gov.bd

সিস্টেম এনালিস্ট (চ.দা.)
কম্পিউটার সেল
স্বাস্থ্য শিক্ষা ও পরিবার কল্যাণ বিভাগ
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়

স্মারক নং- ৫৯.০০.০০০০.১১৪.৯৯.০০২.২৪-১৭০ তারিখ: ৩০/০৯/২০২৫

অনুলিপি সদয় অবগতির জন্য (জ্যেষ্ঠতা ক্রমানুসারে নয়):

১। মহাপরিচালক, পরিবার পরিকল্পনা অধিদপ্তর, ৬, কাওরান বাজার, ঢাকা
২। মাননীয় উপদেষ্টার একান্ত সচিব, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়
৩। মাননীয় বিশেষ সহকারীর একান্ত সচিব, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়
৪। সচিবের একান্ত সচিব, স্বাস্থ্য শিক্ষা ও পরিবার কল্যাণ মন্তণালয়, স্বাস্থ্য ও পরিবার কল্যাণ মন্তণালয়
৫। অতিরিক্ত সচিব (জনসংখ্যা, প.ক. ও আইন)-এর ব্যক্তিগত কর্মকর্তা, স্বাস্থ্য শিক্ষা ও পরিবার কল্যাণ বিভাগ
৬। যুগ্মসচিব (জনসংখ্যা অধিশাখা)-এর ব্যক্তিগত কর্মকর্তা, স্বাস্থ্য শিক্ষা ও পরিবার কল্যাণ বিভাগ



(এ. বি. এম. নুরুল আলম)
সহ. সচিব (জনসংখ্যা-১)

'ছেলে হোক, মেয়ে হোক
দুটি সন্তানই যথেষ্ট'

গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
পরিবার পরিকল্পনা অধিদপ্তর
ক্লিনিক্যাল কন্ট্রাসেপশন সার্ভিসেস ডেলিভারী প্রোগ্রাম
৬, কাওরান বাজার, ঢাকা-১২১৫।
www.dgfp.gov.bd

স্মারক নং-৫৯.১১.০০০০.৫৫০.৯৯.০২৪.২২- ৬৭৭

বিষয় ঃ 'Bangladesh National Family Planning Strategy (2025-30)' মন্ত্রণালয়ের ওয়েবসাইটে প্রকাশের প্রয়োজনীয় ব্যবস্থা গ্রহণ প্রসঙ্গে।

সূত্রঃ স্বাস্থ্য শিক্ষা ও পরিবার কল্যাণ বিভাগ, জনসংখ্যা-১ শাখার
স্মারক নং- ৫৯.০০.০০০০.১১৪.৯৯.০০২.২৪-৮৮, তারিখঃ ১৯/০৬/২০২৫খ্রিঃ

মহোদয়,

উপর্যুক্ত বিষয় ও সূত্রের আলোকে জানানো যাচ্ছে যে, পরিবার পরিকল্পনা অধিদপ্তরাধীন ক্লিনিক্যাল কন্ট্রাসেপশন সার্ভিসেস ডেলিভারী প্রোগ্রামের উদ্যোগে এবং ইউএনএফপিএ এর সার্বিক সহযোগীতায় প্রণয়নকৃত 'Bangladesh National Family Planning Strategy (2025-30)' এবং মেরী স্টোপস্ বাংলাদেশ এর সার্বিক সহযোগীতায় প্রণয়নকৃত 'Strategy of Family Planning for Hard to Reach and Low Performing Areas (2025-30)' মন্ত্রনালয় কর্তৃক অনুমোদিত হয়েছে। মন্ত্রণালয় কর্তৃক অনুমোদিত 'Bangladesh National Family Planning Strategy (2025-30)' স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়ের ওয়েবসাইটে প্রকাশ করা প্রয়োজন। উল্লেখ্য যে, Strategy of Family Planning for Hard to Reach and Low Performing Areas (2025-30) ইতোমধ্যে মন্ত্রণালয়ের ওয়েবসাইটে প্রকাশিত হয়েছে।

এমতাবস্থায়, 'Bangladesh National Family Planning Strategy (2025-30)' স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়ের ওয়েবসাইটে প্রকাশের প্রয়োজনীয় ব্যবস্থা গ্রহনের জন্য বিশেষভাবে অনুরোধ করা হলো।

মহাপরিচালক মহোদয়ের অনুমোদনক্রমে।

বিনীত

সচিব
স্বাস্থ্য শিক্ষা ও পরিবার কল্যাণ বিভাগ
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়,
বাংলাদেশ সচিবালয়, ঢাকা।

দৃষ্টি আকর্ষণঃ অতিরিক্ত সচিব
(জনসংখ্যা, পরিবার কল্যাণ ও আইন অনুবিভাগ)
স্বাস্থ্য শিক্ষা ও পরিবার কল্যাণ বিভাগ।

ডাঃ মোঃ রফিকুল ইসলাম তালুকদার
লাইন ডাইরেক্টর
ক্লিনিক্যাল কন্ট্রাসেপশন সার্ভিসেস ডেলিভারী প্রোগ্রাম।
টেলিফোন ঃ ০২৫৫০১২৩৬২ (অফিস)।
E-mail: ccsdpdgfp@gmail.com

স্মারক নং-৫৯.১১.০০০০.৫৫০.৯৯.০২৪.২২-৬৭৭/১(৫) তারিখঃ ২২/০৯/২০২৫খ্রিঃ

অনুলিপি সদয় অবগতি ও প্রয়োজনীয় ব্যবস্থা গ্রহণের জন্য প্রেরণ করা হলো (জ্যেষ্ঠতার ক্রমানুসারে নয়) ঃ-

১। অতিরিক্ত সচিব (জনসংখ্যা, প:ক: ও আইন), স্বাস্থ্য শিক্ষা ও পরিবার কল্যাণ বিভাগ, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, ঢাকা।
২। যুগ্ম-সচিব (জনসংখ্যা, প:ক: ও আইন), স্বাস্থ্য শিক্ষা ও পরিবার কল্যাণ বিভাগ, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, ঢাকা।
৩। প্রতিনিধি/....................................... ইউএনএফপিএ।
৪। মহাপরিচালক মহোদয়ের ব্যক্তিগত সহকারী, অত্র অধিদপ্তর।

ডাঃ মোঃ কামরুল হাসান
উপপরিচালক (সিএস) ও প্রোগ্রাম ম্যানেজার (এসডি)।

Government of the People's Republic of Bangladesh
Medical Education & Family Welfare Division
Ministry of Health and Family Welfare

BANGLADESH NATIONAL FAMILY PLANNING STRATEGY 2025-2030

Directorate General of Family Planning

United Nations Population Fund

২৭২

Government of the People's Republic of Bangladesh
Medical Education & Family Welfare Division
Ministry of Health and Family Welfare

BANGLADESH NATIONAL FAMILY PLANNING STRATEGY
2025-2030

Directorate General
of Family Planning

United Nations Population Fund

-১৭১-

Published on

....

Published by
Clinical Contraception Services Delivery Program
Directorate General of Family Planning
Ministry of Health & Family Welfare (MOHFW)

Supported by
United Nations Population Fund

Designed by
MMMA Zakaria
mmmazakaria@gmail.com

Printed by

....

Director General
Directorate General of
Family Planning (DGFP)

Forward

It is a great pleasure on my part to see that the National Family Planning Strategy 2025-2030 has been developed. I believe the strategy would help improve the quality of family planning services and ensure human rights in Bangladesh.

Over the last two or three decades, we have seen a significant expansion in the coverage and access of family planning services, but this progress has not been matched by improvement in the quality of care. As we all know, the last several years have witnessed a relatively slower rate of progress, especially in CPR and fertility rates.

This strategy is in line with the vision of the government and development agenda. This strategic document offers a clear, logical framework to create an enabling environment conducive to the provision of quality, comprehensive, and integrated FP and SRHR services in Bangladesh. It also aims to contribute to the development and increased national commitment to FP and accelerate the achievement of the SDGs.

Increased access to integrated FP has many essential benefits for individuals, families, societies, and the nation. By ensuring universal access to integrated FP and related SRHR services, we can reduce MMR, IMR, teenage pregnancies, and resulting unsafe abortions. Planned births will result in savings in maternal and child health care, and a slower population growth rate. Ultimately the country will benefit from the broad-based economic growth, a productive and educated workforce, and achieving demographic dividend. FP undoubtedly plays a critical role in reducing poverty and driving economic growth.

I understand the development of the strategy has taken time and effort of a large number of stakeholders, consultative process and a joint national effort. I thank them for their excellent work. I also thank my colleagues at the ministry as well as our development partners who have provided support in developing the strategy.

Dr. Ashrafi Ahmad, ndc
Director General
Directorate General of Family Planning (DGFP)

-২৬৬-

Director General
Directorate General of
Health Services (DGHS)

Message

The Director General of Health Services (DGHS) is pleased to see the publishing of the Bangladesh National Family Planning Strategy for 2023-2030, developed in cooperation with all stakeholders to unify Bangladesh's future vision for family planning.

This strategy is required to improve the coordination with different ministries (MOHFW, MOLGRD, MOWCA), other directorates (DGHS, DGNM, DG HEU, DGME, NIPORT), and CSOs to ensure implementation of the strategic framework. Strengthening service delivery through service coverage and effective partnership between DGFP and DGHS is vital for successfully implementing the FP program. For that, ensuring collaboration and coordination among government agencies is required, as well as institutionalizing FP services in all facilities of DGHS and DGFP through systematic approaches to securing and providing quality, equitable, and accessible FP services and ensuring and providing quality, equitable, and accessible FP services both in standalone and integrated services by DGFP, DGHS, DGME, and DGNM jointly with the local NGOs/CSOs within the structure of MHOFW and MOLGRDC. Trained service providers are essential to address unmet needs and discontinue contraceptives for managers and counseling for DGFP and DGHS service providers. Also, ensure uninterrupted supply of FP commodities and logistics at DGHS, NGO, and private sector facilities shall be enriched. Developing a human resource plan for the DGFP and DGHS will be required.

The overall responsibility for implementing the NFS at the national and sub-national levels rests with the MOHFW. Under the MOHFW's leadership, DGFP, DGHS with DGNM, NIPORT, and private and NGO sectors must take critical responsibility for the related components. I believe ensuring adequate resources for implementing the national family planning strategy is vital, and the effective management and coordination of the NFS will ensure that all Bangladeshi people benefit from this strategy, in line with securing human rights and choices.

I acknowledge the consultant's and all stakeholders' dedication to working tirelessly to consolidate and synchronize all contributions from different stakeholders and successfully deliver this comprehensive national strategic document.

Prof. Dr. Md. Abu Jafor
Director General
Directorate General of Health Services (DGHS)

Director General
Directorate General of
Nursing and Midwifery
(DGNM)

Message

The Bangladesh National Family Planning Strategy 2023-2030 is a basic reference document for the next seven years that was developed in a participatory manner with strategic partners and stakeholders to ensure quality family planning services in Bangladesh. This strategy directs to improve the coordination with different ministries (MOHFW, MOLGRD, MOWCA), other directorates (DGHS, DGNM, DGME, NIPORT), and CSOs to ensure implementation of the strategic framework for improved access to and utilization of quality, inclusive, equitable FP services.

Institutionalizing FP services in all facilities of DGHS and DGFP through systematic approaches with a particular focus on postpartum, post MR/PAC FP, and engaging DGME and DGNM is essential.

To ensure and to provide quality, equitable, accessible FP services, integrated services are required, and for that, DGNM with DGFP, DGHS, and DGME can jointly work with the local NGOs/CSOs within the structure of MHOFW and MOLGRDC. In this regard, the roles of DGNM with other agencies are distinguished for the implementation. Under the MOHFW's leadership, DGFP, DGHS with DGNM, NIPORT, and Private and NGO sectors can take critical responsibility for effective implementation at all levels.

Thanks to all the stakeholders who worked on developing this important strategy.

Md. Anwar Hossain Akand
Director General
Directorate General of Nursing and Midwifery (DGNM)

Representative a.i.
UNFPA, Bangladesh

Message

The Bangladesh National Family Planning Strategy 2025-2030 represents a significant milestone in the nation's ongoing commitment to promote sexual and reproductive health and rights (SRHR). This comprehensive policy document, crafted through collaborative national efforts, offers a human rights-based framework for strengthening the policy environment and ensuring universal access to family planning (FP) services. It focuses on strategic directions and the importance of improving the coverage and quality of FP services, which will contribute to achieving the sustainable development goals (SDGs) in Bangladesh. The strategy builds on lessons learned and past achievements while setting a clear direction for the future. It adopts a life cycle approach, recognizing the evolving needs of individuals and couples at different stages of life. Designed to be inclusive and responsive, the strategy aims to close gaps in access, quality, and equity across the country. The Directorate General of Family Planning (DGFP), along with all stakeholders, including the technical team of experts and development partners, deserve our sincere appreciation for their invaluable contributions to develop this important strategy.

Bangladesh has undoubtedly made remarkable progress in maternal health and family planning indicators. However, despite these commendable achievements, millions of women and adolescent girls across the country still lack access to comprehensive sexual and reproductive health services, including FP services. The data reveals ongoing challenges, particularly significant district-level disparities in the unmet need for family planning. Adolescent girls, in particular, encounter substantial unmet needs throughout Bangladesh. Although the rate of unwanted pregnancy has been relatively stable between 2014 and 2017, it increased in 2022, especially in the northeastern regions of Bangladesh. This concerning trend is driven by low uptake of modern contraceptive methods, high discontinuation rates, and gaps in SRHR services. Additionally, women and adolescent girls displaced by the impact of climate change and living in informal settlements face serious barriers in accessing SRHR services.

Family planning plays a central role in achieving gender equality and empowering women, and it is also a fundamental component of sustainable development. Moreover, it is one of the most effective and inexpensive ways to improve the populations' present and future quality of life. To this end, the strategy prioritizes inclusive, rights-based, and people-centered approaches that reflect the diverse realities of the population and strengthen the delivery of high-quality, gender and adolescent and youth responsive services.

Looking ahead to 2030, and as the Government intensifies its efforts in reforming the health sector, UNFPA stands alongside with the Government and people of Bangladesh in its journey toward a healthier, more just, and more equitable society, one in which every individual can realise their sexual and reproductive health and rights, and every woman and girl is empowered to reach her full potential.

Masaki Watabe

Masaki Watabe
Country Representative, a.i.
UNFPA Bangladesh

Line Director (CCSDP)
Directorate General of Family Planning (DGFP)

Message

CCSDP of DGFP is pleased to publish the Bangladesh National Family Planning Strategy 2025-2030, developed in cooperation with all stakeholders to unify the future vision for Family Planning in Bangladesh.

This strategy is an essential reference document that includes the outcomes all partners aspire to achieve nationally within the next six years. It has been developed in a participatory manner with strategic partners and stakeholders. I am confident that compliance with the National FP strategy would help standardize Family Planning service delivery at different tiers at the grassroots level.

I thank the MoH&FW for accomplishing the comprehensive strategy. My gratitude also goes to the individual experts from many national and international development organizations whose hard work made the strategy a reality.

Thanks are also extended to UNFPA for providing technical and financial support for developing this strategy.

