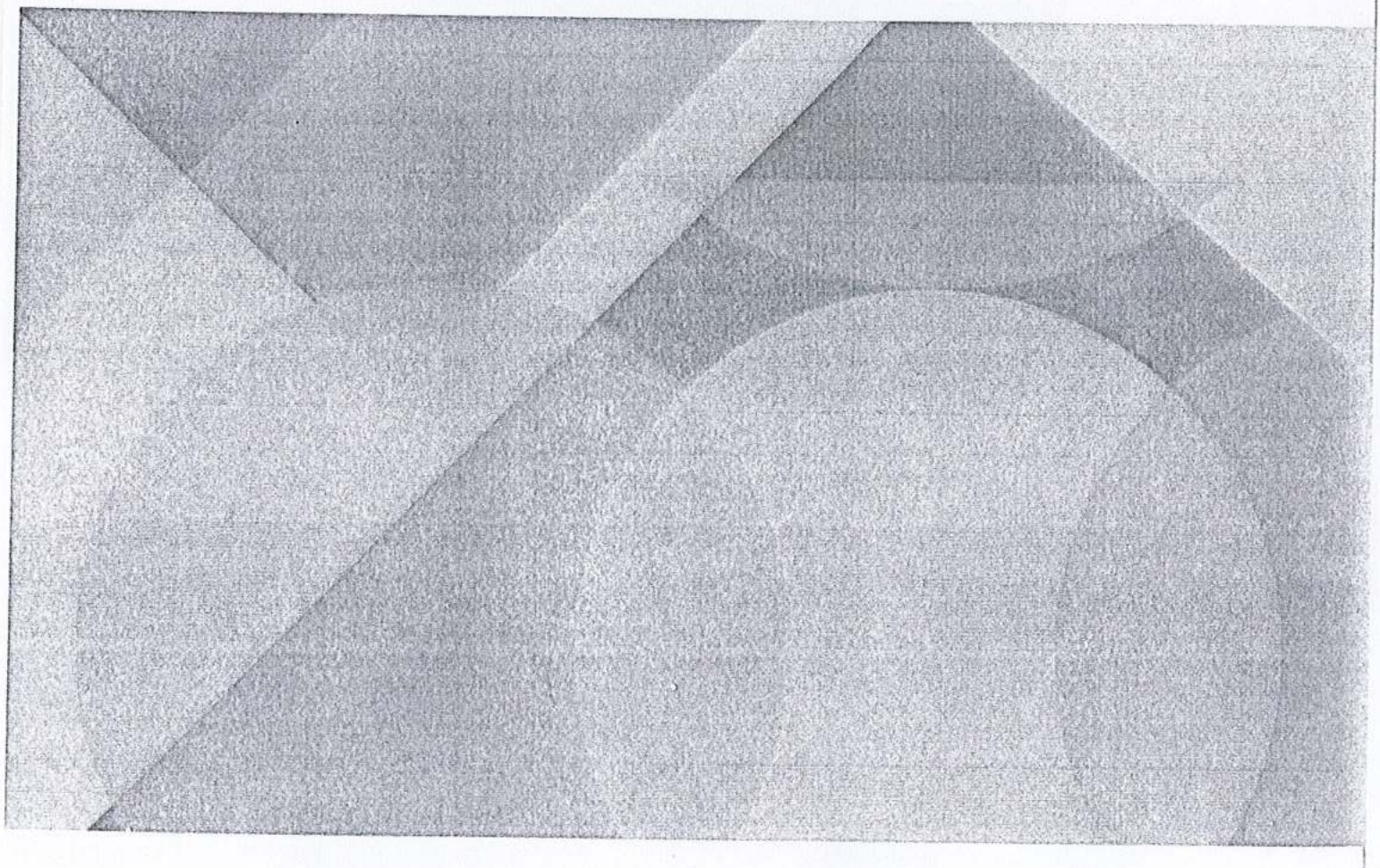
Improving the Availability of
Long-Acting Reversible Contraceptives and Permanent Methods (LARC & PM) Services
at Public and Private Health Facilities

Priority Action Plan 2019 - 2023



Clinical Contraception Services Delivery Program
Directorate General of Family Planning

Medical Education and Family Welfare Division
Ministry of Health and Family Welfare

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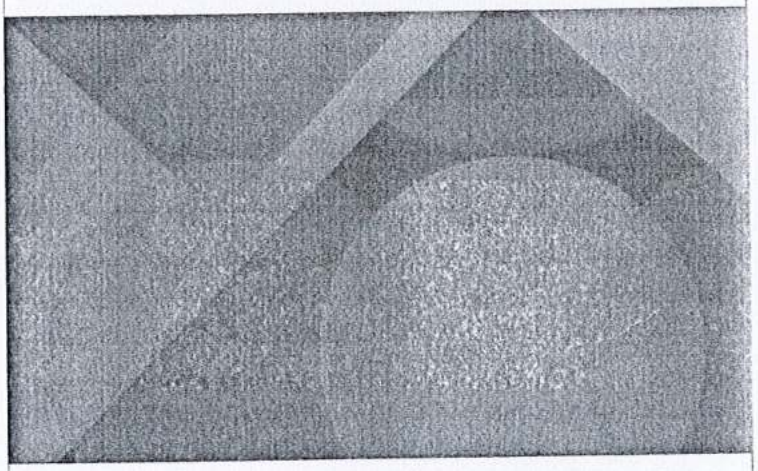

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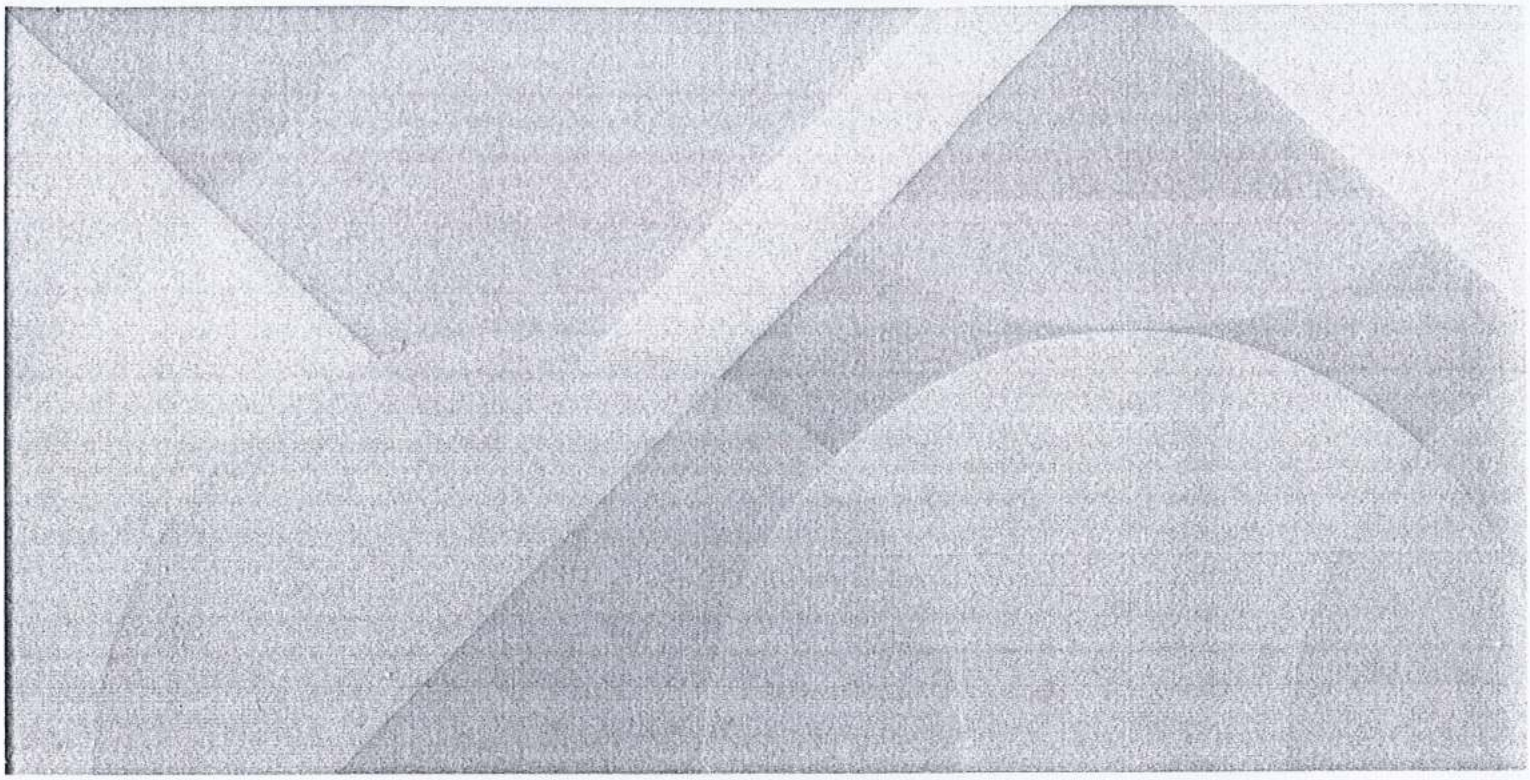
Foreign, Commonwealth & Development Office