Dr. Md. Rafiqul Islam Talukder
Line Director (CCSDP)
Directorate General of Family Planning

-262-

Director (MCH- Services)
Directorate General of Family Planning (DGFP)

Message

I warmly extend my sincere appreciation to the Ministry of Health and Family Welfare and the Directorate General of Family Planning for the development of the Bangladesh National Family Planning Strategy 2025-2030. This milestone reflects our national commitment to ensuring universal access to quality family planning services and improving the health and well-being of women, children, and families in Bangladesh.

As Director (MCH-S), I reaffirm our commitment to working collaboratively with all relevant stakeholders to operationalize this strategy effectively & achieve its vision. I hope, this strategy will play a pivotal role in reducing maternal and child mortality, addressing unmet needs, and building a healthier future for our nation.

I extended my heartfelt gratitude to UNFPA for their cooperation and immense technical support for developing the Strategy.

[Dr. Md. Sultan Ahmed]
Director (MCH- Services)
Directorate General of Family Planning

ACRONYMS & ABBREVIATIONS

ANC	Antenatal Care
ASRH	Adolescent Sexual Reproductive Health
BBS	Bangladesh Bureau of Statistics
BCC	Behavior Change Communication
BNMC	Bangladesh Nursing and Midwifery Council
CCSDP	Clinical Contraception Services Delivery Program
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
CSOs	Civil Society Organizations
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DGME	Directorate General of Medical Education
DGNM	Directorate General of Nursing and Midwifery
DHIS2	District Health Information Software, version 2 (DHIS2) platform
e-MIS	Electronic Management Information System
ESP	Essential Services Package
FP	Family Planning
FP 2030	Family Planning 2030 Commitments
FPI	Family Planning Inspector
FP-FSD	Family Planning Field Service Delivery
FPS	Family Planning Strategy
FWV	Family Welfare Visitor
GoB	Government of Bangladesh
HEU	Health Economic Unit
HIV	Human Immunodeficiency Virus
HPN	Health, Population, and Nutrition
HPNSP	Health, Population, and Nutrition Sector Program
HSD	Health Services Division
ICPD	International Conference on Population and Development, 1994

ঠ২৬০

ICPD+25 Commitments: Nairobi ICPD+25 Summit Commitments

IEM	Information, Education & Motivation
LARCs & PM	Long-Acting Reversible Contraceptives & Parament Methods
LGD	Local Government Division
LNOB	Leave No One Behind
MCH	Maternal and Child Health Services
MIS	Management Information System
MOHFW	Ministry of Health and Family Welfare
MOLGRDC	Ministry of Local Government, Rural Development and Cooperatives
MR	Menstrual Regulation
MRM	Menstrual Regulation with Medication
MOSW	Ministry of Social Welfare
NGO	Non-Governmental Organization
NIPORT	National Institute of Population Research and Training
NNP	National Population Policy
PHC	Primary Health Care
PHN	Population Health and Nutrition
HPNSP	Health, Population, Nutrition Sector Program
PAC	Post Abortion Care
PP	Perspective Plan
PPP	Public-Private-Partnership
SBCC	Social and Behavior Change Communication
SDP	Service Delivery Points
SDGs	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
STDs	Sexually Transmitted Diseases
TFR	Total Fertility Rate
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Population Fund
WHO	World Health Organization

CHAPTER 1

INTRODUCTION

Access to safe, voluntary family planning is a human right[1]. Family planning, a lifesaving intervention, is central to gender equality and women's empowerment and is key to sustainable development. Family planning allows the individual to attain their desired number of children, if any, and to determine the spacing of their pregnancies. It is achieved through use of contraceptive methods and the treatment of infertility[2]. Contraceptive information and services are fundamental to all individuals' health and wellbeing. Preventing unintended pregnancies reduces the risk of maternal and pregnancy-related deaths.

Contraception allows the spacing of pregnancies, delaying pregnancies in young girls at an increased risk of health problems from early childbearing and preventing pregnancies among older women who also face increased risks. By reducing rates of unintended pregnancies, contraception also reduces the need for unsafe and safe abortion. It (e.g., condoms) reduces Sexually Transmitted infecttions (STI), including Human Immunodeficiency Virus (HIV) transmission. Family planning can play a crucial role in protecting the health of women and children. It helps ensure that pregnancies occur at the healthiest time of a woman's life and these pregnancies are wanted and planned. This can also benefit girls' education and create opportunities for women to participate more fully in society, including the formal labor market. Thus, developing a Bangladesh National Family Planning Strategy (2025-2030) will provide a national framework to improve access to and coverage of comprehensive quality integrated family planning and related Sexual and Reproductive Health and Rights (SRHR) services.

1.1 Need for Bangladesh National Family Planning Strategy

In Bangladesh, a specific national family planning strategy is absent, although the country has developed the National Adolescent Strategy for 2017-2030 and the National Strategy for Maternal Health 2019-2030. Although the Bangladesh Population Policy 2012, Bangladesh Population Policy 2025 and National Health Policy 2011 are the guiding documents, these lack concrete direction on what the Family Planning program of Bangladesh should do. The 4th Health, Population, and Nutrition Sector Program (HPNSP) prioritized family planning programs and allocated resources accordingly. Despite these supportive policies and initiatives, the review and analysis of existing policies and guidelines, and embracing the Bangladesh Population Policy and National Health Policy, ICPD (International Conference on Population and Development, 1994), SDGs, ICPD+25 (Nairobi ICPD+25 Summit), UHC commitments,

1. https://www.unfpa.org/family-planning
2. https://www.who.int/health-topics/contraception#tab=tab_1

and FP 2030 country commitment (see Annexure-1) the country needs to develop a human rights-based National Family Planning strategy-with an Action Plan- an implementation strategy and guidelines with a costed action plan and other development policies.

The vision of the Bangladesh Population Policy 2012 was to develop a healthier, happier, and wealthier Bangladesh through planned development and control of the nation's population. However, it is necessary to emphasize population management through ensuring desired fertility and bodily autonomy rather than control from a health and well-being perspective, as reflected in the ICPD 1994 principles and PoA. For that, the family planning program of Bangladesh needs a clear strategy that would guide the program to grow in the coming years where the human rights framework- right to reproductive self-determination (autonomy, empowerment, and informed decision making); right to SRHR services, information, and education (availability, accessibility, acceptability, quality, privacy, and confidentiality and informed choices); and right to equality and nondiscrimination- which will be ensured through accountability and participation.

A National Family Planning strategy is required to improve coordination with different ministries (MOHFW, MOLGRD, MOWCA, MOSW), other directorates (DGHS, DGNM, DG HEU, DGME, NIPORT, BNMC), and CSOs to ensure implementation of the strategic framework for improved access to and utilization of quality, inclusive, equitable, gender and shock- responsive, universal, climate resilient and human rights-based sexual and reproductive health information and service, particularly for the urban and hard to reach population- considering leave no one behind. The FP strategy is also required to strengthen and expand the Family Planning- District Health Information Software, version 2 (FP-DHIS2) platform to improve data quality, ensure data from the private sector, and establish a data sharing mechanism with DGHS- which will help data utilization for FP program planning, monitoring, and evaluation. A national strategy can direct digitalizing supervision and monitoring systems, followed by establishing joint monitoring cells at the central level comprising representatives from different directorates and partners (UNFPA, 2021).

In connection with the Bangladesh Population Policy, an FP strategy is required to examine the impact on progress towards SDG goals and achieve the benefits of demographic dividend by the country. Also, family planning programs in urban settings need special attention. Moreover, the COVID-19 pandemic has given us new thought to develop future family planning program strategies in any unprecedented contexts. The latest Urban Health Survey (UHS) 2021 shows that early marriage and teenage pregnancy have risen sharply among the non-slum urban population during the COVID-19 pandemic. Also, urban areas' total fertility rate is increasing due to child marriage, teen pregnancy, and low use of contraceptives. Here, the use of contraception is lower among the adolescent groups, and the overall usage of contraception has not increased significantly, especially in the non-slum areas. The number of unintended pregnancies are very high, which cause adverse pregnancy outcomes, including abortion, pregnancy complications, maternal and early child morbidity and mortality.

In Bangladesh, significant disparities, as evidenced in contraceptive use, still exist between regions. Thus, we need a family planning strategy- to expand the availability and access to family planning choices; to engage adolescents and youth as agents of change and provide rights-based and gender-responsive services; to strengthen and disaggregate data; to deepen the integration of family planning into national health policies, strategies and plans; to increase sustainability of national family planning programs; to build resilience and improve adaptation, in settings of humanitarian crisis and environmental change; to improve quality of person-centered care and services; and to enhance agency and address discrimination to ensure the full range of family planning services for women and girls from marginalized groups and others at risk of being left behind [3]. Based on the above-stated background, the Bangladesh National Family Planning Strategy 2023-2030 has been developed.

3. UNFPA 2022. Expanding Choices and Ensuring Rights: UNFPA Strategy for Family Planning, 2022–2030, P. 36

1.2 The Bangladesh National Family Planning Strategy Development Process

The Bangladesh National Family Planning Strategy (NFS) has been developed through an extensive participatory process involving the Medical Education and Family Welfare Division, other government line ministries and departments, the UN, development agencies, implementing and technical partners, academia, and civil society. The process involved a comprehensive desk review, field assessment, and several stakeholder consultative meetings (See Annexure 2). DGFP has formed a technical working group to formulate a National Family Planning strategy for outlining the strategic directions to achieve SDGs, UHC, ICPD, and FP2030 commitments. This policy-framework document would be human rights-based and people-centered. Seven strategic priorities have been identified.

- Access and availability of service delivery
- Quality of care
- Inequalities
- Urban Family Planning
- Enabling environment and demand creation
- Multi-sectoral involvement and actions
- Research, monitoring, and evaluation

In developing this strategy, four working groups were formed to work in the 07 thematic areas. The working groups developed thematic area-wise comprehensive activities for ensuring the right-based national family planning strategy. Working group members have reviewed existing laws and policies, UNFPA Strategy for Family Planning 2022–2030, SDGs, UHC, ICPD, and FP2030 commitments and aligned priority strategic directions in the National Family Planning Strategy. The working group's objectives align with the government's overall goal to improve family planning outcomes, including policy recommendations, programmatic interventions, and advocacy efforts. The Working Group was committed to and actively involved in guiding and critically reviewing strategy development.

CHAPTER 2

SITUATION ANALYSIS OF FAMILY PLANNING IN BANGLADESH

Bangladesh turned 50 in 2021 and has made remarkable progress in population and development, such as reducing total fertility, increasing contraceptive prevalence, reducing infant and child mortality, increasing life expectancy at birth, and enhancing gender parity in schooling, women's empowerment, and overall development (Islam et al., 2022). At one time, Bangladesh's family planning (FP) program was regarded as one of the most successful in the world. Compared to the situation in the 1970s, it is evident that the country has undergone remarkable changes in fertility rates. Moreover, arguably, the major credit for bringing about this change goes to the FP programs. Here it can be noted that Bangladesh's family planning program has evolved in two phases- the first started in 1973 and lasted through 1996. The second phase began in 1997 and has continued to the present. The first phase emphasized population control as an essential part of national development efforts and witnessed the implementation of a demographic target-driven family planning program. The 1994 International Conference on Population and Development (ICPD) influenced the second phase, and it has been characterized by a transition from a target-driven to a client-centered approach. In 1994, a paradigm shift occurred when the world's countries reached a rare consensus that the focus should not be on *population*, per se, but on people. The groundbreaking ICPD heralded a shift in focus from 'human numbers' to 'human rights. This shift has also included increasing the scope of the population policy from addressing family planning needs to dealing with a broader range of reproductive health issues targeted at a more significant number of population groups. Undoubtedly, Bangladesh has made remarkable progress in socio-economic advancement following the demographic transition. Political support and program administration, the extension of services to the community level, social acceptance of family planning, and equity in access to contraception all contributed to the success of the family planning program (Talukdar et al., 2022). Some studies attribute the rapid fertility decline mainly to the success of FP programs (Cleland et al., 1994; Carty et al., 1993). Carty et al. (1993) emphasized the Government's commitment to reducing the population growth rate. They argued that this resulted in widespread success despite any notable change in economic development, urbanization, employment of women, and education. Later, Cleland et al. (1994) also concluded that 'we have found that it is unnecessary and indeed implausible to invoke economic change and shifts in the utility of the children as the central determinant.' For some scholars, the fertility transition in Bangladesh was a paradox (Adnan, 1998). However, the fertility transition from the 1990s onward is arguably attributed to an increase in female education and changes in other socio-economic indicators in Bangladesh, where the effect of FP programs was losing momentum (Khuda & Hossain, 1996; Bora et al., 2022; Caldwell et al., 1999).

The Total Fertility Rate (TFR) was 6.24 in 1974, reduced to 3.44 in 1993-1994. During this time, the TFR was higher in rural areas (3.54). Over time, the TFR decreased significantly to 2.3 in 2011 but remained stable till now. According to the Bangladesh Sample Vital Statistics (SVRS), 2023 TFR is currently 2.17. However, this rate of TFR significantly varies in different administrative divisions. For example, TFR is highest in Chattogram (2.48) and lowest in Dhaka (1.94), but TFR in Mymensingh (2.40), Barisal (2.28), Rangpur (2.19), Khulna (2.15). Here, all the administrative divisions are above the replacement level of 2.1 except Dhaka and Sylhet (2.04). Bangladesh is close to attaining replacement of fertility. Currently, 2 of 8 divisions, Dhaka and Sylhet, have achieved replacement fertility (respectively 1.94 and 2.04) (SVRS 2023). Earlier, the BDHS 2017-2018 reported four divisions- Khulna, Rajshahi, Rangpur, and Dhaka reached the replacement level, but the scenarios have been changed in the SVRS 2023. BDHS 2022 refers to TFR being higher in rural areas (2.3), households of the lowest wealth quintile (2.6), and mothers with no education or who did not complete the primary level (2.6). Regarding the rural-urban divide infertility, the replacement level fertility has been achieved in urban areas (2.1) but is much higher in rural areas. In 2014, the TFR in rural areas was 2.3 in 2017-18, which was increased to 2.4 in 2022. The desired total fertility rate is well below the replacement level, e.g., 1.8 in rural areas but 1.6 in urban areas, with a national figure of 1.7 (NIPORT & ICF, 2020). Thus, the TFR is much higher than the couple's desire (1.7), reiterating the importance of FP programs in Bangladesh (NIPORT & ICF, 2020). Moreover, TFR varies among the wealth quintiles. For example, women in the lowest wealth quintile had a TFR of 2.8 children, whereas the highest quintile had 2.0. The gap in TFR between the lowest and highest quintile increased to 0.8 children in 2022 from 0.6 in 2017-18 (NIPORT & ICF, 2023). The fertility by wealth index also demonstrates that fertility declines as we move from the poorest to the wealthiest segment.

Fertility in Bangladesh has declined rapidly since the mid-1970s, but the country has experienced two fertility stalls. The first stall occurred at TFR 3.3 from 1996 to 2000, and the second stall occurred at 2.3 births per woman from 2011 to 2022 (NIPORT & ICF, 2023; Rahman, 2018). CPR also seems to have stagnated in recent decades. In 1975, the CPR was only 8 percent, significantly increasing to around 62 percent in 2011. After that, it did not change during 2011-2018. The CPR among married women aged 15-49 years was 64 percent (BDHS 2022), whereas 61.0 percent use modern contraception (SVRS 2023) with no visible improvement in longer-acting or permanent methods. Here, the use of modern methods among adolescents is relatively high (64.5%) (SVRS 2023). Contraceptive use for modern methods is also highest among the lowest quintile at 60.6 percent and lowest among the highest quintile at 47.8 percent (BDHS 2022). According to the BDHS 2022 the CPR is 63.0 percent in rural areas, 2.5 percent less than in urban areas. There also exists significant regional variation in terms of CPR, such as, by Division, the use of modern contraceptives is highest in Rangpur (61.3%) and lowest in Sylhet (44.3%) and Chattogram (49%), representing a difference of 17 percent and 12 percent (NIPORT & ICF, 2023). CPR is highest at 68.6 percent in the lowest quintile and lowest at 58.4 percent in the highest quintile in BDHS 2022. The BDHS 2022 also states that CPR use of any modern method and any traditional way is much higher in urban areas than in rural areas (10.9% vs. 8.6%).