United Nations Population Fund



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Abbreviations

ADCC	Assistant Director, Clinical Contraception
AFHS	Adolescent Friendly Health Services
AFWO	Assistant Family Welfare Officer
ANC	Antenatal care
APR	Annual Program Review
BAVS	Bangladesh Association for Voluntary Sterilization
BCC	Behavior Change Communication
BDHS	Bangladesh Demographic and Health Survey
BHFS	Bangladesh Health Facility Survey
CBD	Community Based Distribution
CCSDP	Clinical Contraception Services Delivery Program
CPR	Contraceptive Prevalence Rate
CYP	Couple Year Protection
DDFP	Deputy Director of Family Planning
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DLI	Disbursement Linked Indicator
EPI	Expanded Program on Immunization
FoC	Fundamentals of Care
FPCS-QIT	Family Planning Clinical Supervision and Quality Improvement Team
FP-FSD	Family Planning-Field Service Delivery
FPI	Family Planning Inspector
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
FWVTI	Family Welfare Visitors' Training Institute
GOB	Government of Bangladesh
H&FWC	Health and Family Welfare Center
HPNSP	Health Population and Nutrition Sector Program
IPC	Interpersonal Communication
IUD	Intra Utérine Contraceptive Dévies.
LARC & PM	Long-acting Reversible Contraceptive and Permanent Methods
MCHTI	Maternal Child Health Training Institution
MCWC	Maternal and Child Welfare Center
ME&R	Monitoring, Evaluation and Research
MFSTC	Mohammadpur Fertility Services and Training Institute
MIS	Management Information System
MISHD	Managing Innovations for Sustainable Health Development
MO	Medical Officer
MOCC	Medical Officer-Clinical Contraception
MO (MCH-FP)	Medical Officer-Maternal Child Health and Family Planning

MOHFW	Ministry of Health and Family Welfare
MOLGRDC	Ministry of Local Government, Rural Development and Cooperatives
MOU	Memorandum of Understanding
MSB	Marie Stopes Bangladesh
MSR	Medical Surgical Requisites
NGO	Non-Government Organization
NIPORT	National Institute of Population Research and Training
NSV	No-Scalpel Vasectomy
NTC	National Technical Committee
Obs-Gyn	Obstetricians and Gynecologists
OGSB	Obstetrical and Gynecological Society of Bangladesh
PAC	Post Abortion Care
PAP	Priority Action Plan
PINA	Performance Improvement Needs Assessment
PNC	Postnatal Care
POP	Progestin only Pill
Post-MR	Post-Menstrual Regulation
PP BTL	Postpartum Bilateral Tubal Ligation
PP IUD	Postpartum Intra Uterine Devices
PP Implant	Postpartum Implant
PPFP	Postpartum Family Planning
PPV	Paid Peer Volunteer
QoC	Quality of Care
RMO	Resident Medical Officer
SACMO	Sub-Assistant Community Medical Officer
SMC	Social Marketing Company
Sr. FWV	Senior Family Welfare Visitor
SSFP	Smiling Sun Franchise Program
SRH	Sexual and Reproductive Health
SVRS	Sample Vital Registration System
TA	Technical Assistance
TFR	Total Fertility Rate
TOT	Training of Trainers
UFPO	Upazilla Family Planning Officer
UH&FPO	Upazilla Health and Family Planning Officer
UP	Union Parishad; Upazila Parishad
UPHCP	Urban Primary Health Care Project
USAID	United States Agency for International Development
VSC	Voluntary Surgical Contraception
YMC	Young Married Couple

Chapter 1
Background and Situation Analysis

The Annual Program Review (APR) of the 4th Health Population and Nutrition Sector Program (HPNSP) held during 20th January to 20th February 2019. The review covered the period from January 2017 to end of June 2018. The APR team has provided a list of recommendations linked to the three components of the 4th HPNSP as well as on cross-cutting issues. In family planning section under the component 3-Quality Health Services, the recommendation was to develop a priority action plan (PAP) for the improvement of current low availability LARC and PM services at public and private facilities. The CCSDP unit of the DGFP will lead for the development of this PAP which will be agreed upon by the DGHS and DGFP.

Total Fertility Rate (TFR) remains relatively unchanged although the actual level varies depending on the data source used. BDHS-2017 data suggests that the 2.3 births per woman remain the same since 2011. Bangladesh Sample Vital Registration System (SVRS-2020) data shows a lower TFR baseline and a small decrease to 2.04. The 4th HPNSP aims to reach TFR 2.0 by 2022. Rural fertility is a bit higher than urban fertility and it shows some sign of decline in the last three years. Bangladesh has experienced immense regional disparities in fertility and contraceptive use. The FP program has successfully reduced fertility to the replacement level or below in the western region (Khulna, Rajshahi and Rangpur Divisions), on the other hand fertility rate is still high in eastern region (Chattogram and Sylhet Divisions). The new Mymensingh division has emerged as another low performing division having a TFR 2.5. The share of LARC & PM is 8.6% in the method mix of 62% CPR (BDHS-2017) which is very low. This share needs to be increased to 20% by 2022 which is very challenging.

Facility readiness for providing FP services at public facilities has improved from 38% in BHFS 2014 to 52% in BHFS 2017. However, all health facilities are not ready to provide FP services particularly LARC & PM services. BHFS 2017 showed that very few District Hospitals, Union Static Clinic/Rural Dispensaries and private health facilities are providing FP services. One in four health facilities in Bangladesh are providing LARC & PM services. Less than 5% of all health facilities provide PM services. The household visitation by the DGFP field workers for providing FP services is also low. Findings of BDHS 2017 reported that, field workers visited only 20% of the married women in last 6 months, which declined sharply from 43% in 1993/94. Both the FP-FSD and CCSDP OPs recruited volunteers to provide FP services.

Post-partum Family Planning (PPFP) is an important innovative approach to improve maternal, neonatal, and child health outcomes. Bangladesh developed a National Action Plan for Post-partum, Post-menstrual regulation (Post-MR) and Post-abortion care(PAC) family planning with integration of PPFP counseling during ANC, PNC, delivery care and EPI session, with a focus on LARC & PM. Moreover, the DGFP issued a circular in 2016 jointly signed by both the Director General of DGHS and DGFP encouraging PPFP counseling during all ANC, PNC, delivery care and EPI sessions. DGFP also issued a circular about the use of implants and POPs as immediate postpartum method, in order to encourage greater PPFP coverage. In addition, to increase the availability and performance of PPFP services in the DGHS health facilities (Medical College Hospitals, District Sadar Hospitals and Specialized Hospitals), the MOHFW has provided approval to allocate "Imprest fund" to the respective head of the facilities to deal with the spot payment (travel cost, food cost and compensation of wage lost for LARC and PM services recipients) for PPFP services. One of the issues raised during the APR is that of early marriage and child bearing is common among Bangladeshi women. The median age at first marriage among women age 20-49 years has continued to rise slowly, increasing from 15.3 years in 2007 to 16.3 years in 2017 (BDHS-2017).

The proportion of women age 20-24 who married before age 18 declined from 66% in 2007 BDHS to 65% in 2011 BDHS, and finally to 59% in 2014 BDHS. Since 2014 BDHS there has been no further decline in early marriage. The unmet need for family planning is higher among the 15-19 age group (15.5 %) compared with the national average of 12%. On the other hand, CPR is lowest among the teenage women (49%) compared with other reproductive age group (62%).

In Bangladesh, social stigma, fear of side-effects, religious restrictions and misbelieves on FP still exists in some areas. All FP method discontinuation rate has increased from 30% in BDHS 2014 to 37% in 2017. More clients are obtaining contraceptive from a pharmacy/drug store without proper counseling.

The share of private sector as a source of contraceptive supply has increased mostly for temporary family planning methods. LARC & PM are usually obtained from a public facility. Facility delivery increased from 37.4% in BDHS 2014 to 49.6% in 2017 BDHS. Most of this increase in facility deliveries happened in the private sector (from 22.4% in 2014 BDHS to 31.55% in 2017 BDHS). The proportion of deliveries taking place in public health facilities increased from 12.8% in 2014 BDHS to 14.3% in 2017 BDHS only during the same period. The BHFS 2017 also showed the readiness of the health system to address two main causes of maternal death (hemorrhage and eclampsia, accounting for 54% of maternal deaths) and other complications in maternal health is not sufficient. Thus, the quality of services provided at private health facilities is likely to have the most impact on avoiding maternal deaths and morbidity.

Challenges in improving availability of LARC & PM services

The challenges are categorized as demand side, supply side and policy side issues:

Demand sides issues

- The share of LARC & PM in the method mix of CPR is low (8.6%, BDHS-2017) and need to increase it to 20% by the year 2023 which is very challenging.
- Despite of increasing trends in institutional delivery (50%) uptake of PPFP is very low.
- Low levels of awareness on LARC & PM including PPFP at the facility and community level.
- Myths & misconception about LARC & PM including PPFP.
- Need for increased male participation in programs.
- Decreasing trend of interval tubal ligation.
- Unmet need for PPFP is still very high which is 44% (SVRS-2018) though reduced from 65% in 2007 (BDHS-2007)
- Unsupportive Kwami religious leaders (a faction of Imams)

Supply side Issues

- Family planning service delivery at urban areas particularly for the slum dwellers and the floating and poor people in the city corporation areas.
- Staff shortages and lack of timely recruitment
- Inadequate availability of skilled service providers at appropriate places.
- Limited number of trained and skilled service providers to offer PPFP services at the time of delivery at DGHS facilities.

- Lack of positive attitude and attention of service providers and field workers.
- Ensuring counseling on PPFP during ANC, Delivery, PNC & EPI sessions.
- Lack of continuity in the supply of contraceptives, especially IUDs and implants;
- Strengthening quality of LARC & PM including PPFP services

Policy side issues

- To impart knowledge about Imprest fund management and streamlining supply of FP commodities and other logistics at DGHS facilities to provide PPFP services.
- Strengthening coordination & collaboration between DGFP and DGHS.
- Strengthening coordination and collaboration between DGFP and private medical college hospitals and private clinics.
- Introduction of LARC & PM including PPFP services at private medical college hospitals and private clinics
- Adolescent birth rate (aged 10-19 years) per 1000 women of that age group is very high which is 113 per 1000 live birth (BDHS-2014)
- Strengthening supervision and monitoring system in the program

Chapter 2
Vision, Mission and Objectives

Vision

Increased availability and popularity of long-acting reversible and permanent methods (LARC & PM) of contraception, making them the method of choice for all couples who wish long-term spacing or who would like to limit their childbearing.

Mission

To achieve CPR from 62.4% to 75% with 20% share of LARC & PMs in the total method mix by the year of 2023.

Specific Objectives

1. Increase CPR to 75% with 20% share of LARC & PM by 2023.
2. Reduce Total Fertility Rate (TFR) from 2.3 to 2.0 by 2023.
3. Provide quality LARC & PM services including PPFP and Post MR/MRM, PAC FP services with special focus in hard-to-reach and low performing areas including urban slums
4. Reduce the unmet need for LARC & PM (including for young married and postpartum women) to 10%
5. Reduce adolescent birth rate (aged 10-19 years) per 1000 women in that age group to 70 by 2020 from 113 per 1000 live birth in 2014 (BDHS-2014)
6. Strengthen service capacity and improve the quality of care including clinical supervision and monitoring in delivering LARC & PM services.
7. Advance and strengthen partnerships among GO-NGOs and private sectors to increase availability of LARC & PM including PPFP services.
8. Increase the use of LARC & PMs by generating demand.
9. Ensure commodity security.

Chapter 3
Strengthening Service Delivery by Capacity Building and Availability

Accessibility and availability of LARC & PM services means the degree to which these services can be offered and or obtained at an effort and cost acceptable to and within the means of the majority of the population. There is decreasing trend of LARC & PM performances and the yearly acceptance is far below the number of couple eligible for accepting LARC & PMs, and there is a large unmet need for spacing and limiting. For strengthening service delivery and capacity building and availability the following initiatives would be taken.

1. Availability of skilled service providers at appropriate places

Inadequate availability of skilled service providers at the facilities is a great challenge for th Family Planning Program and in particular for LARC & PMs. Approaches to meet the need for skilled providers include:

- Ensuring the availability of the requisite skilled service providers maintaining appropriate selection and administrative rules in posting and placement;
- Establishing skilled service providers pools at district level and provide services within the district as per need;
- Ensuring continuous skills-based training and on the job training;
- Endorsing circulars for providing LARC & PM particularly PPFP services by DGHS providers;
- Let DGHS/ NGO physicians provide LARC & PM services in places where an MO(MCH-FP) is not available;
- Involving Surgeons and Obs/Gyn professionals for service delivery and recanalization;
- Formation of Roving teams with public and/or private doctors, in particular for the hard to reach areas.