According to the SVRS, 2023 the total use of modern Contraceptive Prevalence rate is 61.0 percent. Among the modern methods, temporary methods are highly used, such as using pills at 35.5%, followed by Injectables use at 14.0 percent, and male condoms at 6.9 percent. Among the long-acting and permanent methods, female sterilization is 2.2 percent, followed by IUD use at 1.3 percent, and use of Norplant/Implant is 0.6%, and male sterilization is only 0.2% (SVRS 2023). Female sterilization decreased from 8.1 percent in 1993-1994 to only 4.8 percent in BDHS 2017-18 and 2.2 in SVRS 2023. Male sterilization has remained the same or declined at 0.2 percent over the years. IUD use had also sharply dropped from 2.2 in BDHS 1993-94 to only 0.6 percent at BDHS 2017-18 but 0.6 percent in SVRS 2023.

২৫৮-

Although the CPR rate has risen in city corporation slums significantly from 58 percent in 2006 to 70 percent in 2013 and to 71.6% in 2021;; in city corporation non-slum areas, the CPR rate has not increased much (68.0% in 2021). The use of modern contraception is also higher in city corporation slum areas (62.9%) in comparison to city corporation non-slum areas (59.2%) in 2021 (BHUS, 2021). The latest Bangladesh Health Facility Survey (BHFS) 2022 revealed that facilities providing modern FP methods and services with stocks decreased nationwide, requiring proactive interventions to address this (NIPORT 2023 b).

The unmet need for family planning was has reduced substantially since 1993 with 21.6% to 10% in 2022. The pace of reduction has slowed considerably in recent years. The unmet need for contraception has been reduced by only 1.5 percent from 2011 to 2018 and 2.0 percent in 2022 from 2017-2018. Unmet need in urban areas has seen the biggest decrease, primarily among the poorest This reduction was nearly 2.4 percent higher in rural areas (10.7 percent) than in urban areas (8.7%) (NIPORT & ICF, 2022). The unmet need for FP was much higher in Chattogram (31.85%) and Sylhet (31.49%) (SVRS 2023). In BDHS 2022, the unmet need for family planning is at the lowest percent in the lowest quintile and the highest percent in the highest quintile. The unmet need for spacing in total was 5.4 percent, according to BDHS 2017 -18, where by age group, the unmet need for spacing was 15 percent for the age group 15-19, followed by the age group 20-24 at 13 percent. On the other hand, the unmet need for limiting is 6.6 percent, which was low for the age group 15-19 and 20-24 at 0.6 and 2.7 percent, respectively, in BDHS 2017-2018.

Characteristically for FP programmes that are dominated by short term methods, the discontinuation rate is high. Almost four in 10 contraceptive users discontinue a method within the first year. The discontinuation rate increased from 30 percent in 2014 to 37 in 2017-2018 (NIPORT & ICF, 2020). Moreover, the country could not fulfill the objectives and goals of the National Population Policy (NPP) 2012. The NPP 2012 aimed to achieve a replacement level fertility of 2.1 by 2015. Ironically, this target was the same with a different timeline in the NPP 2004. The CPR target is to reach 72 percent by 2015 in the NPP 2012. None of these could be achieved.

The discontinuation rate for pills over the years has decreased slightly from 45 percent in 1993-94 to 42 percent in 2017-2018. Discontinuation rates for injectables have reduced significantly from 1993-1994 to 2017-2018. In line with this, the discontinuation rate for male condoms has also decreased considerably. According to BDHS 2017-18, the main reason for contraceptive discontinuation rate is side effects/health concerns at 10.5 percent. The side effects of fertility-related reasons and the desire to become pregnant are the second and third most common reasons for contraceptive discontinuation. Notably, side effects/health concerns remain the most significant reason for discontinuation throughout the three BDHS surveys. Regarding the sources of specific modern methods, the BDHS 2022 states for modern contraceptive methods the most common is the private medical sector (57.3 percent), followed by the public sector (36.5 percent). Only 2.5% use NGOs and 3.2% use other private sources for modern contraceptive methods.

Adolescent motherhood is one of the burning challenges in Bangladesh (Islam et al., 2017), with the age-specific fertility rate (15 to 19 years) of 18.5 percent (SVRS 2023). In 1993-94, this rate was 33 percent among adolescent mothers aged 15-19 years, only a 10 percent reduction in the last 29 years (1993-2022). In particular, the prevalence of adolescent motherhood is 5.4 percent higher in rural areas (25.2%) than in urban areas (19.8%) (NIPORT & ICF, 2023). Also, the unmet need for contraceptives is the highest (34.96% and 29.14% respectively) among the age groups 15-19 and 20-29, whereas the unmet national need is 25.77 percent (SVRS, 2023). Therefore, it is essential to devise efficient interventions to reduce the prevalence of adolescent motherhood in Bangladesh, especially targeting rural areas. Along with fulfilling the unmet need for contraception among teenage mothers, the root of the problem, i.e., child marriage (50.1% in BDHS 2022), needs eradication.

२२७ -

According to BDHS 2022, 23.7 percent of women aged 15-19 had begun childbearing. Teenage pregnancy was significantly higher in rural areas at 25.2 percent compared to urban areas at 19.8 percent. It was the highest at 29.1 percent among the women of the poorest quintile, whereas among the wealthiest quintile, it is 13.8 percent (NIPORT & ICF, 2023). The percentage decreases as the wealth quintile increases. In Bangladesh, teenage pregnancy was comparatively low among Sylhet (10.8%), Chattogram (21.9%), and Mymensingh (22.1%) divisions and significantly higher in Khulna (31.1%), Rangpur (30.8%), and Rajshahi (27.8%) divisions (NIPORT & ICF, 2023). Teenage pregnancy had increased significantly (7%) in city corporation non-slum (BUHS 2021).

Significant Challenges and Issues of Family Planning Program in Bangladesh

There are a few overarching and cross-cutting issues present which need immediate attention.

- **The unmet need for family planning is high among** among younger women compared to older age groups and the national average in Bangladesh Unmet need for family planning by Division among married women aged 15-49 varied (e.g., Chattogram=31.85%, Sylhet=31.49%, Barishal=22.85%, SVRS 2023).

- **Early marriage, early childbearing, low contraceptive use, and premarital sex**: Adolescence pregnancy or motherhood (23.7%, BDHS 2022) is primarily driven by the high rate of child marriage (50.1% in BDHS 2022) coupled with limited contraceptive utilization among young married females. Notably, premarital sex has emerged as an additional factor leading to adolescent pregnancy, with 27 percent of ever-married girls reporting premarital sex before marriage (BDHS 2017-2018). The latest Bangladesh Urban Health Survey 2021 also refers to increasing evidence of teenage pregnancy. Bangladesh houses a substantial population of 16,320,000 adolescent girls aged 10-19, with 52 % falling within the 15-19 age bracket (Census 2022). Given this considerable demographic, the pressing issues of high unmet needs, inadequate data on sexual and reproductive health awareness, limited knowledge on family planning services among both unmarried and married adolescent girls, highlight the urgent need for investment in data to explore underlying causes, and ensuring access to family planning information and services.

- **Stagnating or slowing increase in contraceptive use:** The CPR among married women aged 15-49 years was 64 percent (BDHS 2022), whereas 61.0 percent use modern contraception (SVRS 2023) with no visible improvement in rebalancing the skewed method use. The use of LARC & PM makes a very small contribution to the method mix. The lower proportion of IUDs remains to be a significant challenge.

- **Low acceptance of postpartum family planning program (PPFP):** (PPFP): The PPFP program in Bangladesh is, by and large, focused on providing postpartum IUDs, implants, and tubectomies during facility delivery. These methods have lower discontinuation and failure rates than the widely used short-acting methods. Moreover, 1.1 percent of married women aged 15-49 reported using traditional methods in SVRS 2023. The PPFP program has not successfully provided the methods with lower discontinuation and failure rates to women who want them at delivery (NIPORT & ICF, 2023).

- **High discontinuation of short-acting methods and dependency on temporary/short-acting methods:** High discontinuation of contraceptive use (e.g., The BDHS 2017-2018) refers to the percent of contraceptives discontinued within 12 months among women aged 15-49 for all-37%; pill-42%, condom-45%, injectables-34%, and implants-11%.

- **High unintended pregnancy:** There is evidence of increasing rates of unintended pregnancy due to inconsistent use of contraceptive in Bangladesh. The unintended pregnancy is known to cause adverse pregnancy outcomes, including abortion, pregnancy complications, maternal and early child morbidity and mortality.

- **Significant disparities in contraceptive use** still exist between regions. Currently, the lowest use of modern contraceptives in Bangladesh is evidenced in the Sylhet, Chattagram, and Dhaka divisions (SVRS 2023).

- **Lower Satisfying demand for family planning by modern methods and promoting contraception for older age cohorts:** The demand for FP modern methods for reproductive women aged 40-44 (62%), 45-49=58% (BDHS 2017-2018).

- **Quality of services and facility readiness:** Quality services for LARC & PM or short-acting methods is an issue- lack of proper attention to side-effect management and appropriate counseling is critical. Facility readiness is one major challenge in enhancing service coverage for LARC & PM. Only one-fourth (26%) of the facilities are ready to provide such a service, whereas accessibility is more critical at private facilities (UNFPA, 2022).

- **Under-served FP in urban areas, including slums:** Urban poor and ultra-poor, garment workers, older adolescent girls aged 15-19, etc., are critical sub-groups of the population here. In urban areas, particularly in urban slums, NGOs are working under the Urban Primary Health Care Services Delivery Project under the Local Government. In contrast, FP commodities are received from DGFP of MOHFW. The Ministry of Local Government, Rural Development, and Cooperatives (LGD) is responsible for urban health. Still, less coordination and actions regarding the responsibility of family planning services between the two ministries remain.

- **High dependency on the private sector without considering them as part of the health system:** The Bangladesh Urban Health Survey 2021 found that a significant portion of women, 73.6%, obtain contraceptives from private sector pharmacies. Specifically, 88.7% of women use pills, 92.6% use condoms, and 60% use injectable contraceptives from these pharmacies. Unfortunately, the pharmacies do not get due acknowledgment for their contribution to FP nor receive any support for improving quality of services.

- **Climate change challenges and family planning:** Climate change is a critical concern in Bangladesh. As we know, access to family planning reduces maternal and child mortality and produces better health outcomes, but it also strengthens climate change communities' ability to adapt. With fewer unintended pregnancies, slower population growth reduces pressure on climate-sensitive resources.

- **Male involvement in family planning:** The family planning sector in Bangladesh is mainly women-centric by design- targeting male clients remains a significant challenge. There is a lack of an effective strategy to take the family planning message to male involvement in this regard to change the gender norm.

- **Inadequate human resources and addressing the emergency** is a matter of concern where a significant number of posts of the field level staff (e.g., FWA/ FWVs) are vacant throughout the country. For family planning, increased human resources are needed (e.g., during a pandemic or humanitarian situation).

- **Ensuring collaboration and coordination among Government agencies, GO-NGOs, and public-private partnerships to increase accessibility to FP services and coverage:** Strengthening service delivery through service coverage and effective partnership between DGFP and DGHS is vital for successfully implementing the FP program; this effective collaboration is critical for the postpartum family planning program (PPFP).

- **To reach the unreached, underprivileged, and underserved population, including hard-to-reach and low-performing areas:** Strengthening and prioritizing FP service delivery to the unreached, disadvantaged, and underserved populations like adolescents, unmarried, sexual minorities, older aged cohorts (40+ years aged women), people living with disabilities, ethnic minorities, ensuring access to SRH and FP services require.

- **Limited Monitoring and Evaluation (M&E) and Research:** Effective monitoring, supervision, and supportive mentorship are critical challenges in service provision. Follow up with clients to manage any side effects caused by specific contraceptive methods and mitigate service providers' biases on method choice and other aspects. Conducting timely, relevant research on FP to address knowledge gaps and the right interventions are needed. New FP commodities can be introduced through evidence generation—adopting an evidence-based SBCC strategy.

Current Policies and Programs

Historically, Bangladesh's national policies were initiated immediately after independence and widened as new national and international challenges emerged. The country has specific policies such as National Population Policy 2012 (NPP 2012), National Health Policy 2011, and sector-wide programs. Achieving the policies' and strategies' goals and objectives needs linking, integrated coordinated actions, and timely updates, which direct better implementation (Islam, 2019a). Bangladesh's achievements are rooted in quantitative and qualitative population changes, as a consequence of the successful family planning program. In Bangladesh, this has positively affected infant and child mortality, the total fertility rate, and women's empowerment (Sen, 2013). While the prospects appear promising, existing obstacles are also present (Islam, 2019a; & Islam, 2019b). The COVID-19 pandemic is just over, which unleashed multi-dimensional challenges and caused enormous damage to the economy and people's livelihoods for over two years. Current global unrest might cause further challenges. Given the above scenarios, considering the FP 2030 Commitments, SDGs, and ICPD+25, the opportunity to achieve the demographic dividend national family planning strategy has been developed.

CHAPTER 3

FRAMEWORK: VISION, GOAL, OBJECTIVES, TIME FRAME, VALUES AND GUIDING PRINCIPLES

The overall direction for family planning is to adopt a life cycle approach that addresses different family planning needs at each stage of the life cycle. Family planning behavior across the life cycle in Bangladesh to reach women and couples/ individuals needs attention.

The Vision

By the end of 2030, Bangladesh aspires to be a country where everyone, particularly women and girls, leads a healthy life with equitable and inclusive access to and utilization of rights-based family planning services towards attaining zero unmet need for family planning, zero preventable maternal death and zero gender-based violence and harmful practices.

The Goal/Mission

To ensure universal access to rights-based family planning in Bangladesh, where every person can access quality and integrated family planning information and services delivered through innovation and coordination that empowers women and girls, affirms individual human rights, and leaves no one behind.

Objectives

1. To Improve availability, accessibility, affordability, acceptabiliy, and utilization of quality modern contraceptives, focusing on adolescents, postpartum, and post MR/ PAC users, to reduce high discontinuation rates and unmet need for family planning.
2. To strive for distinct behavioural science approaches to increase demand for equitable, gender-responsive, climate-resilient, respectful, and human rights-based FP information and services with particular attention to the disadvantaged, underserved, and unprivileged population.
3. To achieve Three Zeros commitments of ICPD+25 (the unmet need for family planning, preventable maternal death, gender-based violence, and harmful practices including child marriage), FP 2030 country commitments, and Health Sector Program targets.
4. To expand choices and ensure voluntary and human rights rights-based family planning approach through establishing contraceptive security and satisfaction to all and infertility services at all levels.

5. To implement evidence-based programming, costing, budgeting, resource allocation, and tracking budget implementation, data management systems that are linked with the multi-year and annual budgetary framework for decision-making and knowledge management in the family planning program.
6. To update, adapt, and implement policy framework, regulations, accountability, and compliance to improve SRHR, including FP, through an integrated, multi-sectoral, and human right-based approach targeting leaving no one behind (LNOB) across the development and humanitarian continuum.

Time frame

2025-2030

Values and guiding principles

Values

Universal access, rights, and choice-based, efficiency and accountability.

Guiding principles

Human rights-based approach to family planning, voluntarism and informed choices, access to information and services, gender equality, equity and social inclusion, nondiscrimination, privacy, quality of care, evidence-based approach, sustainability, partnership, and participation.

Table: Guiding Principles for Human Rights-Based Family Planning

Principle	Level			
	Individual: Empowered and satisfied client	**Service Delivery:** Quality information and services	**Community:** Supportive culture	**Policy:** Enabling environment
Availability	v	v		v
Accessibility	v	v	v	v
Acceptability	v	v	v	v
Accountability	v	v	v	v
Quality	v	v	v	v
Informed Decision Making	v	v		v
Agency/Autonomy/Empowerment	v		v	v
Privacy and Confidentiality	v	v	v	v
Non-discrimination and Equality	v	v		v
Participation	v	v	v	v

CHAPTER 4

STRATEGIC DIRECTIONS

The key Strategic Directions (SD) of the Bangladesh Family Planning Strategy 2025-2030 are:

SD1 : Access And Availability of Service Delivery
SD2 : Quality of Care
SD3 : Inequalities
SD4 : Urban Family Planning
SD5 : Enabling Environment and Demand Generation
SD6 : Multi-sectoral Involvements and Actions
SD7 : Research, Monitoring And Evaluation

SD1 ACCESS AND AVAILABILITY OF SERVICE DELIVERY

Problem Statement:

There are gaps to ensuring universal access, availability, and utilization of FP services along the different stages of the life cycle of the individuals/ couples and across the different levels of service delivery systems. The progress reducing unmet need for FP is slow and the rate of unmet need is highest among adolescent girls. High discontinuation and dependency on short-acting methods still exist.

Context:

DGFP has been providing both domiciliary and facility-based services through field workers named Family Welfare Assistants (FWAs), Family Planning Inspectors (FPIs), and Family Welfare Visitors (FWVs). At present, approximately 23,500 FWAs are involved in distributing condom, oral pill and Injectables to the acceptors at domiciliary and Community Clinic levels. Through house-to-house visits, the FWAs register the Eligible Couples (ELCOs) for FP services. FWAs conduct courtyard meetings with the eligible couples in the respective areas. A significant number of posts are vacant which are in process of recruitment. Only doctors are allowed to provide vasectomy, tubectomy and implants. However, midwives and FWVs are allowed to provide IUDs from health facilities. Evidence and practice in the resource poor settings suggest that to provide reproductive health services including family planning, maternal and child health services it needs to have well prepared facilities backed up by strong community level interventions.

High unmet need for family planning, discontinuation of short-acting methods and dependency on short-acting methods have also been evidenced in national surveys. Low acceptance of postpartum family planning program (PPFP) is common. The PPFP program in Bangladesh is, by and large, focused on providing postpartum IUDs, implants, and tubectomies during facility delivery. These methods have lower discontinuation and failure rates than the widely used short-acting methods. However, POP is the widely distributed postpartum contraceptive. The PPFP program has not successfully provided LARCs (with lower discontinuation ratse) to women who want them at delivery (NIPORT & ICF, 2023).

Strategic Objective:

Principle	Principle
1.1 To improve availability, accessibility, and utilization of quality services through modern contraceptives	**Availability of Services and Facility Readiness:** • For availability of FP services facility readiness should be ensured at all types of public health facilities: *community clinics (CC), union sub-centers/rural dispensaries (USCs/RDs), union health and family welfare centers (UHFWCs), upazila health complexes (UHCs), mother and child welfare centers (MCWCs), and district hospitals (DHs), medical college hospitals and private facilities including private hospitals/NGO static clinics/hospital/facilities.* • Institutionalizing FP services in all facilities of DGHS and DGFP through systematic approaches with a particular focus on postpartum, and post MR/PAC FP and also by engaging DGME and DGNM. Ensuring and providing quality, equitable, and accessible FP services both in standalone and integrated services by DGFP, DGHS, DGME, and DGNM jointly with the local NGOs/CSOs within the structure of MHOFW and MOLGRDC; • Emphasizing the advantages of postpartum and post-abortion FP services and counseling during ANC visits • Integration of FP & MR-PAC with UHC having focal persons at the DGHS and DGFP. Information on MR-PAC is to make readily available in health facilities, especially regarding the post-MR care. • Ensure availability of services through existing Health and Family Welfare Centers including Satellite and Community Clinics in the community; • Expand community clinic (CC) based FP information and services on all working days of the week. • Ensure continuous FP training for DGHS and private sector staff • Revisit number of satellite clinics be conducted to make it need based • Ensure physical screening (e.g., blood pressure, nutrition status, iron level) is done before initiating a method used to reduce side effects (e.g., severe bleeding, lower abdominal pain, dizziness, weakness);

Principle	Principle
	• At the upazila level, undertake local level planning exercises involving multi-stakeholders to ensure client-oriented family planning services; • Operationalizing all union level facilities for 24/7 services through deploying midwives in a phase-wise manner.
1.2 To ensure the availability of well-trained, supervised, and motivated service providers with adequate human resources	• Trained service providers should be ensured. Training program addressing unmet needs and discontinuation of contraceptives for managers and counseling for the service providers of DGFP and DGHS; • Ensuring all FP service providers are well trained and client-focused through strengthening the capacity of providers on FP information and counseling at all levels; • Strengthening the capacity of providers through pre-service and in-service training on FP information and counseling at all levels. For that, the inclusion of qualified counselors in the program with room facilities at the upazila and district level should be made available to deliver quality services. • Guiding timely and expedited actions in filling vacant positions and improving the deployment system to ensure the right staff (with appropriate knowledge and skill) in the right place and incentives for the retention of staff in hard-to-reach areas; • Creation of need-based posts and recruitments of service providers and support staff. • Addressing the shortage of skilled Doctors and paramedics to provide LARC & PM and PPFP services to provide quality FP services in partnership with private and NGO sectors; • Ensuring client vs. service provider ratio (low-medium-high) is based on performance area selection • Using Family Planning Handbook for Medical Students and Physicians with updates of the medical, nursing and midwifery curriculum and its application at respective levels.
1.3 To improve facility based and door-to-door services to ensure client centered services and undertake the strategies to make them complement each other	• Continue providing door-to-door services to all eligible couples, especially to people experiencing poverty, and ensure a mechanism for referral from the field level. Also, establish digital services for reproductive health care. • Revisit of domiciliary services in line with program needs. • Undertake targeted home visitation and more frequent contact through different means with couples having rapid repeat pregnancies. Counseling services while providing domiciliary FP services as well as at the services centers (Satellite clinics/ Community Clinics) should be ensured. • Ensure client-centered services through the participation of Non-governmental Organizations (NGOs) & private sectors in remote, hard-to-reach & urban areas.

Principle	Principle
1.4 To support couples and individuals and to provide family planning services through life cycle needs specially on youth, adolescents and newly-weds through adequate counseling in choosing their preferred method of contraception and when to use it	• Promoting and improving counseling for appropriate method use, avoiding misconception towards method use and side effect management, avoiding missing in uptake of everyday oral pills, and reducing possible health problems; • Focus on providing age-appropriate FP information and services to the youth and adolescents irrespective of their marital status. • Addressing different family planning needs at each life cycle stage- from adolescents to older cohorts, like promoting contraception for older age cohorts (45+ years women, postmenopausal women). • Collaborate with other ministries such as the Ministry of Education, Ministry of Youth and Sports, MOWCA, MOLGRD&C, etc., private sector, and CSOs to expand and strengthen comprehensive sexuality education (CSE). • Prioritize reaching groups with information and services who have the highest unmet need: newly-weds, adolescents, parents of two children; • Ensure Family Welfare services to Newlywed Couple-like, orientation program on FP-MCH services- support to organize quarterly sessions, orientation for marriage registers, FPIs and FWAs; procurement of gift boxes, certificate for the newlywed couples on FP-MCH services at upazila level) to address unmet need for family planning services among the newlywed couples aged 15-19 years; • Supportive supervision systems existed in all public and private health facilities to ensure the quality of family planning and adolescent and youth-responsive services.
1.5 To ensure campaign and advocacy on family planning messages to address unmet need, earlypreg-nancy, and disco-ntinuation of contraceptives	• Identify couples with unmet needs for family planning information and services and ensure delivery of those services. • Introducing a right-based, timely, relevant FP Slogan-emphasizing a planned childbirth birth and spacing campaign. • Organize special campaigns periodically to increase utilization of FP services focusing on low-performing, hard-to-reach and underserved communities. • Addressing discontinuation of short-acting and LARCs due to not correctly managing side effects.
1.6 To ensure supply-chain management and commodity security	• Taking necessary steps to ensure contraceptive security at all levels. Forecasting, budgeting, procurement, storage, and supply management) of family planning commodities will be well managed. • Discouraging traditional methods with separate roles and actions maintains a safeguard for different methods.

Principle	Principle
	• Introduction of new contraceptives (Hormonal IUD, DMPA-SC, etc.) and increasing use of modern methods of contraception and reducing dropouts and unmet needs. Promoting procurement of generic contraceptives for the national pharmaceuticals. • Encouraging the private sector to make long-acting and permanent methods (LAPM) available. • Ensure availablity of Emergency Contraceptive Pills (ECP) at all public health facilities with proper user guidelines. • Making SDP selection criteria and process easier to increase the availability of FP commodities at NGO/Private sector facilities. • Making FP commodities available among the armed forces personnel, police, railway and other organized sectors. • Ensure availability of supplies of contraceptive methods, while seasonal barriers due to excessive raining, flood, poor road communication, distance, opportunity costs, etc. • Ensure regular supply of required medicine and equipment to all service centers; make sure that family planning supplies are readily available at public and private service centers; and ensure the security of all such centers; • Ensure uninterrupted supply of FP commodities and logistics at DGHS, NGO and private sector facilities.
1.7 To address unintended pregnancy due to ontraceptive failure	• To take effective coordination between the contraception providers at the healthcare facilities and the households and the proactive role of FP workers to make couples aware of the consistent and effective use of contraceptives.
1.8 To address mental health and family planning	• Apart from focusing on preventing unintended pregnancies, family planning tailored to the needs of those with mental health problems should specifically address (involuntary) childlessness, insecurities about (possible) motherhood, and the influence of mental health on sexuality.

8৬-

SD2 QUALITY OF CARE

Problem Statement:
There is a lack of SOPs (Standard Operating Procedures) that specify minimum quality standards and the range of methods that should be offered. There is also limited capacity to implement quality services, including monitoring, supportive supervision and review systems. Failure of effective and timely managed interventions may have adverse consequences on contraceptive acceptance. Ensuring quality implies the minimum requirements for infrastructure, trained staff, and commodities (as in SOPs) are met through quality management systems at all levels.

Context:

Clients' basic rights such as their rights to information, access, choice, safety, privacy and confidentiality, dignity, opinion, comfort and continuity are critical concerns to provide quality services particularly in the field of FP and reproductive health services. The supply of contraceptives to the millions of clients across the country is one of the major activities of the DGFP. However, here the private sector has emerged as a major service provider rather than public sector where quality of care is a critical concern for both sectors. Both the public and private health sectors have varying strengths and weaknesses in delivering quality FP care. The consequences of poor quality of care are discontinuation, unwanted pregnancy, unsafe abortion, method failure, side effect and complications, etc. Thus, regardless of the managing authority, there is substantial room for improvement in the quality of FP services, through measuring clients' experience of quality FP care reflecting- structure (physical attributes of the facility), process (delivery of care), and outcome (impact of care).

Principle	Principle
2.1 To provide universal access to quality of Care (QoC) of the FP services	• Developing SOP for each service and monitoring and follow-up will be ensured. A national framework for a quality improvement action plan will be developed along with quality of care indicators (like service providers provide high quality FP services to standards; clients are given information on all methods and are free to choose the methods they prefer; clients are satisfied with the services and continue using the methods; written guidelines, protocols, and standards are regularly updated and consistently implemented, regular on-site supervisions and hands-on practice should be applied. The FPCS-QI team will be further strengthened through capacity building and required logistic support. • Ensuring continuum of care- follow-up, and developing a referral system and age-specific intervention will be under taken. Continuum of care (ANC, delivery, NC, immunization, etc.) in the life cycle approach should be provided through quality clinical supervision/mentorship and FP will be integrated throughout • The facility should be ready with adequate HR and commodities-including logistics and equipment. Supportive supervision systems exist in all public and private health facilities. Each level will be required to report on indicators and accountability mechanisms strengthened.

-282

Principle	Principle
	Performance management training for the DGFP & DGHS field level service providers on quality of care can be ensured. • Dedicated counseling and provision of quality services among adolescents and young people, in particular, can reduce unmet needs substantially. Dedicated FP counselors will be recruited in different levels of health facilities. • Ensure that all women and individuals have ready access to a wide range of quality modern methods of contraception with quality services addressing side effects and complications. Also, ensure equitable access to quality infertility care. • Strengthening FP services, especially post-partum and post-abortion FP and demand generation through effective coordination of services with DGHS and DGFP utilizing appropriate opportunities. • Training on effective counseling and quality screening for all service providers. Organize onsite training sequentially on knowledge of the quality of care. Capacity building through pre and post services should be ensured. • Ensure use of WHO Medical eligibility criteria wheel for screening of co-mobidity offen an appropriate method. • Strong referral linkage has to be established. • Infrastructure and quality of the Operation Theatre (OT), IUD, and labor room must be at standard level. • Field-based studies and implementation research will be conducted regularly, potentially covering the following areas: unmet need for FP, discontinuation, client satisfaction on short acting FP methods, infertility, male engagement, satellite clinic, community clinic and volunteer-based intervention; • Recruitment of Program Support Officers (PSO) to support and facilitate Maternal Child and Adolescent Health (FP-MCRAH) services and ensure quality of care in all respects at the targeted districts (hard to reach and low performing districts)

২৪০—

SD3 INEQUALITIES

Problem Statement:

Wide inequities and gaps in access and utilization of family planning services still prevail, resulting in socio-economic, and demographic disparities in gender, age, administrative divisions, geographic location (rural-urban, hard-to-reach), ethnic, disability, migratory status, etc.

Context:

Factors that affect access to FP and/or SRHR services differ between males and females in general, married women in unions and single sexually active women, and between adolescents and youth versus other women of reproductive age. In addition, the challenges they experience are influenced by their reproductive roles; socially constructed gender roles and the power imbalances cause women and adolescents and young girls to be in disadvantaged positions that compromise their choice of preferred contraceptive method or even deciding on whether to take contraceptives or not. These population sub-groups most disadvantaged include but are not limited to those who live in rural-urban residence, on the streets, in slum dwellings, in char- haor/ hard-to reach areas, with disability, married and pregnancy, who are engaged in sex work- and living in areas prone to natural disasters. However, data on these special population groups is often not available or, when it is, not reliable. Significant disparities in contraceptive use still exist between regions in Bangladesh. To make further progress in reducing the existing equity gaps in access and effective utilization of FP services, action needs to be taken on both the supply and the demand side, requiring action within and beyond the Health and Family Planning sector.