2. Capacity Development on LARC & PMs

Capacity development on the LARC & PMs refers to the approaches or strategies used by the stakeholders to improve performance at the individual, organizational, or broader system level. The following capacity building strategies are proposed:

Making better use of existing capacity

- Utilizing the capacity of the existing 10(ten) Regional Training Centers; MCHTI, Azimpur and Lalkuthi; and MFSTC, Mohammdpur to provide basic and refresher training on LARC & PMs;
- Activate all the Model FP clinics attached to the Medical college Hospitals for LARC & PMs pre-service and in-service training and service provision;
- Utilizing NIPORT in collaboration with DGFP for non-clinical training related to LARC & PMs; like religious leaders orientation, field workers orientations/ training;
- Identify potential NGO and private sector agencies that can provide LARC & PMs training and ensure their certification;
- Recognize and list all National Trainers on LARC & PMs of the public, private and NGO sector;
- Work with the Obs/Gyn practitioners who already have the capacity to provide LARC & PMs without additional training;

Strengthening existing capacity

- Provision of TOT/Training/Orientation on LARC & PMs according to needs identified;
- Development of national and regional trainers pools;
- Organize skills-based training by trainers from the pool;
- Adaptation of the existing curricula, standard guidelines, technical issues;
- Set up training centers with all training equipments, models and facilities;
- Use a variety of training approaches, including on the job training, and long distance online training courses.

Creating new capacity

- Provision of training in post-partum tubal ligation(PPBTL), post-partum IUD (PPIUD) and post-partum Implant (PPImplant);
- Integration of LARC & PMs in the training curricula of pre-service training of the medical colleges, nursing, midwifery and medical assistant;
- Involve and train clinical staff who have the capability to serve as LARC & PMs providers (eg. –Nurses for IUD services, private doctors for NSV & Tubectomy).

3. Ensuring supervision and clinical monitoring for quality LARC & PM services

- Utilizing 10 Regional and 54 District Consultant, FPCS-QIT for clinical supervision, monitoring and hands on coaching in different service delivery facilities at division, district and upazila level to strengthen quality of LARC & PM service delivery;
- Use checklists to assess performing to standard for clinical methods;
- Use checklists to assess facilities for providing quality LARC & PMs services;
- Develop a system of accountability;
- Develop a system of on-the-job training to address skills-deficiencies.

4. Fill in vacant positions of service providers

There are about 20% of the post of MO(MCH-FP), 25% of the post of FWVs and 20% of the post of field workers (FPIs and FWAs) are vacant. These positions need to be filled in within shortest possible time. This will help in improving the availability of LARC and PM services. In this connection, advocacy with the concerned authority of the MOHFW and DGFP need to be initiated as early as possible.

5. Establishing Training MIS System in the Public sector

The CCSDP unit of the DGFP already started to establish a training MIS system incorporating all the trainings provided by the CCSDP unit of the DGFP through its 10 Regional training centers and two training center in Dhaka (MFSTC and MCHTI). Through this training MIS system, CCSDP unit will understand who are trained, who are not trained and who needs training on LARC & PMs and accordingly plan for their training. The unit also understands after the training who is performing and who is not performing. If needed plan for refresher training can be developed.

6. Strengthening LARC & PM services in hard to reach, low performing areas through Regional Service Package

- Recruitment of Paid Peer Volunteers (PPVs): Recruitment of Paid Peer Volunteers (PPVs) in hard to reach Upazilas to support the FWAs who are working with high load of eligible couples and where the post of FWAs are vacant. After recruitment they would be trained on LARC & PM and FP as a whole. They would also be trained on IPC and use of digital resources as job aids to conduct interactive discussion and counselling effectively. These PPVs will do court yard meeting and house hold visitation in their catchment area to provide necessary information to prospective clients on FP and motivate them to adopt a LARC & PM method. So far 50 Upazilas have been included and another 50 Upazilas would be included within next two years covering more than 10000 PPVs.
- Utilization of Roving Team to provide LARC & PM services: Utilization of Roving Team to provide LARC & PM services where the post of service providers is vacant or not trained or skilled to provide LARC & PM services.
- Organization of special training / workshops/ orientation program: Organization of special training / workshops/ orientation program for demand generation on LARC & PM. Promote use of eLearning courses on FP for knowledge management.

7. Organization of "Client Fair"

Periodic organization of "Client Fair" throughout the country would boost up LARC and PM Service coverage and performance. Prior to "Client Fair" all the FP managers and service providers including the field level staff would be oriented and advised to provide information, motivation to the prospective clients to get LARC & PM services. Organize outreach events to disseminate right information on LARC & PM at the community level around "Client Fair". A plan would be developed who, when and where to provide the services.

8. Initiatives to Increase the Availability of No-scalpel Vasectomy (NSV) Services

During 2010 to 2014, the yearly performance of No-scalpel Vasectomy (NSV) was more than 1, 00,000. After that the performance is gradually going down. To increase the popularity of NSV, more demand generation activities will be undertaken by reducing myths and misconception of NSV. In this connection, the following initiatives would be undertaken:

- **Utilization of Model Family Planning Clinics in Public Medical College Hospitals**

  Presently, 8 Model Family Planning Clinics in 8 Public Medical College Hospitals are providing FP services. Additional Model Family Planning Clinic need to be introduced in the rest of the Public Medical College Hospitals. In these Model Family Planning Clinics, more focus will be given to provide NSV services. The NSV services will be provided here by the urologist, general surgeons and male doctors and the counselor will be male.

- **Utilization of MCWC and UHC**

  The Regional/ District Consultant, FPCS-QIT, ADCC, MOCC and MO(MCH-FP) will take the lead to provide NSV services in these facilities. They will undertake demand generation activities by organizing orientation program at community level to reduce myths and misconception of NSV.

- Utilization of BAVS Clinics

  18 BAVS clinics nationwide will give more focus on NSV in its catchment area to increase NSV performance.

- Utilization of Marie Stopes Bangladesh Clinics and Roving Teams

  Marie Stopes Bangladesh has several clinics throughout Bangladesh. They have also mobile Roving teams. These clinics and Roving teams will be utilized for demand generation and to provide NSV services.

- Demand Generation Activities by CCSDP

  The CCSDP unit also will take more advocacy programs to increase demand generation of NSV. FWAs /frontline workers can use e-Toolkit to do IPC with potential clients,

9. Ensure Universal Access to LARC & PM Services at All Levels

Although Bangladesh has vast health infrastructure, to enable access to LARC & PMs almost up to the community level, in spite of intensified efforts for developing skilled manpower on LARC & PMs significant progress could not be achieved. To ensure easy access to LARC & PMs services must be accessible up to the Union level (H&FWCs). Increased access to LARC & PMs may be achieved by involvement of the DGHS, NGO, and private sector providers at all levels of service delivery, and adding postpartum family planning in the maternity sites. Specific action will include:

- Ensuring provision of LARC & PM including PPFP services in every working day in MCWCs, UHCs, and District Sadar Hospitals, and Model clinics of Public Medical College Hospitals.
- Provide all ranges of LARC & PMs including PPFP from all MCWCs, UHCs, and upgraded H&FWCs, NGOs facilities having doctor providers, and organize periodic provision of Implant, NSV and if possible tubectomy from all other FWCs,
- Ensure provision of IUD from all existing FWCs, RDs, and rural and urban NGO FP service centers.
- Ensure provision of Implant services from all upgraded H&FWCs.
- Organize satellite clinics at Community clinics along with provision of IUD services,
- Strengthening mode of LARC & PMs service delivery, particularly in urban and rural deprived areas,
- Integrate LARC & PMs especially, scaling-up postpartum clinical FP methods from all Public Medical College Hospitals, District Sadar Hospitals, Private Medical Colleges Hospitals, and larger private clinics having full-time doctor.
- Expansion of IUD service provision involving Obs/Gyn specialist including female private practitioners (may be on payment basis),
- Ensure availability of LARC & PMs services is to extended hour and sometimes round the clock in certain facilities. Within geographical areas where back-up services have been established, development of the whole referral chain will be concentrated upon.