Principle	Principle
3.1 To reduce socio-economic and demographic inequalities of access and use of FP services among vulnerable population groups and individuals	• Strengthening access and utilization of FP services among the poorest, rural-urban residents, age differentials needed by various approaches, like wealth quintile/ richness of experience and contribution provided by NGOs and others. • With a focus on inclusion and equality, following the SDG indicator framework calls for disaggregating family planning data, where relevant, by age, sex, income, ethnicity, migratory status, disability, place of residence, or other characteristics to take intervention. • Focus will be placed on sex, age- mainly on youth (15-24 years), ethnic, minorities migrants- vulnerable and marginalized groups. • Ensuring family planning information and services to unmarried youth and adolescents. Innovative implementation approaches will be designed, implemented, and evaluated to reach them, i.e., pre-marital counseling to delay adolescent pregnancies and promote healthy spacing in priority areas. • Provider bias on FP methods and eligible clients will be addressed as part of training, SOPs, supportive supervision and monitoring. • Ensuring workplace and out-of-institution-based FP information and services. • Inclusion of new evidence-based and innovative approaches, mainly using social media (Facebook, Twitter, TikTok, YouTube, pod casts, etc.) to reach the adolescent and young population for promoting contraceptives.

Principle	Principle
	• Conducting evidence based behaviour changeIEC/BCC activities where traditional norms are prevalent, particularly in rural, remote, and indigenous communities can affect the use of family planning services (as compared to other financial or geographic barriers).
3.2 To reduce geographical inequality of access and use of family planning services among various administrative regions/ vulnerable areas/ hard-to-reach areas	• To improve the quality and coverage of FP services for hard-to-reach areas (hills, chars, and haors), tea gardens workers, etc., a tailored strategy will be based on an in-depth analysis of the complexity and bottlenecks in such areas. FP in hard-to-reach areas will be addressed through a developed *Family Planning Strategy for Hard-to-Reach Areas (see Annexure-2). For that,* inter-sectoral collaboration will be sought to improve communications and sub-contracting to NGOs working in areas with chronic HR shortage/ scarcity. • Consolidating lessons learned from good-performing districts/ areas and replicating effective models in other areas • Taking special FP support to climate-induced vulnerable areas, and displaced and migrant populations. Climate change affected and low performing areas, recruitment of volunteers, training (basic and refresher) and logistics support to them. • Quarterly monitoring, supervision and performance review meeting with the district and Upazila level managers of the lowest performing districts.
3.3 To gender mainstreaming and integrate gender, including transgender in family planning services	• This strategy will ensure that gender equity is at the center of all interventions and ensure specifically, that the role and needs of men and boys are fully addressed and supported. All capacity building initiatives for service providers on FP, and SRHR service provision will therefore mainstream gender, in both pre and in-service settings. *Gender Issues* will be addressed while providing guidance and reference information to service providers regarding FP/SRHR services, including demand generation and advocacy • Ensuring gender-responsive FP services with active male engagement. • Fulfilling needs, Services and distribution of essential FP commodities to the transgender people and sex workers without any discrimination.
3.4 To facilitate the inclusion of persons with disabilities in FP programming	• Educating and providing training to the service providers about the FP services for disabled persons following the SOP • Ensuring disability friendly infrastructure at all service delivery points.
3.5 To employ research and innovation	• The value of research and innovation will be accelerated as a means to address inequalities in FP.

SD4 URBAN FAMILY PLANNING

Problem Statement:

There is a lack of FP services across the urban areas both in limited public and unregulated private sectors. Also, there is a lack of effective coordination among MOHFW, LGD/MOLGRDC and Urban Local Government Institutions (City Corporations/ Municipalities) on the provision of urban health and family planning services to meet the demands and to ensure the urban family planning services by addressing urban inequality among various sub-groups of the population.

Context:

About thirty-two percent of Bangladeshi population lives in urban areas, where the current annual urban population growth rate is more than double than national growth rate (BBS, 2022). The UN Population Division estimates by 2040 one in every two people will be in urban areas. A significant portion of them will be living in urban slums. Urban migrants, displaced, and other vulnerable sub-groups of population face various challenges. Rapid urbanization and increased high urban population growth poses significant challenges on FP that warrants special attention. In addition, expanding workplace intervention to increase access to and use of FP information and services needs to be strengthened. But with overall patchy FP services coverage in urban areas, huge disparities exist between slums and non-slum population in terms of availability and accessibility of FP services (Urban Health Survey 2021). Here TFR was 2.01 births per woman in the slums in 2013, which rose to 2.14 in 2021—about 13 percent rise over a period of seven years. Adolescent pregnancy also increased sharply for non-slums. The private sector is the major source of contraceptive methods in each of the three urban domains. The MOHFW has been involved in providing minimum primary health care services including FP in the urban areas for more than two decades. The roles of service providers for urban populations are unclear, which contributes to the public sector, such as DGFP, not offering enough services. This issue deserves more attention to ensure that urban populations receive the necessary care. As long as the private sector, particularly pharmacies, are the primary source of contraceptives for urban populations, there is a need to strategize how best they can be engaged and the distribution of contraceptives is reflected in the DGFP MIS.

Principle	Principle
4.1 To Strengthen Family Planning Services in Urban Areas including slums and non-slums	Access to Family Planning Services: • Establish well-equipped family planning clinics, reproductive health centers, and outreach programs that provide counseling, contraceptives, and reproductive health services that are easily available and affordable.. • Recruitment of volunteers for assigned urban areas, providing training/ orientation on FP-MCRAH; • Make FP commodities available to all existing and newly created urban public and private facilities • Introduce afternoon/evening clinics/services to all existing and newly created urban public and private facilities • Operationalize mobile and satellite clinics in inaccessible and remote urban slums and non-slums with effective referral system; • Foster partnerships with private sector organizations, NGOs, and community- based organizations to expand the reach of family planning services in urban areas.

Principle	Principle
	• Collaborate with private healthcare providers to offer subsidized or free contraceptives and services and ensure quality standards are met. • Strengthening Model Family Planning Clinic at Medical College Hospitals & and gradually establish LARC & PM services in all Medical College Hospitals • Expansion of Sylhet City Corporation FP model through strategic outsourcing of FP services in other City areas • Simplification of Private and NGO affiliation systems and make easier access to contraceptives through establishing supply system.
	Awareness and Education • Promote awareness about family planning methods and their benefits through targeted campaigns in urban areas. • Conduct community outreach programs, workshops, and information sessions to educate individuals and couples about the importance of family planning and the available contraceptive options.
	Integration with Urban Health Services • Integrate family planning services with existing urban health programs and services. • Collaborate with primary healthcare centers, maternity clinics, and other healthcare facilities to ensure that family planning is integrated into routine healthcare visits, antenatal care, postnatal care and child immunization.
	Target High-Risk Groups: • Identify high-risk groups within urban areas, such as migrants, slum dwellers, and vulnerable populations, and tailor family planning interventions to meet their specific needs • Operationalize mobile and satellite clinics in the inaccessible and remote urban slums and non -slums with effective referral system • Recognize the specific needs of urban adolescents and youth and develop an enabling environment to offer confidential and non-judgmental counseling and services.
	Advocacy and Policy Support: • At the policy level facilitate effective coordination between MOHFW and LGI through ensuring DGFP's OP's representation in different standing committees as per the National Urban Health Strategy 2020; • Advocate for supportive policies and legislation that prioritize and enable urban family planning. • Engage with policymakers, urban planners, and stakeholders to ensure family planning is integrated into urban development plans and strategies.

২৬৭-

Principle	Principle
	• Strengthening inter-ministerial committee/ coordination committees to harmonize roles and responsibilities of MoHFW and MoLGRD through meeting regularly to review and guide the process of health care delivery in urban areas, including harmonization of NGOs works. • Leverage information technology and digital solutions to enhance access and uptake of family planning services in urban areas.
4.2 To strengthen Family Planning Services in Workplaces:	• Explore potential workplaces beyond factories that fall under BGMEA and BKMEA and make partnership agreements with them • Advocate for supportive environment in the factories and their association for the promotion of and availability of FP commodities • Provide systematic information dissemination on SRHR and FP-MCH services to workplace workers including a special satellite clinic for workplace workers to address their immediate FP-MCH needs and provide them with takeaway BCC materials • Provide uninterrupted supply of contraceptives to the workplace/factory clinics • Organize special LARC/PM camps in the workplaces/factory clinics • Orientation/Training program for the supervisors/managers and service providers on SRHR and FP-MCH services; • Strengthen monitoring and reporting/health information management system through introducing digital system; • Quarterly coordination meeting (in a shaped Forum) among GO-NGO-Private Sector to share the updates and strengthen coordination.

SD5 ENABLING ENVIRONMENT AND DEMAND GENERATION

Problem Statement:

There is a lack of accessibility to policy decisions by all stakeholders to engage effectively to create an enabling environment for family planning (FP). Social norms and barriers that inhibit family planning use. Efforts to strengthen FP service delivery and communication capacity through the availability of skilled service providers in all designated service centers are also not adequate for demand creation. The additional potential of applying behavioural science to overcome demand side barriers is yet to be realized.

Context:

FP is crucial for preventing unintended pregnancies and improving maternal and child health and well-being. In Bangladesh, there are significant inequities in family planning use, particularly among individuals and groups; programs face challenges in increasing access to and use of contraception among those most in need. Outreach by community health or family planning workers, as well as local communication programs, are significantly associated with increased use of modern contraceptive methods. The targeted, multilevel demand generation activities informed by research, can make an essential contribution to increasing modern contraceptive use and could impact SDGs for improved maternal and child health and access to reproductive health for all.

Principle	Principle
5.1 To ensure an enabling environment, strengthen FP service delivery and communication capacity by ensuring the availability of skilled service providers in all designated service centers, including in underserved and hard-to-reach areas	• ***Ensuring ownership and sustainability of successful FP policy-plan- and program through stakeholders' participation*** *(like political leaders, religious and other opinion leaders, program managers, the medical community, clinic managers and FP service providers, advocacy groups, community organizations, and satisfied male and female clients).* For enabling environment, facility readiness of the FP services at first is required with support of DGFP, DGHS, and LGED. • ***Identifying FP policy-plan and programmatic barriers and initiating advocacy by leadership for changes:*** There are a variety of policy-programmatic challenges that impede access to and use of FP services. To address the barriers' the National Family Planning Advisory Committee can be used to identify, prioritize, and work on policy plans, programs, and advocacy for change. • ***Developing a human resource plan for the DGFP and DGHS:*** This plan can include a clear vision for addressing the unequal distribution/ shortage of human resources and propose a new approach for attracting and keeping the workers with a career structure/ career perspective. • Ensure adequate policy for flexibility and task shifting (multi-tasking) of FP staffs within DGFP,- DGHS, and provision of incentive scheme (non-financial) for service providers. • FP coordination committees at district, upazila, and union levels to ensure multi-sectoral involvement, increase coordination, provide a consistent supply of commodities, supplies, and logistics, and address administrative and policy barriers. More regular advocacy meetings can be organized with NGOs and private sector professionals to increase the use of services. For optimum utilization of their facilities in delivering services- Local government officials, locally elected bodies, NGO workers, community leaders, religious leaders, local elites, women

Principle	Principle
	leaders, and slum leaders influence the behavior of the community members.leaders, and slum leaders influence the behavior of the community members. • Satisfied clients can turn into advocates, which can be a powerful tool. Media is a powerful force and can be key to information dissemination. • Community engagement and including male involvement- male participation/ gender-integrated family planning. • Social Behavioral Change Communication (SBCC) activities for motivating and referral of LARC & PM services by field-level workers; • Orientation regarding the responsibility of local-level government • Strengthening courtyard meetings and satellite clinics in vacancy areas and in general. • Domiciliary visits should be strategic and need-based in targeted hard to reach and low performing locations. • Inclusion of Updated family planning contents at different levels of medical education following the national family planning program. • Satisfied clients can turn into advocates, which can be a powerful tool. Media is a powerful force and can be key to information dissemination. • Community engagement and including male involvement- male participation/ gender-integrated family planning. • Social Behavioral Change Communication (SBCC) activities for motivating and referral of LARC & PM services by field-level workers; • Orientation regarding the responsibility of local-level government • Strengthening courtyard meetings and satellite clinics in vacancy areas and in general. • Domiciliary visits should be strategic and-need based in targeted hard to rach and low performing areas • Inclusion of updated family planning related contents at different levels of medical education following the national family planning program.
5.2 To increase the use of FP methods through demand creation and community mobilization with special attention to marginalized communities and hard-to reach areas.	• Demand generation through service providers in hard-to-reach areas (hilly, char-haor, etc.) or vulnerable age-specific targeted groups/individuals. Strategic positioning, message, and theme development, implementing BCC (e.g. introducing vending machines for FP commodities) campaigns and promotional initiatives, and developing BCC materials for multiple channels. The digital content of demand generation needs more attention, considering the current and potential target groups. • Developing and disseminating SBCC materials on male, youth, and boy's engagement- capacity buildings and male involvement are needed for demand generation. • Strengthening FP awareness-building efforts through short- and long-term SBCC campaigns with local specifications to address child marriage, teenage pregnancy, unmet need for FP, dropouts, and massive PPFP and LARC/PM promotion.

SD6 MULTI-SECTORAL INVOLVEMENTS AND ACTIONS

Problem Statement:

Various factors impact FP and SRH services. Lack of ownership and responsibility, low political commitment, lack of clear and feasible communication strategy, and lack of financial and skilled human resources are some significant factors that impede effective multi-sectoral collaboration.

Context:

A multi-sectoral approach to family planning (FP) in Bangladesh is critical for community empowerment and engagement to improve access and utilization of FP and SRH services. There is an absence of an essential framework to promote and protect the rights of couples and individuals throughout their life cycle and to eliminate inequality, discrimination, and gender-based disparities. The issues of high unmet need for family planning, child marriage, and teenage pregnancy among adolescents and youth are examples that require engagement from both the government and non-government sectors- partners, the private sector, civil society organizations, community-based organizations, professional bodies, etc.

Principle	Principle
6.1 To direct key actions regarding multi-sector involvement	• **Local stakeholders' engagement:** Sharing meetings with the members of the district/upazilla family planning committee with a particular focus on the prevention of child marriage, teenage pregnancy and ANC & PNC, spacing and limiting births, girls' education, etc. • **Action to improve awareness about the importance of appropriate family planning practices,** including FP choices, rights, and reproductive health, through the school-based program/system. • **Revitalization of Union FP committees and satellite clinic management committees** and engage them in the movement against child marriage, teenage pregnancy, and malnutrition. • **Action to promote gender equality**, fight gender-based discrimination at all levels of society, including FP services, and legislation adopted for the minimum age at marriage and also to build the capacity of the FP service providers' gender-integrated family planning services delivery linking SRHR and Gender- right based approach and male engagement (direct use/support) in family planning, understanding gender roles, norms, and power dynamics concerning FP service delivery, reporting of GBV with FP services in the register and referral slip. Mainstreaming MOHFW protocol for health sector response to gender-based violence (GBV).

Principle	Principle
	• **Financial resources provided to the FP sector** can be gradually increased and allocated to ensure that FP services reach the poorer and all vulnerable sections of the population. • **Functionalize accountability systems to ensure good governance.**
6.2 To identify key actors involved with the Government and social sector	• **Inter-Ministerial Coordination:** Within the Government, key roles should be played by the Ministry of Health and Family Welfare, Ministry of Women & Children Affairs, Ministry of Youth, Ministry of Religion, Ministry of Local Government, Rural Development & Cooperatives, Ministry of Education, Ministry of Law, Ministry of Social Welfare, Ministry of Food & Disaster Management and NGO Affairs Bureau, among others (e.g., to address harmful practices including child marriage). • **An Inter-Ministerial Committee/National FP Advisory Committee/Council** under the leadership of the Ministry of Health and Family Welfare (MOHFW) can be formed to serve as a body for coordinating the activities of all ministries and agencies. The stewardship role of MOHFW can be strengthened to involve other allied ministries, partners, and the private sector in creating a positive environment within which FP and SRH can be governed appropriately. • **Coordination with Different Policies and Plans:** faith-based organizations (religious leaders), academia, community-based organizations, and professional bodies to improve FP and SRH. • **The MOHFW will engage Civil Society Organizations,** faith-based organizations (religious leaders), academia, community-based organizations, and professional bodies to improve FP and SRH. • **Public-Private Partnership (PPP):** Investment of the private sector in FP should be encouraged. Provide technical support to the private sector to increase their capacity in providing FP services. Utilize and nurture the existing coordination forums like the HPN Coordination Committee and BCC Working Group, a GO-NGO platform for coordination and collaboration; and Engage the private sector in hard-to-reach, low-performing, and unattended areas. • **Collaboration with the ministries** running separate hospitals (like M/O Home Affairs, Defense, Railway, Labor and Employment, etc.) to introduce compre- hensive FP information and services.
6.3 To determine the role of international agencies and other development partners	• The MOHFW directorates, namely DGFP, DGHS, DGNM, and NIPORT, can maintain and further strengthen, as recommended by the 5th HPNSP, the current coordination mechanisms for health and family planning sector policy and strategy with the development partners, UN organizations, NGOs and private sector for effective program implementation and innovation in addressing the identified gaps in coverage, equity and quality of care of family planning services.

-২৬২-

Principle	Principle
	• Multi-lateral and bi-lateral development partners can continue to align their financial and technical inputs and support the Government of Bangladesh (GoB) in ensuring the capacity and supplementing resources in critical Family Planning areas according to HPNSP recommendations. This partnership can be informed by the principle of supplementing and complementing program approaches toward enhancing efficiency and impact. Partnerships should be strategic, and roles should be determined based on the comparative advantages of the parties involved. • An inter-ministerial committee chaired by the MOHFW can be formed to serve as a body for coordinating the activities of all concerned Ministries and Agencies. Local elected bodies can strengthen their role in multi-sector mobilization around FP issues. • Current coordination mechanisms with development partners, UN organizations, NGOs and private sector will be strengthened for effective program implementation and innovation.

১৬০-

SD7 RESEARCH, MONITORING AND EVALUATION

Problem Statement:

There is a lack of research, monitoring, and evaluations to measure the success or identify means for failure through study so that it can help the next phase of action.

Context:

Currently, FP methods performance is continuously monitored through the MIS of DGFP. In addition, regular Bangladesh Demographic and Health Surveys (BDHS) are conducted every four (04) years, providing information on the overall performance of family planning, including method options. The SVRS of BBS and Multiple Cluster Survey (MICS) are also reporting the data on FP annually. These regular surveys, the MIS data, and the data from other research/studies should inform the monitoring and evaluation plan for the FP to ensure tracking implementation status. Monitoring and evaluation are continuous processes. Information from this process should be used to improve program design and implementation and, in turn, to redefine implementation, if necessary, to more effectively contribute to the strategic results. For effective programming, trackable and credible evidence is essential. The FP program can generate essential data for developing an investment case for FP as a development issue- which involves using data and evidence to determine lessons learned, replication of best practices, identify good and impactful intervention and service delivery models, drop ineffective interventions/ activities, use evidence for planning, etc.

Operational Research is essential for evaluating and improving the design of FP intervention, policies, and service delivery modes. The capacity to conduct and participate in operational research outside well-recognized research institutes is currently low, and capacity building is needed starting from pre-service training and in-service courses. Priority research can help in understanding critical programming and policy issues. In this regard, a research plan should identify key research areas and appropriate data dissemination.

Principle	Principle
7.1 To conduct research, monitoring and evaluation in line with all thematic areas to generate new knowledge and evidencebased good practice	**Research:** • All FP activities related to data and research must be aligned considering FP and MCH. Moreover, through mutual collaboration and prioritization, hormonal, physical, biological, social, and mental change research should be included in the operational plans through the participation of academicians and researchers, including government research bodies like NIPORT, NIPSOM, etc. In addition, outsourcing or 3rd Party inclusion in the research program needs to be included. • A research wing, including an ethical review committee formation, is necessary. • Establish a research repository for knowlaedge sharing within the FP department. • The research wing can be included along with the MIS. • Sharing FP research findings, ensuring real-time quality data, and managing internal coordination for data to be strengthened inside DGFP. • Prioritize the evaluation assessment, implementation, and action research by DGFP following short, medium, and long-term targets.

Principle	Principle
	• Providing strategic research direction for NGOs and private sectors. • Government and development partner supported research always Include where appropriate a cost-benefit analysis. In this connection, international TA should be obtained when needed and capacity built locally.
7.2 To improve monitoring and evaluation of family planning program	**Monitoring and Evaluation** • Tools for performance monitoring and evaluation will be developed/updated. The FP indicators in all policy and program documents (including the 5th HPNSP) should be reviewed and aligned at available all-level data, including BDHS, SVRS, and relevant national surveys. • Strengthening data visibility and cross-checking MIS data between DGFP and DGHS to ensure harmonization of MIS data. Visualization with the dashboard should be adopted. Data Quality Assessments (DQA) should be conducted periodically and a both-way feedback mechanism should be established. • Strengthening digital monitoring and supportive supervision system. • Local-level data should be used to review progress and guide decision-making at all levels. Data collected from facilities and communities should be compiled, reviewed, and analyzed at lower levels before being reported to the higher level. • Interventions need to be taken so that NGOs and the private sector comply with the MOHFW'S recordkeeping and service provision guidelines to incorporate into DGFP e- MIS/DHIS2. • Maintain adequate and accurate records of clients and commodities by all FP service providers to plan, monitor, and evaluate. • Incentivising improved data collection such as a periodic assessment of completeness, accuracy and timeliness with staff appreciation or recognition will be considered. • An annual FP Bulletin will be prepared and published by the MIS Unit in coordination with Planning Unit of DGFP. • Encouraging innovations and innovative activities including usages of artificial intelligence (AI) in FP.

CHAPTER 5

IMPLEMENTATION

Implementing the National Family Planning Strategy (2023-2030) will require a concerted and coordinated effort among all relevant partners in the field of FP and SRH. Of primary importance is the engagement of all critical Ministries who must collaborate with the MOHFW and play a supportive role. In addition to these Ministries and the associated units, Development Partners and Civil Societies will also have to play a crucial role in implementing activities to meet the goal outlined in this strategy (SD-6). Establishing a 'Management and Coordination' structure becomes imperative to coordinate these different actors and ensure the effective implementation of activities. This 'Management and Coordination' structure will fall under the direct purview of the Directorate General of Family Planning as the principal custodian for implementing the National Family Planning Strategy. The functions of the 'Management and Coordination' structure are detailed below.

Family Planning Strategy requires a multi-sectoral and multi-dimensional approach to effectively meet the needs of all. Therefore, the effective implementation of this strategy will depend on the collective responsibility of government ministries, departments and agencies, civil society organizations, the private sector, religious authorities, communities, families, and individuals. All these bodies must play a strategic and complementary role in the next seven years. This strategy requires effective implementation mechanisms, starting from an operational plan to be developed in conjunction with sector programs and alignment with overall perspective development plans, with a precise accountability framework. At the same time, the strategy needs to consider social and economic changes and, therefore, be conceived as a dynamic process requiring periodic review and updating based on impact evaluation and review.

This strategy can be sought for monitoring impact and updating the strategy:

- A costed action plan of all the strategic directions and defining key responsibilities and timeline will be developed by MOHFW. Roles of agencies will be distinguished, including DGFP, DGHS, NIPORT, and DGNM, during the implementation process.
- An accountability framework for sector and multi-sector actions will be defined together with operational plans.
- Impact and coverage targets indicated in national, international, and UN commitments (SDGs, ICPD+25, etc.), enriched by the targets identified for monitoring the implementation and the impact of the strategy (See Table: Performance Monitoring Plan, 2023-2030)
- Independent agencies, academia, and civil society groups can be involved in monitoring, implementing, and ensuring this strategy's implementation.

The overall responsibility for implementing the NFS at the national and sub-national levels rests with the MOHFW. Under the MOHFW's leadership, DGFP, DGHS with DGNM, NIPORT, NIPSOM, Private and NGO sectors must take critical responsibility for the related components. The MOHFW will establish relevant Committees with sectoral representation to ensure quality implementation at divisional and district levels. At divisional, district, and upazila levels, similar multi-sectoral coordination mechanisms will need to be established where DGFP and DGHS will ensure the delivery of FP services at the community level. Local Govt's involvement is also essential to identify FP strategies at the community level. Thus, the strategy suggests good governance and accountability for all to harness the benefits of this FPS. Ensuring adequate resources for implementing the national family planning strategy is critical, and the effective management and coordination of the NFS will ensure that all Bangladeshi people benefit from this strategy, in line with securing human rights and choices.

Table: Performance Monitoring Plan, 202-5-2030

Indicators description	Baseline	Target for 2027	Target for 2030	Means of verification
Maternal Mortality Ratio	156 per 100000 live births, 2022 SVRS	100	70 - SDG 3.1.1 0 - ICPD+25 Commitment	SVRS/ MMEIG
Adolescent Birth Rate	92 per 1000 women BDHS 2022	65	60	BDHS/SVRS
Unmet Need for Family Planning	10% BDHS	7%	0 - ICPD+25 Commitment	BDHS
The proportion of women of reproductive age (aged 15– 49 years) who have their need for family planning satisfied with modern methods	73.9% BDHS 2022	85%	90%	BDHS/SVRS
Percentage of Modern contraceptive prevalence rate (mCPR) increased	54.7% BDHS 2022	60%	65 %	BDHS/SVRS/ MCS
Modern contraceptive prevalence rate (mCPR) among adolescent clients (15-19 years) increased from 47% in 2018 to 57% in 2030	48.1% BDHS 2022	53%	57%	BDHS/SVRS/ MCS
Percentage of service delivery points (SDPs) reporting no stock out of any contraceptive methods	76% BHFS 2022	85%	90%	BHFS
The number of women, adolescents, and youth benefitted from family planning during and after any humanitarian disasters	TBD	Actual in number	To be determined	A system will be developed to capture this data periodically

REFERENCES

Bangladesh Bureau of Statistics (BBS) (2022). Preliminary Report on Population and Housing Census 2022, Ministry of Planning, Govt. of Bangladesh

Bora, J., Saikia, N., Kebede, E. & Lutz, W. (2022). Revisiting the causes of fertility decline in Bangladesh: The relative importance of female education and family planning programs. Asian Population Studies, 1-24. https://doi.org/10.1080/17441730.2022.2028253.

Caldwell, J. C., Barkat-E-Khuda, Caldwell, B., Pieris, I., & Caldwell, P. (1999). The Bangladesh fertility decline: An interpretation. Population and Development Review, 25(1): 67–84.

Carty, W. P., Yinger, N. V. & Rosov, A. (1993). Success in a challenging environment: Fertility decline in Bangladesh. World Bank.

Cleland, J., Phillips, J. F., Amin, S. & Kamal, G. M. (1994). The Determinants of Reproductive Change in Bangladesh: Success in a Challenging Environment. Washington, DC World Bank.

DGFP (Directorate General of Family Planning) and Marie Stopes Bangladesh (2023). Family Planning Strategy for Hard-to-Reach Area

Islam, Mohammad Mainul, Md. Anwer Hossain and Rahul Sanjowal (2022). Bangladesh at Fifty: Changes and Challenges on Population and Development, Journal of Governance Security & Development (JGSD), Volume 3, No. 1, July 2022

Islam, M. M. (2019a). Integration of population and development issues into plans and policies, pp. 9-31, Bangladesh Monograph 5, Population Management Issues, General Economic Division (GED), Planning Commission of December 2019. Government of the People's Republic of Bangladesh.

Islam, M. M., Islam, M. K., Hasan, M. S. & Hossain, M. B. (2017). Adolescent motherhood in Bangladesh: Trends and determinants. PloS one, 12(11), e0188294. https://doi.org/10.1371/journal.pone.0188294

Khuda, B. & Hossain, M. B. (1996). Fertility decline in Bangladesh: Toward an understanding of major causes. Health Transition Review, 6: 155–167.

Ministry of Health and Family Welfare (2023). Strategic Investment Plan (SIP) for 5th Health, Population and Nutrition Sector Program (2024-29). Dhaka: Planning Wing, Health Service Division

Ministry of Health and Family Welfare (2023). Bangladesh Population Policy 2023 (Draft)

NIPORT (National Institute of Population Research and Training) & ICF. (2023). Bangladesh Demographic and Health Survey 2022: Key Indicators Report. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT and ICF.

NIPORT (National Institute of Population Research and Training) & ICF. (2020). Bangladesh Demographic and Health Survey 2017-18. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT and ICF.

National Institute of Population Research and Training (NIPORT b) and icddr,b (2023). Bangladesh Health Facility Survey (BHFS) 2022: Preliminary Report, Dhaka, Bangladesh.

National Institute of Population Research and Training (NIPORT) (2022). Urban Health Survey (UHS) 2022, Dhaka: NIPORT

Sen, A. (2013). What's happening in Bangladesh? Lancet. 382(9909): 1966-1968.