10. Priority Action Plan in Urban areas

Urban Area is under the control of the Ministry of Local Government through the City Corporation and the Municipal areas. There are no home visitation services and community based distribution (CBD) program at urban areas because there are no grass root level field worker of DGFP there. Most of the clients received facility based services and there is no registration of couples residing at urban areas. To improve the availability of LARC & PM services in urban areas the following action plans should be taken:

- Coordination between MOHFW and MOLGRDC

  Undertake action plans through effective coordination between the Ministry of Local Government and the Ministry of Health and Family Welfare with the aim of ensuring urban health care services, especially family planning, mother and child health care services for the slum-dwellers and the floating and destitute people in the City Corporation and the Municipal areas. Especially undertake plans and strategies to ensure client-centered services in the urban areas.

- Utilization of NGOs working in urban areas

  The main NGOs working in urban areas are Marie Stopes Bagladesh (MSB), Family Planning Associations of Bangladesh (FPAB), and Smiling Sun Franchisee Clinics through their facility based services. They would be encouraged to provide client-centered LARC & PM services in urban slums and other areas of City Corporation and Municipalities. If necessary, CCSDP unit will provide training on LARC & PM to the service providers of these NGOs on priority basis through selection of untrained providers.

- **Counseling and motivational activities**

  Organizing counseling and motivational activities about LARC & PM through outsourcing NGOs working in urban areas.

- **Utilization of service delivery facilities at urban area**

  Azimpur Maternal and Child Health Training Institute (MCHTI), MCHTI, Lalkuthi, Mohammadpur Fertility Services and Training Center (MFSTC, Government Medical College Hospitals, Specialized Hospitals, District Sadar Hospitals, Private Medical College Hospitals, private clinics, NGO clinics, and MCWCs at District level will be utilized to provide LARC & PM including PPFP services.

11. Involvement of Private Sectors

The private sector plays a major role in the provision of contraceptives, but not yet for LARCs & PMs. To extend LARCs & PMs to more clients, public private partnerships should be strengthened. In this connection, a circular has been issued throughout the country jointly signed by both the Director General of the DGFP and the DGHS providing guidelines how to implement LARC & PM including PPFP services in the private medical college hospitals and private clinics. To strengthen the collaboration, an MOU among DGFP, DGHS and Private Medical College Owners Association is in the process of development and finalization to strengthen PPFP services in private medical college Hospitals. Similarly, an MOU among DGFP, DGHS and Association of Private Hospitals and Clinics is also under development and finalization to strengthen PPFP services. Besides, OGSB, SMC and Marie Stopes Bangladesh could play a major role in implementing LARC & PM services in the private sectors;

- **Involvement of OGSB in LARC & PM services**

  Members of the OGSB throughout Bangladesh are involved in providing LARC and PM services in their private clinics in collaboration with SMC. EngenderHealth provided training on LARC & PM to OGSB physicians through the Managing Innovations for Sustainable Health Development project (MISHD) of SMC funded by USAID

- **Involvement of Marie Stopes Bangladesh**

  Marie Stopes Bangladesh (MSB) has been supporting the CCSDP unit in improving LARC & PM services throughout the country in many ways. MSB have 50 clinics nationwide and these clinics provide LARC and PM services. Besides, MSB has 7 Roving Teams to provide LARC and PM services and 8 Roving Teams to provide IUD services. These Roving Teams usually provide the services in the facilities where the post of the service provider is vacant or not skilled in providing the services.

12. Initiatives to popularize LARCs among young married couples (aged 15-24 years)

According to Bangladesh Bureau of Statistics-2015 (BBS-2015) Bangladesh has 36 million adolescents (age 10-19 years) which comprises more than one-fifth of the country's total population. Additional 14 million young people belong to ages between 20-24 years. So, 50 million adolescents and youth comprises of more than 30% of the country's total population. These adolescents and youth have low levels of knowledge on SRH and STI/HIV, high prevalence of child marriage, high levels of teen age pregnancy (31% as per BDHS-

2014) and limited access to quality information and services. The unmet need for FP is 15.5% among this age group compared with national average of 12% (BDHS-2014). The CPR is 49% among these teen age women compared with 62% for other reproductive age group (BDHS-2014). The adolescent birth rate per 1000 young women(age 10-19 years) is 113/1000 live birth of that age group (BDHS-2014) which need to be reduced to 50 by 2030 according to SDG requirement which is very challenging. In order to achieve this SDG indicator 3.7.2, a concerted efforts need to be taken. These are as of following:

- **Implementation of National Plan of Action for National Adolescent Health Strategy 2017-2030**

  Under this action plan there are 3 objectives which are a) To create an enabling environment for the adolescents to get SRH services at all level, b) To integrate comprehensive sexuality education programs at all academic and training institutions, and c) To improve the SRH status of adolescents by engaging a range of evidence based and effective interventions. The goal of the action plan is to ensure that adolescents receive timely and effective health promotion and care and disease prevention through holistic approach

- **Increasing Adolescents access to SRH information and services**

  DGFP is committed to increasing adolescent's access to SRH information and services through adolescent friendly health services (AFHS) at MCWCs, UHCs, UH&FWCs and Community Clinics. These AFHS centers will use SBCC audio-visual materials on AH developed for enter educate program by Ujjiban.

- **Counseling and motivation for LARC and PM**

  Strengthen counseling and motivation to young married couple for LARC & PM by paid peer volunteers (PPV). Similarly, strengthen counseling and motivation to young married couple to adopt a LARC&PM method through FWAs and FWVs of the public sector and paramedics of NGO facilities.

13. Record Keeping and Reporting System

The record keeping system for LARC & PM including PPFP need to be developed in the DGHS facilities. In this connection, a unified register containing all FP methods acceptance related information would be recorded in the DGHS facilities of Chattagram and Sylhet Division as per the DLI-9 requirement. At the end of each month, LARC and PM including PPFP performance would be reported to CCSDP unit of the DGFP through the concerned DDFP office. This initiative would reduce the under reporting of LARC & PM including PPFP. This system of recording in unified register would be replicated rest of the divisions.

Chapter 4
Strengthening Post-partum Family Planning (PPFP) Services

In Bangladesh, the current national unmet need for FP is 12% (BDHS 2014) but during post-partum period it is 44%. Therefore, post-partum family planning (PPFP) has an important role to play in developing and implementing strategies to reduce the unmet need for FP. PPFP aims to prevent the high risk of unintended and closely spaced pregnancies during the first year following child birth. It is one of the highest impact interventions to avoid adverse maternal health outcomes, avoid increased risk of premature birth, low birth weight, fetal and neonatal death.

In Bangladesh around three million births take place every year and nearly 1.5 million take place at the facility level; 500,000 in the public sector facilities and remaining in private health centers. In addition, approximately, 1.3 million illegal abortions and legal menstrual regulation (MR) procedures are performed annually (Singh et al 2011). Therefore, around 4.3 million girls and women are in need of post-partum, post-MR and post abortion care (PAC) FP information , counseling and services each and every year. In order to provide these services, capacity development of the service providers in both the Directorate General of Family Planning (DGFP) and the Directorate General of Health Services (DGHS) are extremely needed. This section will describe the a) **Steps taken so far to strengthen PPFP services and b) Next steps to strengthen PPFP services**

A. Steps taken to strengthen PPFP services

The following initiatives have been taken to strengthen PPFP, Post-menstrual regulation and Post-abortion care family planning services in Bangladesh:

- Bangladesh National Action Plan for PPFP

  Developed Bangladesh National Action Plan for Post-partum, post-menstrual regulation and post-abortion care family planning with definite goal, outcomes, outputs and major activities with support from UNFPA, other international and national NGOs and development partners. Proper implementation of this action plan will be able to increase community awareness and demand for PPFP, increase capacity of the service providers to provide PPFP services, increase access to quality PPFP services and ultimately reduce the unmet need for PPFP.

- Approval to allocate "Imprest Fund" at DGHS facilities

  To increase the availability and performance of PPFP services in 96 DGHS health facilities (Medical College Hospitals, District Sadar Hospitals and Specialized Hospitals), the MOHFW has provided approval to allocate "Imprest fund" to the respective head of the facilities to deal with the spot payment (travel cost, food cost and compensation of wage lost) for LARC and PM services recipients for PPFP services.

- Circular issued jointly signed by both the DG of DGHS and DGFP

  A circular has been issued nationwide jointly signed by both the Director General of the DGFP and DGHS instructing how to implement the PPFP services in the DGHS facilities. Similarly, a circular already been issued throughout the country jointly signed by both the Director General of the DGFP and the DGHS instructing all level of field workers and service providers of the DGFP and DGHS to provide information on PPFP methods to prospective mothers during antenatal care, postnatal care and immunization sessions.

- Orientation Program on Imprest Fund Mangement and PPFP Services at DGHS facilities

  The CCSDP unit of the DGFP started orienting the concerned Manager of the DGHS facilities including staff of finance unit and officials of Obs/Gyn unit about imprest fund management and PPFP services. These orientation programs will help in increasing PPFP services in their facilities.

- Development of PPFP Compendium and other PPFP Job-aids

  The PPFP has been incorporated in the comprehensive national social and behavior change communication plan of the MOHFW. A PPFP compendium has been developed, printed and distributed to all the service providers throughout the country. PPFP related job-aids, posters, brochures and leaflets has been developed, printed and distributed throughout the country.

- Training of Service Providers on PPFP

  A total number of 1350 physicians and paramedics/FWVs have been trained on PPFP to increase the capacity of the service providers to provide quality PPFP services nationwide.

- Introduction of Implant as an Immediate PPFP Method

  The DGFP introduced implants as an immediate PPFP method throughout the country through an approval of the National Technical Committee (NTC) of the Ministry of Health and Family Welfare (MOHFW). Accordingly, medical and social eligibility criteria of FP methods during post-partum period has been updated based on the national context in Bangladesh National Family Planning Manual, Training Curricula and Medical Eligibility Criteria (MEC) wheel used by the service providers and FP Managers.

- Disbursement Link Indicators-9 (DLI-9)

  Through World Bank supported Disbursement Linked Indicators-9 (DLI-9), steps has been taken to increase the number of facilities at the district level (District Sadar Hospital and MCWC), at upazila level (UHCs), and at Union level (UH&FWCs) meeting the defined facility readiness criteria to routinely deliver immediate post-partum family planning services in Sylhet and Chattagram Divisions.

B. Next Steps to Strengthen the PPFP Services

- Strengthening collaboration and coordination between DGFP, DGHS and private sectors.
- Training/ orientation of the concerned managers, service providers and supporting staff of the Obs/Gyn unit of 96 DGHS facilities to provide PPFP services.
- Capacity development of the service providers of the DGFP, DGHS and private sectors to provide PPFP services.
- Regular allocation of 'Imprest fund' to 96 DGHS facilities from the CCSDP unit of the DGFP for smooth operation of PPFP services from these facilities.
- Regular supply of FP commodities and other MSR to 96 DGHS facilities for proper functioning of PPFP services.
- Provision of FP kit containing all related FP commodities at labor room in 96 DGHS facilities.
- DLI-9 in left out divisions must be included for expansion of PPFP services.
- Community awareness raising programs through organizing advocacy/ orientation workshops.
- Develop and distribute PPFP related job-aids, posters, brochures and leaflets to reduce myths and misconception related to PPFP services.

- Ten Regional and 54 District Consultants in FPCS-QIT have been working for improving the quality of LARC & PM services including PPFP. The FPCS-QIT is composed of one Regional / District Consultant, one Senior Staff Nurse, one Electro-medical technician, one office cum computer operator and one driver. They have been provided vehicles for their easy movement to the service delivery facilities.
- A total of 2869 Paid Peer Volunteers (PPV) have been recruited and trained in 50 hard to reach upazilas of different districts to provide information on FP, counsel the clients and referral to adopt LARC & PM including PPFP services. Another 3631 PPV would be recruited in 28 hard to reach upazilas.

Chapter 5
Improving the Quality of Care

IFor LARC & PMs service quality management and improvement the following two aspects need to be ensured effectively and efficiently: 1) Ensure constant and sustained attention to the fundamentals of care and 2) Establish clients' rights and provider's needs as the core of LARC & PMs service delivery. This section also includes WHO quality dimensions and tools to measure improvements in quality

1. Ensure Constant and Sustained Attention to the Fundamentals of Care (FoC)

The Fundamentals of care consists of three important components: These are:

a. Ensuring informed and voluntary decision making

To make an informed choice about their reproductive health, a client must have access to service options and receive and understand the information relevant to making a decision. To ensure informed and voluntary decision making, the following aspects need to be in place.

- Service options are available and accessible
- Providers give clients accurate information to help them in the decision-making process
- Providers ensure effective counseling and client provider interaction
- Providers enable a voluntary decision-making process

b. Assuring safety for clinical techniques and procedures

Clinical techniques and procedures are considered safe when skilled providers practice according to updated, evidence based-standards and guidelines and infection prevention protocols, and procedures are performed within a physical structure appropriate for managing clinical and surgical services. For assuring safety for clinical techniques and procedures the following provisions need to be in place.

- Providers perform FP/RH services, according to up-to-date national standards
- Medical guidelines, protocols, and standards are regularly updated and consistently implemented.
- Providers correctly implement all infection prevention practices and procedures to protect themselves and clients.
- Providers appropriately handle emergency situations.
- Providers ensure prompt and appropriate management of side-effects and complications.
- Supervisors regularly conduct medical monitoring at the facility level to assess the readiness and the processes of service delivery and make recommendations for improvement using checklists.
- Service statistics data are collected and used for decision-making at the service delivery level.

c. Providing a mechanism for ongoing quality assurance and management

There should be systems for supervision, training, logistics, and monitoring and evaluation function effectively to provide high quality services that satisfy its clients and increase demand. For providing a mechanism for ongoing quality assurance and management the following provisions need to be in place.