Talukdar, Md. Noorunnabi, Ubaidur Rob, Ahmed Al Sabir, Abdullah Al Mahmud Shohag (2022). Fifty Years of Family Planning in Bangladesh, Dhaka: Population Council

National Institute of Population Research and Training (NIPORT). 2022. Urban Health Survey 2021, Dhaka: NIPORT

Ministry of Health and Family Welfare (MOHFW). 2012. Bangladesh Population Policy 2012. Dhaka: MOHFW, Government of the People's Republic of Bangladesh

Ministry of Health and Family Welfare (MOHFW). 2012. National Health Policy 2011. Dhaka: MOHFW, Government of the People's Republic of Bangladesh

UNFPA. 2021. Achieving Zero Unmet Need for Family Planning by 2030: Country Road Map, Final Draft, December 2021, UNFPA Bangladesh

UNFPA 2022. Expanding Choices and Ensuring Rights: UNFPA Strategy for Family Planning, 2022–2030

Annex 1

Group-1. Access and availability of service delivery and Quality of care

Sl#	Name and Address	
1	Dr. Nurun Nahar Begum	Line Director (CCSDP), DGFP
2	Md. Niajur Rahman	Director (Finance) and Line Director (FP-FSD), DGFP
3	Dr. Shamim Akram	DD and PM (Q&A), CCSDP unit, DGFP
4	Dr. Abu Syed Md. Hasan	Program Specialist, UNFPA
5	Dr. Mahbuba Khan	NPO, WHO
6	Prof. Dr. Abul Bashar Md Jamal	ADG (Medical Education), DGME
7	Prof. Farhana Dewan	President-Elect, OGSB
8	Dr. Muniruzzaman Siddiqui	Director, MFSTC, Mohammadpur
9	Dr. Jahangir Alam Prodhan	PM (MCH), MCH services unit, DGFP
10	Hasan Amin Suman	Program Manager (FSD), FP-FSD, DGFP
11	Dr Nadira Sultana	Health Technical Specialist, GAC
12	Dr. S.M. Asib Nasim	Consultant, World Bank
13	Dr Umme Salma Jahan Meena	Family Health Team Lead, USAID
14	Dr Geeta Rani Debi	DPM, CBHC, DGHS
15	Dr. Fauzia Akhter Huda	Project Coordinator, Maternal and Neonatal Health, ICDDR,B
16	Farida Begum National	Consultant-Midwifery, UNFPA
17	Rabeya Basri	Midwifery Officer, DGNM
18	Dr. Gazi Md Rezaul Karim	Program Director-SRHR, Jhpiego Bangladesh
19	Dr. Nuzhat Nadia	DPM (EOC, Maternal Health), MNH
20	Dr. Supria Sarkar	Program Manager, HSM, DGHS
21	Dr Shafiqul Islam	Health Advisor, British High Commission
22	Dr. Md. Harun Or Rashid	Technical Advisor-Governance and Coordination, Save the Children
23	Dr. Md Sanowar Hossain	ADCC and District Consultant, Shariatpur
24	Dr. Kazi Taslima	Junior Consultant, QIS, HEU
25	Toslim Uddin Khan	Deputy Managing Director, Social Marketing Company (SMC)

Group-2. Inequalities and Urban Family Planning

Sl#	Name and Address	
1	Abdus Salam Khan	Joint Secretary, ME&FW, MOHFW
2	Dr. Md Mahmudur Rahman	Director (MCH-Services) and Line Director (MCRAH), DGFP
3	Dr. Md. Manjur Hossain	Program Manager (A&RH), DGFP
4	Dr. Dewan Md. Emdadul Hoque	Health System Specialist, UNFPA
5	Md. Azmal Hossain	Program Analyst, Urban Health, UNFPA
6	Dr. Syed Kamrul Islam	Program Manager (Tribal Health & Urban Health), UHC, DGHS
7	Dr. Zahirul Islam	Health Advisor, SIDA
8	Prof. Dr. Rowshan Ara	Past President, OGSB
9	Dr. Shamsul Karim	Director (MCHTI), Lalkuthi, Mirpur, DGFP
10	Dr. Azizul Alim,	Program Manager, Maternal Health Program, DGHS
11	Dr Pijush Chandra Sutradhar	Program Manager, FP-FSD, DGFP
12	Dr. Md. Shamsul Hoque	Program Manager (Adolescent & School Health Program), DGHS
13	Dr. Momena Khatun	Health Technical Specialist, GAC
14	Shamima Pervin	Chief-Gender, UNFPA
15	Dr. Muhammad Munir Hussain	Program Analyst- A&Y, UNFPA
16	Dr. Syed Rubayet	Country Director, Ipas, Bangladesh
17	Dr. Fatema Shabnam	Adolescent and Youth Specialist, Pathfinder International
18	Dr. Syed Mohammad Munavir Yusuf	Senior Technical Specialist (SRHR), Jhpeigo
19	Mamtaz Begum,	Assistant Director, DGNM.Mohakhali, Dhaka
20	Monjun Nahar	Advocacy Lead, Marie Stopes Bangladesh
21	SM Saikat	Executive Director, SERAC Bangladesh
22	Dr. Pintu Kanti Bhattacharjee	DD-FP, Cox`s Bazar
23	Dr. Esrat Jahan	Technical Unit Manager, Humanity Inclusion (HI)
24	Dr. Rafiqus Sultan	Freelance Consultant
25	Harun-Or-Rashid	Chief Executive, Lighthouse

৩২৮

Group-3. Enabling environment and demand generation & Multi-sectoral involvements and actions

Sl#	Name and Address	
1	Dr. Ashrafi Ahmad, ndc	Additional Secretary (Population, Family Welfare and Law Wing), ME&FW, MOHFW
2	Abdul Latif Molla	Director (IEM) & Line Director (IEC), DGFP
3	Dr. Rafiqul Islam Talukder	Assistant Director and DPM (Q&A), CCSDP unit DGFP
4	Dr. Md. Azad Rahman	Technical Officer (FP & MNH), UNFPA
6	S.M. Ahsanul Aziz	Deputy Secretary(Population-1), ME&FW, MOHFW
7	Dr Farid Uddin Ahmed	Program Manager (New born and Child Health), DGFP
8	Asma Hasan	Program Manager (PM), IEM, DGFP
9	Mohammad Mohiuddin Ahmed	Head of Behavior Change Communication, SMC
10	Israt Zabin	Asistant Director (PM), IEM unit, DGFP
11	Md.Mahbub ul Alam	Country Director, Pathfinder International, Bangladesh
12	Asma Akter	National Programme Officer-Communication, UNFPA
13	Dr. Nahida Naznin	Director (MCHTI), Azimpur, DGFP
14	Dr. Farzana Taher Munmun	DPM, CBHC, DGHS
15	Dr. Sahnaj Khan	ADCC and District Consultant, Dhaka, DGFP
16	Md. Abu Taher	General Manager-Outreach & PSS Marie Stopes Bangladesh
17	Dr Sharmina Rahman	BRAC James P Grant School of Public Health, BRAC University
18	Dr. Kazi Golam Rasul	Sr. Director and Head of Health, Freindship
19	Dr. Sharmin Sultana	FP Specialist, Pathfinder International
20	Dr. Syeda Samia Naj	Principal, FWTI, Dhaka
21	Mr. Aman Ullah	DDFP, Dhaka

Group-4. Research, monitoring and evaluation

Sl#	Name and Address	
1	Sabina Parvin	Director (MIS), DGFP
2	Mohammad Ahsanul Alam	Director (Research) & Line Director (Training research and Development), NIPORT
3	Abu Taher Md. Sanaullah Nury	Deputy Director (Per), DGFP
4	Dr. Quazi Mamun Hossain	Technical Officer (HMIS& LMIS), UNFPA
6	Md. Matiur Rahman	Director (Planning), DGFP
7	Dr. Ferdousi Begum	President, OGSB
8	Prof. Dr. Humayun Kabir Talukder	Director (Research, Publication and Curriculum Development), DGME
9	Mehbub Morshed	Deputy Director (MIS), DGFP
10	Sirajul Islam	Research Officer & Assistant Chief, Planning Unit, DGFP
11	Dr. Abdullah Al Faisal	DPM (Monitoring), PMR, DGHS
12	Bobby Rawal Basnet	Monitoring and Evaluation (M&E) Specialist, UNFPA
13	M. Shahidul Islam	Programme Specialist - P&D, UNFPA
14	Dr. Md. Abdul Wadud	DPM (Monitoring & Amp Data Quality), DGHS
15	Dr. Wahida Siraj	Chief of Health, Ipas Bangladesh
16	Sharif M.I. Hossain	Acting Country Representative, Population Council
17	Marufa Aziz Khan	Knowledge Management and Learning Manager, Pathfinder International
18	Dr. Md. Aminul Haque	Professor, Population Science Department Dhaka University
19	Dr. Ahmed Ehsanur Rahman	Associate Scientist, MCHD, icddr,b
20	Dr. Abu Jamil Faisel	Freelance Consultant
21	Dr. Ferdousi Begum	Lead SRHR, Plan International Bangladesh

-222-

Government of the People's Republic of Bangladesh
Ministry of Health and Family Welfare
Medical Education and Family Welfare Division
Population-1 Section
www.mefwd.gov.bd

Memo No. 59.00.0000.114.24.008.18.225 Date: 06.11.2022

Subject: Bangladesh FP2030 Country Commitment

Ref : Letter of FP2030 Secretariat, Dated 30.06.2022

In response to the above mentioned subject and references, as directed, this is to inform you that the Medical Education and Family Welfare Division, Ministry of Health and Family Welfare, Government of Bangladesh is agreed to the invitation for making a rights based FP2030 family planning commitment. As directed, the document titled "Bangladesh FP2030 Country Commitment' is sent herewith (attached) for necessary actions.

Encl.: as stated

Kind regards,

06.11.2022
(S. M. Ahsanul Aziz)
Deputy Secretary
Phone: 55100791
E-mail: population1@mefwd.gov.bd

Dr. Samukeliso Dube
Executive Director
FP2030 Partnership
1750 Pennsylvania Ave NW, Suite 300
Washington, DC, 20006
United States of America

Memo No. 59.00.0000.114.24.008.18.225/1(6) Date:06.11.2022

Copy for information:

1. Director General, Directorate General of Family Planning, 6, Karwan Bazar, Dhaka
2. PS to Secretary, Medical Education and Family Welfare Division, Ministry of Health and Family Welfare, Bangladesh Secretariat
3. PS to Minister, Ministry of Health and Family Welfare, Bangladesh Secretariat
4. Country Representative, UNFPA-Bangladesh, IDB Building, E/8, Begum Rokeya Sharani, Agargaon, Dhaka-1207
5. PO to Additional Secretary (Population, FW and Law), Medical Education and Family Welfare Division, Ministry of Health and Family Welfare, Bangladesh secretariat
6. PO to Joint Secretary (Population), Medical Education and Family Welfare Division, Ministry of Health and Family Welfare, Bangladesh secretariat

06.11.2022
(S. M. Ahsanul Aziz)
Deputy Secretary

Bangladesh
FP2030 Country Commitment

VISION STATEMENT

By the end of 2030, Bangladesh aspires to be a country where everyone particularly women and girls lead healthy lives with equitable and inclusive access to and utilization of rights-based family planning services towards attaining sustainable development goals.

COMMITMENT OBJECTIVES

Commitment Objective 1(key elements are underlined):

Update, adapt and implement <u>policy framework</u>, regulations, <u>accountability</u> and compliance to improve SRHR including FP through an integrated, multi-sectoral and human right-based approach targeting leaving no one behind (LNOB) across the development and humanitarian continuum.

Objective Statement: Commits to ensuring enabling policy environment and accountability to achieve the national FP goals for 2025 (8th five-year plan) and 2030.

Rationale:

Bangladesh has a conducive environment for policies and strategies. The government approved the first population policy and guidelines in 1976 considering both FP and non-FP measures which were updated in 2012. The National Population Council has been formed headed by the honorable Prime Minister and assigned MoHFW for implementation of recommendations and decisions. The country has also developed the National Adolescent Strategy for 2017-2030 and National Strategy for Maternal Health, 2019 - 2030.

The current 4th Health, Population and Nutrition sector programme prioritized family planning programmes and allocated resources accordingly and the current 8th Five Year plan has also reflected the priority of the family planning programme and ICPD Programme of Action and commitment with specific targets to achieve by 2025 and 2030. Despite having many supportive policies and regulations, the country should support strict implementation strategies with adequate resource allocation. There is also a need for developing a family planning strategy and implementation guidelines with a costed action plan.

STRATEGIES:

- The Ministry of Health and Family Welfare (MoHFW) and its directorates particularly DGFP through participatory processes especially by engaging civil society organizations (CSOs), research organizations, academicians, professional societies and related stakeholders will review the existing relevant legal and policy framework, regulations, accountability mechanisms and will identify strategic areas for improving the access and use of SRH services particularly FP to achieve FP2030.
- Based on the review and analysis of existing policies and guidelines and by embracing the National Population and Health Policy, ICPD, SDG & UHC commitments of the country DGFP through an inclusive, and transparent process, will develop a human rights-based National Family Planning strategy with an Action Framework to achieve the country's FP2030 goal and commitments.
- The framework will be translated into implementation plan/s with budgetary provisions to support Line Directors and Programme Managers to allocate adequate resources in the respective operational plans of the sector-wide programme of MoHFW with special attention to the Hill Districts, urban and other underserved areas.

-320-

- DGFP will coordinate with DGHS, NIPORT, DGNM, DGME, CSOs and other ministries like MOE, MOWCA, MOSW and MRA to ensure the implementation of the strategic framework.
- Considering that 30% of the population lives in the urban areas to address the urban population, DGFP will facilitate MOHFW to coordinate with the Local Government (LG) Division of MOLGRD&C and along with CSOs will support them to set up very specific policies, strategy, and programme for urban areas for improved access to and utilization of quality, inclusive, equitable, gender and shock-responsive, universal, climate-resilient and human rights-based sexual and reproductive health information and services.
- An urban SRHR coordination body (Technical Committee/Task Force) will be formed jointly with LG Division, DGFP, DGHS and other stakeholders to monitor progress in the urban areas.
- Develop and implement a monitoring and evaluation strategic framework to strengthen routine monitoring systems with an eye toward making available adequate human resources.
- A small independent monitoring group (FP2030 Technical Team) involving key stakeholders will be formed to track the progress with existing and available secondary data from national population-based surveys, policy and programme documents and routine MIS data.

INDICATOR (S) TO REVIEW PROGRESS:

a. Review, and update National Population Policy and Health Policy;
b. A human rights-based National Family Planning Strategy with an Action Framework developed;
c. A functional urban SRHR Coordination body/Technical Committee/Task Force formed and periodic meeting minutes recorded.

INDICATOR (S) with the frequency of reporting:

Work on setting up the indicator benchmarks will be completed as mentioned in the Table below to serve the purpose of finding out the achievement of Objective # 1. Then every three (03) years' will review the progress.

Sl. No.	Indicators	Timeline /Frequency of reporting	Means of verification	Responsibility
a.	Bangladesh Population Policy 2012 updated:	December 2023	Updated Population Policy	Additional Secretary (Population, family Welfare and law), Medical education and Family Welfare Division, Line Director- Planning, DGFP, UNFPA
b.	1b. A human rights-based National Family Planning Strategy, and guidelines with a costed action plan (CIP) developed; 2b. FP strategy implementation plan developed	1b. December 2023 2b. December 2023	Endorsed FP Strategy available	Line Director-CCSDP, UNFPA LD-CCSDP, UNFPA, and Pathfinder
c.	A functional urban SRHR Coordination committee formed	December 2022	Meeting minutes	LD-CCSDP LD-FSD Additional Secretary (Population, Family Welfare and law), Medical education and Family Welfare Division,

১৯-

Commitment Objective 2 (key elements are underlined):

Improve availability, accessibility, and utilization of modern contraceptives with a special focus on adolescents, postpartum, and post MR/PAC users, to reduce high discontinuation rates and high unmet need for family planning both in public and private facilities and at communities.

Objective Statement: Firm commitment to achieve universal access to integrated, equitable, inclusive, and quality SRH and right-based FP services targeting high-risk and marginalized groups with available routine reporting systems.

Rationale:

Although Bangladesh has made remarkable progress toward universal access to SRH and FP services still some districts have been left behind in the country's development trajectory. The child marriage rates remained high and the increased CPR is largely dependent on short-acting methods and more than 90% method users are female. Compared to the national CPR of 62%, among young couples aged 19-24 is low at 48.9% and the adolescent birth rate is high at 74 births per 1,000 women aged 15-19 years. The unmet need for family planning is 12% and remained plateaued over the last 10 years.

The discontinuation rate has also increased to 37% (BDHS, 2017) which was 30% in the previous survey (BDHS, 2014). Expanding strategies are required to increase geographical coverage including urban areas and coverage for the targeted populations and equitable access to quality right-based family planning services. Moreover, the inclusion of indicators in DGFP and DGHS DHIS-2 to monitor the progress is required.