- For effective supervision and monitoring of quality improvement activities of LARC & PM services 10 Regional and 54 District FPCS-QIT are deployed in 64 Districts of the country. The FPCS-QIT is composed of one Regional / District Consultant, one Senior Staff Nurse, one Electro-medical technician, one office cum computer operator and one driver. They have been provided vehicles for their easy movement to the service delivery facilities. These FPCS-QITs will use QI checklist during their facility visits and provide recommendations and suggestions for quality improvement and if necessary provide hands-on coaching for improvement.
- Quality improvement mechanisms are implemented at the facility level to analyze and address service delivery issues.
- Facilities and providers receive supportive /facilitative supervision to create an enabling environment for service provision.
- Providers have adequate knowledge and skills to perform their job.
- Facilities have adequate infrastructure, supplies, and equipment to deliver quality services.
- Providers have clear job expectations.
- Providers regularly receive feedback on their performance.
- Providers are adequately motivated to perform according to standard.
- Providers participate in a process of ongoing problem-solving and quality improvement at facility level; and provision of a supportive management system, including appropriate reward system for good work.
- At the management level, there are needs for well-functioning LARC & PMs training, supervision, and supply of logistic system based on up-to-date and evidence-based protocols and guidelines that meets the client's needs.

2. Establish Clients' Rights and Provider's Needs as the Core of LARC & PMs Service Delivery

At the center of LARC & PM service delivery is the encounter between an informed client and a skilled, motivated service provider taking place in an appropriately staffed, managed, and functioning clinical facility resulting in meeting the needs of the client in a quality manner. Such an encounter will produce a satisfied LARC & PM acceptor and thus increase the overall number of quality LARC & PMs acceptors.

Suggested quality of care indicators and tools to measure improvements in quality are attached in Appendix 1.

3. WHO Quality Dimensions

WHO quality dimensions are as of following:

- Safe: Avoiding harm to patients from care
- Effective: Providing services based on evidence and which produce a clear benefit
- Patient Centered: Meeting patients' preferences and comfort
- Accessible: Removing barriers to reach services
- Timely: Reducing waiting time and sometimes harmful delays
- Efficient: Avoiding waste
- Equitable: Providing care that does not vary in quality because of a person's characteristics

Things to do to address WHO quality dimensions

- Safe

  Infection prevention [Hand wash, PPE use, Sterilization (Autoclave/Boiling), Waste management, Spill management etc, Medication error, Safe blood transfusion, Safe Surgery, Checklist use, Prevention of fall etc

- Effective

  Use of protocol/SOP/Guideline/Standards. For example: Tubectomy protocol, Vasectomy protocol, Copper T insertion protocol, Implant insertion and removal protocol etc

- Patient Centered

  Privacy , Confidentiality, Cleanliness, Safe drinking water, Safe food, FAN/AC, Well behavior, Counselling etc

- Accessible

  Less waiting time (Easy admission and discharge system, Proper planning for patient services)

- Timely

  Doing things on time as per protocol

- Efficient

  Maximization of resource (Inputs & Time) utilization. Avoiding unnecessary investment

4. Tools to Measure Improvements in Quality

To ensure quality of care the LARC & PMs service providers and the clinical supervisors should have appropriate tools to measure the quality of care, be it for improving provider's knowledge and skills, or for increasing clients' satisfaction, or for improving facilities for providing LARC & PMs services, or for understanding why clients do not use services.

Tools for specific items include

- Improving provider knowledge and skills related to LARC & PMs
  - Pre- and post-tests; follow-up "post-post-tests"
  - Provider observations
  - Provider surveys
  - "Mystery clients"
  - Reviews of records
- Increasing client satisfaction related to LARC & PMs services
  - Client exit interviews
  - Household interviews
  - Focus group discussions
  - Service statistics
- Improving facilities' capability or readiness to provide quality LARC & PMs services
  - Facility audits or assessments
  - Provider surveys/focus group discussions
  - Mystery clients
  - Reviews of records
  - Client flow analyses

Chapter 6
Demand Generation and Community Mobilization

The aim of the LARC & PM including PPFP demand generation is to popularize LARC & PM as a method of choice among eligible couples. To do this there are several audiences to be reached: potential users, service providers, and community change agents and leaders. For each of these audiences specific strategies, messages and materials need to be developed to ensure that they are reached with appropriate information that they understand and that will convince them to act favorably. This chapter will outline the objectives, audiences and actions proposed to create demand for LARC & PM including PPBTL, PPIUD, PP-Implant and involving communities in this effort.

The objectives are

1. Position LARC & PM including PPBTL, PPIUD and PPImplant as a convenient method for couples who want to space or limit their family size;
2. Provide accurate information on LARC & PM including PPBTL, PPIUD and PPImplant to potential users;
3. Encourage potential users to contact services providers and satisfied customers for more information;
4. Encourage satisfied customers and community change agents to talk in favor of LARC & PM including PPBTL, PPIUD and PPImplant;
5. Equip service providers with adequate skills and knowledge to counsel clients on LARC & PM including PPBTL, PPIUD and PP Implant.

The LARC & PM BCC strategy will follow a three pronged approach

First of all it is important to implement a holistic national campaign to popularize LARC & PM including PPBTL, PPIUD and PPImplant among the general public. Beyond that, getting more specific for the intended audiences, BCC activities should take place at national and local level to create demand. To ensure an enabling environment in which people feel encouraged and enabled to adopt an LARC & PM including PPBTL, PPIUD and PPImplant, community mobilization and advocacy activities should be conducted towards elderly family influencials, community change agents, and community leaders to ensure that they have a positive attitude on LARC & PM. Satisfied customers and service providers will be given the communication skills and necessary information to talk to potential clients on LARC & PM including PPBTL, PPIUD and PPImplant to encourage them to adopt these methods.

The strategic communication approach/communication on LARC & PM including PPBTL, PPIUD and PPImplant should address four segments of audiences, as follows:

Segments	Key Audiences	Recommendations
Potential FP clients (BCC)	Men and women of Reproductive age having one or more children Young married couple Post-partum women	Repeated LARC & PM communication campaigns using mass media and other indigenous source to create awareness, remove myths and misconceptions and generate confidence among potential clients Comprehensive audience-specific/method specific BCC materials that unpack LARC & PM services to the potential clients Active involvement of the male in FP decision-making to reduce discontinuation IPC and repeated follow-up to build confidence
Service providers (BCC)	Men and women of Reproductive age having one or more children Young married couple Post-partum women	Developing providers' skills on client-centered counseling and ensuring follow- up of LARC & PM clients to build up their confidence level Use of e-Toolkit as source of knowledge management and customer counseling Introduce and use e-Learning course to enhance knowledge and skills of service providers and frontline workers Use IPC training tool of Ujjiban to build their skill on counselling Training / orientation to enhance providers' communication capacity to- convey critical and up-to-date information on LARC & PM including PPBTL, PPIUD and PPImplant both verbally and by providing IEC/BCC material/job aids offer LARC & PM to couples who have reached their desired family size or need spacing Ensure availability and use of BCC materials at all FP service delivery points Share experience of best performing facilities and replication of best practices Ensure effective monitoring and supervision by the manager/supervisor
Community members (Community Mobilization)	Husband and other family member Youth GOB, NGO and Community Networks Local folk talent Satisfied clients Urban Slum	Community discussions to help in deepening the awareness level of the community decision makers and dispelling LARC & PM including PPBTL, PPIUD and PPImplant related myths and misconceptions Utilization of community resources, existing network, and communication channels to assist in increasing the reach of messages Addressing the adolescents/youths to empower them to seek and disseminate correct information on reproductive health