STRATEGIES:

- DGFP and stakeholders will work with DGHS for institutionalizing FP services in DGHS facilities through systematic approaches with a particular focus on postpartum, and post MR/PAC FP and also by engaging DGME and DGNM.
- Expand provision of FP services in urban slums and private health sectors including factory clinics through a public-private partnership including supply of commodities wherever necessary.
- A comprehensive urban FP/SRHR implementation strategy including tools and matrixes will be developed to ensure the quality and coverage of inclusive, equitable, and nonjudgmental FP services.
- Expand FP information/SBCC and service provision for potential male clients by engaging other health service providers, including general surgeons, urologists, venereologiest for clinical contraception services and pharmacists'/drug sellers, alternative medicine providers, and LG representatives, community-level providers, and 1st line supervisors for counseling and referral for FP services.
- DGFP in collaboration with other directorates (DGHS, DGNM, etc.) and partners will ensure FP services during any pandemic (COVID-19, new emerging diseases, etc.) or emergency situation that arises. The necessary preparedness and response plan will also be developed as required.
- Introduction and scaling up new evidence-based contraceptives and technologies in the national FP program.
- Improve availability of contraceptives in the open market, especially IUDs and Implants.
- Initiatives will be taken to improve/strengthen monitoring, mentoring, and on job support for quality improvement through developing and implementing a strategy for functioning QI initiatives in a sustainable approach. The district quality improvement team will be capacitated with the required knowledge, skill, logistics support, and standard tools and matrix to conduct monitoring and provide mentoring support to DGFP, DGHS, and private FP facilities and their providers.

INDICATOR (S) TO REVIEW PROGRESS:

a. Post-partum, post-MR, and PAC contraceptive service statistics are available in DHIS2 and reviewed periodically.
b. Percentage of district and sub district health facilities providing human rights-based post-partum and post-abortion care family planning services
c. Modern contraceptive prevalence rate (mCPR) among adolescent clients (15-19 years) increased from 47% in 2018 to 57% in 2030.
d. The unmet need for family planning among adolescent clients reduced from 15% in 2018 to 10% in 2030.

INDICATOR (S) with the frequency of reporting: DGFP and DGHS MIS (DHIS2) can provide disaggregated data regarding contraceptive use among adolescents, and postpartum women, and Post MR/PAC users both from the public and private sectors. Contraceptive use among adolescents can also be obtained from national population-based surveys.

Disaggregated data collection system will be set up to track the progress of Objective # 2 as mentioned in the table below. Progress will be reviewed every year till 2030.

Sl. No.	Indicator	Timeline /Frequency of reporting	Means of verification	Responsibility
1	Post-partum, post-MR, and PAC contraceptive service statistics are available in DHIS2	December 2022	DHIS2 and DGFP MIS	LD-MIS
2	Percentage of district and sub district health facilities providing human rights-based post-partum and post-abortion care family planning services	Starting in the last quarter of 2022 and then every quarter	DHIS2 and DGFP MIS	LD-MNCAH LD-CCSDP LD-FSD LD-MIS (DGHS and DGFP)
3	Modern contraceptive prevalence rate (mCPR) among adolescent clients (15-19 years) increased from 47% in 2018 to 57% in 2030	Every 3 years	BDHS	LD-CCSDP LD-FSD LD-MCRAH
4	Unmet need for family planning among adolescent clients reduced 15% in 2018 to 10% in 2030	2030	SVRS + BDHS	LD-CCSDP LD-FSD LD-MCRAH LD-IEC

Commitment Objective 3: (key elements are underlined):

Thrives for distinct information, education, and communication interventions to increase demand for equitable, gender-responsive, climate-resilient, respectful, and quality FP information and services with special attention to adolescents, young population, the male, disadvantaged population including people living with disabilities

Objective Statement: Determined to increase demand for SRH and family planning services to achieve the targets of key FP indicators by 2030.

Rationale:

In 1975 under the Directorate General of Family Planning the Information, Education and Motivation (IEM) unit was established with key objectives to promote the concept of small family size and to generate demand for family planning and maternal and child health services. The IEM unit is responsible for the design, development, distribution, and dissemination of SBCC materials including audio-visual aids. In 1993, the MoHFW developed the first-ever National FP-MCH IEC strategy (1993-2000), and in 2008 the National Communication strategy for FP and reproductive health. Despite recent development in communication and access to information, women and adolescents especially from poor and marginalized segments are left out who have poor access to required information and knowledge. Moreover, male engagement remained absent in their role and engagement in the FP. Innovative, evidence-based, and targeted approaches will be required to reach high-risk groups like adolescents, young people, and male and disadvantaged populations. A review and update of the current IEC strategy will be required to achieve the commitment.

৩১৭

STRATEGIES:

- Review and update Social and Behavior Change Communication (SBCC) strategy with the inclusion of new evidence-based approach and innovation, particularly using **social media (FB, Twitter, YouTube, etc.)**. The SBCC strategy will focus on developing standard messages, and defining modes of communication to improve knowledge, attitude toward SRH behavior, and care-seeking. Message and communication modes will be customized based on different groups, including adolescents, the young population, males, the disadvantaged population such as people living with disability, and others. High Impact Practices (HIP) in SBCC will be integrated into the strategy.
- Develop and implement a strategy for knowledge upgrading and attitude transformation of all levels of providers to provide respectful and non-judgmental FP information and services
- Collaboration mechanism with different Directorates (DGHS, DGNM, DGME, NIPORT) and ministries, including the Ministry of Youth and Sports, MOLGRD, MOWCA, Information Ministry and Education Ministries will be established with DGFP to ensure the promotion of standard SRHR messages and to promote Comprehensive Sexuality Education (CSE) for adolescents through life-skills education and and using school health program.
- Activities will be implemented to increase access to SRHR information for adolescents and young populations irrespective of their marital status through comprehensive sexuality education, premarital and preconception counseling.
- SBCC activities will be targeted towards reaching working women such as garment workers, slum dwellers, and floating population through satellite sessions.
- Available indicators to assess SRH knowledge at the population level collected through different national surveys, including DHS, and MICS will be reviewed and necessary formative and validation study will be conducted to identify standard indicators for the evaluation of SBCC strategy.
- Collaborate with the Ministry of Religious Affairs to improve SRHR and FP knowledge among religious leaders, imams, and marriage registrars.
- Premarital and preconception counseling intervention packages will be strengthened and expanded to reach adolescents and youths.
- Utilize professional bodies working in health and other sectors to reach people with the SBCC messages.
- Strengthen community support systems to ensure men and boys' engagement and participation in the FP activities at the community level.

INDICATOR (S) TO REVIEW PROGRESS:

a. SRH knowledge at the population level is collected through SVRS and BDHS, reviewed, and analyzed, as and when available.
b. A number of CSE modules are incorporated into the national school curriculum.
c. A number of religious leaders are oriented toward updated SRHR information.
d. Number/Proportion of male clients counselled on modern contraceptives
e. Proportion of pregnant women counselled on PPFP during ANC visits

INDICATOR (S) with the frequency of reporting:

IEC/SBCC materials, and demand creation activities of DGFP are ongoing. New approaches (like reaching people through community radio, digital messages through mobile phone, local TV channels/YouTube and social media, etc. shall have to be introduced. Appropriate indicators included in MICS, BDHS and SVRS, and DGFP MIS by September 2022. Progress will be reviewed every year.

Sl. No.	Indicator	Timeline /Frequency of reporting	Means of verification	Responsibility
1	SRHR knowledge at the population level available in national surveys	Every Fourth quarter of fiscal year	Data collected through SVRS of BBS and future BDHS	DGFP and partners
2	Number of CSE modules incorporated in the national school curriculum. Target: 6 among 8 by 2026	June 2024	Revised national curricula	DGHS, DGFP, DISHI
3	Number of religious leaders oriented on updated SRHR information.	June 2024	Annual report	LD-IEC
4	Number/Proportion of male clients counselled on modern contraceptives	Periodic/ every six months	DHIS2 and DGFP MIS	LD-IEC
5	Proportion of pregnant women counselled on PPFP during ANC visits	Periodic/ Every six months	DHIS2 and DGFP MIS	LD-IEC

Commitment Objective 4 (key elements are underlined):

Improve evidence-based programming, budgeting, resource allocation, and data management systems for decision-making and knowledge management in the area of the Family Planning Program.

Objective Statement:

Advocacy to allocate adequate budgetary allocation and efficient use for FP programmes and sustained during the period of commitment.

RATIONALE:

The 4th Health, Population, and Nutrition sector program (2017-2022) contains 30 operational plans of which 7 are for DGFP. The total budget for these 7 OPs is 4923.48 crore BDT. Share for the DGFP is 11% of the total HPNSP budget. In the 3rd Health, Population, Nutrition sector Development program (2011-2016) the allocation for DGFP was 413,4.59 crore BDT. So the budget in the current sector program for DGFP has increased by 19 percent.

A Costed Implementation Plan for National Family Planning Program in Bangladesh (2020-2022) was developed in March 2020. All strategies along with their activities and sub-activities were identified and costed. The full cost covers the cost of contraceptive commodities, filling up the vacant post, and other relevant costs. The cost for three years (2020-22) is 6100 crore BDT. Adjusting for the costs already included in the OPs, the additional cost required to carry out all the strategies is USD 530.34 million.

DGFP has a robust electronic logistics management system to monitor the supply chain of all commodities. The LMIS data needs to be reviewed on a quarterly basis to find out any problems in the supply chain system. DGFP has also been transforming open access FP MIS into DHIS2. The FP DHIS2 should expand in all 64 districts with improved data quality.

STRATEGIES:

- Each year an operation research or implementation research will be commissioned to expand contraceptive method mixes and evaluate the effectiveness of FP programs.
- Budgeting and need-based resource allocation will be ensured through periodic program reviews and revising respective operational plans as per requirements.
- Strengthening the DGFP Data management system and ensuring standard FP data from DGHS and private facilities by strengthening DHIS2 of DGHS and establishing a data-sharing mechanism between DGHS and DGFP MIS.
- Expand FP-DHIS2 in all districts for improving data quality and its utilization for program planning and monitoring. Monitoring contraceptive availability and FP performance at district and sub-district levels would be strengthened.
- Introduce Data Quality Assurance (DQA) systems to improve the quality of data for appropriate program planning and budgeting.

INDICATOR (S) TO REVIEW PROGRESS:

a. Conduct need-based operation or implementation research
b. At least 85% of the allocated budget of 07 FP operational plans is utilized every year.
c. FP data collection system introduced into DHIS2 of DGHS. The FP data of DHIS2 will be connected with DGFP MIS and attempts will be made to look at the aggregate situation of the contraceptive use in the country every year.
d. Contraceptive sales data from SMC and other major private sector entities will be collected every six months, reviewed, and analyzed.

INDICATOR (S) with the frequency of reporting:

Every year till 2030 the achievement of the indicators set up for the achievement of this objective will be reviewed.

Sl. No.	Indicator	Timeline /frequency	Means of verification	Responsibility
1	At least 85% of the allocated budget of 07 FP operational plans utilized in every year	July 2023	Annual Progress Review report	All LDs of DGFP
2	FP data available in DHIS2 of DGHS	End of 2022.	DHIS2	LD-MIS of DGHS and DGFP

COMMITMENT CONSULTATION PROCESS

In Bangladesh the consultative process used to develop this commitment is described below.

- **A mutual accountability approach** where Bangladesh Government (DGFP), in collaboration with key stakeholders, have obligated to deliver on the commitments they have made, and civil society is galvanized to support the implementation of action plans and engaged to monitor progress toward achieving the commitments along with the government. For developing the Bangladesh FP 2030 Government Commitment a multi-member Technical Working Group comprising representatives from MOHFW, development partners, CSOs, and academicians with the leadership of DGFP has been constituted. The technical group has been met several times to draft the government commitments and had consultations with greater stakeholders including the private sector and senior government officials to vet the commitments.

- **Accountability structures** and processes will span the full cycle of the commitment, meaning assessing the previous commitments, developing new commitments, implementing commitments, and tracking progress. Progress will be tracked using DGFP MIS and any other data collected through special efforts. In the Bangladesh accountability structure, we will try to obtain service data from the private sector on a sample basis and analyze it accordingly. Every quarter special online meeting with the Divisional officials of DGFP will be held where achievements on the commitments will be discussed and implementation hurdles will be identified.

COMMITMENT ACCOUNTABILITY APPROACH

A **Mutual accountability** approach has been set up where the government (DGFP and MOHFW) are obligated to deliver on the commitments they have made, and civil society partners are engaged to support the government to deliver on the commitments and monitor progress. The accountability steps are as follows:

- The FP 2030 Technical Working Group/Support Network (former FP 2020 Country Engagement Working Group) will work with the Bangladesh Government to ensure that commitments are anchored in evidence and rights-based approaches, and will share information on the country's progress through annual reports and country updates.
- International/national nongovernmental organizations (I/NGOs), Development Partners and other organizations will support the commitments by implementing programs consistent with national commitments and priorities.
- Donors will support commitments through financial and technical assistance.
- Civil societies will drive accountability at the national level by working in collaboration with other stakeholders to monitor progress and advocate for action.

Bottom-up accountability approach that elevates the role of civil society and youth partners: In this regard, every quarter special online meeting with the District officials of one Division of DGFP will be held where achievements on the commitments will be discussed and implementation hurdles will be identified. Progress will be tracked using DGFP MIS and any other data collected through special efforts. In Bangladesh, accountability structure systems will be set up to obtain service data from the private sector on a sample basis and analyze it accordingly.

Meaningful participation of traditionally underserved and overlooked groups through existing and new *inclusive* platforms, in implementation and monitoring of progress. In this regard, specific data will be obtained from the use of the Adolescent Friendly Health Service Centers and that will be reviewed periodically. Information/data will also be obtained from nationally recognized youth-led organizations and analyzed to decide on future action steps. All of these will ensure a process of participation of the largest underserved and overlooked group, the youths, and adolescents.

Visibility and transparency in sharing information on the country's progress towards meeting the commitments will be ensured. In this connection, field-level information will be shared with MOHFW and the IMED of the Planning Commission. Data from other sources such as BDHS of NIPORT, MICS, and SVRS of BBS relevant to DGFP MIS will be reviewed periodically on progress and shared that data/information with partners and MOHFW.

The DGFP MIS data reflecting the work being carried out in regard to achieving FP2030 objectives will be aligned **with other national processes** for monitoring other commitments such as EWEC, ICPD+25, SDG, etc.

Remedial actions will be taken at the country level if there is a lack of progress or if there are outright violations of sexual and reproductive health and rights in the country. The actions will be jointly decided at the DGFP headquarters in consultation with the MOHFW and FP 2030 Technical Committee. The actions will be implemented in a facilitative manner.

The above-mentioned **accountability approach will be funded** in majority by the Directorate General of Family Planning and supplemented in specific areas by UNFPA and other Development Partners (DPs) such as USAID, FCDO, GAC, Sida and World Bank,

The technical assistance (TA) needed to fully implement the above accountability approach will be planned by UNFPA and other DPs in consultation with DGFP. The TA actions will be lined up with the DGFP activities as laid out in their different Operational Plans.

COMMITMENT LAUNCHING

The Bangladesh FP 2030 Commitment will be presented to the MOHFW senior officials for their review and validation. It would be launched by the Minister of MoHFW by first week of September 2022 while uploading it to MoHFW website and other relevant websites.