Segments	Key Audiences	Recommendations
		Establishing linkages with all relevant actors, including NGOs and private sector, to increase the sustainability of the promotion of LARC & PM services
Advocates (Advocacy)	**Local level** Representative of local government Community and Local leaders (religious leader, teachers) Community Support Group Media -Print and electronic media **Policy level** Officials from MOHFW, DGHS, DGFP Government officials of other sectors Development partners Political leaders Media personnel	Proactive role of national level leadership for promotion of LARC & PM that contribute greatly to break the silence and create a momentum BCC activities with the community leaders to assist in creating an enabling environment for LARC & PM acceptance Establishing linkages with all relevant actors, including private medical hospitals and clinics, NGOs and private sector, to increase the sustainability of the promotion of LARC & PM services Involvement of religious leaders .and effective orientation to break religious conservatism and negative barriers regarding FP Continuous presence of demand generation activities in the media to generate confidence among the potential clients. National stewardship/strong government leadership on promotion of LARC & PM service to improve overall performance Involvement of political leaders at national level in making public statements on family planning Strong collaboration between GOB and NGO/private sectors to ensure service availability Reduce policy barriers about availability of IUD at the open market

Chapter 7
Ensuring Commodity Security

Reproductive health commodity security exists when every person is able to choose, obtain, and use quality contraceptives and other essential reproductive health products whenever s/he needs them. The FP logistics system within the country is satisfactory, but the obstacles to timely international procurement create stock-outs at a time when unmet demand for family planning needs to be met promptly.

Experience over the years has resulted in the development of detailed procurement lists and specifications of equipment, commodities and supplies needed for ensuring LARC & PM services. On many occasions a lack of synchrony between placements of skilled service providers and the supply of commodities, drugs and equipment has hampered LARC & PM services. A detailed procurement and distribution plan will be prepared tailored to match the human resource development plan to ensure synchrony. In-facility capacity in management of equipment, commodities, drugs and supplies will be strengthened. In the recent past there are many instances of long stock-out of contraceptives including the supply of IUD and Implant. Therefore, there is a strong need for strengthening the contraceptive commodity security and to ensure adequate supplies to all the LARC & PM service facilities.

Possible actions include

- Ensuring availability of LARC & PM contraceptives, MSR and others
- Identify the bottlenecks of RH commodities security and address those issues and meet up the needs before stock outs.
- Ensure synchrony between facility need and the supply of commodities (IUD, Implant, imprest fund, and logistics, instruments and equipment for LARC & PM s), and expandable items for infection prevention must be ready on hand.
- Develop projections of specific needs of individual targeted districts and/or upazillas based on local data and estimated expansion, that can be later rolled up into the contraceptive procurement tables (CPTs);
- Coordinate between MOHFW and other stakeholders to minimize procurement delays and lack of commitment to prompt decision in the procurement process;
- Identify how public and private sector could both play a major role to work together;
- Ensure to build up technical capacity and updated procurement knowledge as per international law and policy.

Chapter 8
Workplan: Tentative Work plan frame

Sl. #	Activities	Responsibility	Time Line			Remarks
			Immediate	Mid-term	Long term	
HR related issues						
1.	Availability of skilled service providers at appropriate places: In this connection, LD-CCSDP will request Director (Admin) to place skilled service providers in appropriate facilities	Director (Admin) & LD-CCSDP	Ongoing	Ongoing	Ongoing	
2.	Fill in vacant positions of service providers: Proper advocacy with the concerned authority to expedite the recruitment process of the vacant positions of the service providers	Secretary, Medical Education & Family Welfare Division, MOHFW; DG, DGFP & Director (Admin)	Ongoing	Ongoing	Ongoing	
Capacity Development of Service Providers to Provide LARC & PM including PPFP						
3.	Capacity Development on LARC & PMs: It include a) better use of existing capacity, b) Strengthening existing capacity through refresher trainings on LARC & PM and c) Creating new capacity through organizing LARC & PM basic trainings in 10 Regional training centers outside Dhaka and three training centers in Dhaka which includes MCHTI, Azimpur and Lalkuthi, and MFSTC, Mohammadpur	LD-CCSDP, Director, MFSTC; Superintendent, MCHTI, Azimpur; Director, MCHTI, Lalkuthi & Regional Consultant, FPCS-QIT	Ongoing within current program	Ongoing within current program	Ongoing within current program	
4.	Training of Service Providers on PPFP: The CCSDP unit will gradually train the service providers of the DGHS facilities on PPFP to enhance PPFP performance.	Directors and Superintendents of DGHS facilities, LD - CCSDP, PM (SD), PM (QA),	Ongoing within current program	Ongoing within current program	Ongoing within current program	
5.	Orientation Program on Imprest Fund Management and PPFP Services at DGHS facilities: The CCSDP unit of the DGFP started orienting the concerned Manager of 96 DGHS facilities including staff of finance unit and officials of Obs/Gyn unit about imprest fund management and PPFP services. in increasing PPFP services in their facilities.	Directors and Superintendents of DGHS facilities, LD-CCSDP, PM (SD), PM (QA)	Ongoing within current program	Ongoing within current program	Ongoing within current program	

Sl. #	Activities	Responsibility	Time Line			Remarks
			Immediate	Mid-term	Long term	
6.	Establishing Training MIS System in the Public sector:	LD-CCSDP, PM (SD), PM (QA)	Ongoing within current program	Ongoing within current program	Ongoing within current program	

Strengthening LARC & PM including PPFP Service Delivery

7.	Strengthening LARC & PM services in hard to reach, low performing areas through Regional Service Package: These include a) Recruitment of Paid Peer Volunteers (PPVs) in hard to reach Upazilas to support the FWAs who are working with high load of eligible couples. 100 Upazilas would be included within next two years covering more than 10000 PPVs, b) Utilization of Roving Teams to provide LARC & PM services where the post of service providers is vacant or not trained or skilled to provide LARC & PM services and c) Organization of special training / workshops/ orientation program for demand generation on LARC & PM.	LD-CCSDP, PM (SD), PM (QA)	Ongoing within current program	Ongoing within current program	Ongoing within current program	
8.	Periodic organization of "Client Fair" throughout the country to boost up LARC and PM service coverage and performance	LD-CCSDP, PM (SD), PM (QA)	Ongoing within current program	Ongoing within current program	Ongoing within current program	
9.	Ensure Universal Access to LARC & PM Services at All Levels: Provide all ranges of LARC & PMs including PPFP from all MCWCs, UHCs, and upgraded H&FWCs, NGOs facilities having doctor providers, and organize period provision of Implant, NSV and if possible tubectomy from all other upgraded FWCs,	LD-CCSDP, PM (SD), PM (QA)	Ongoing within current program	Ongoing within current program	Ongoing within current program	
10.	Initiatives to increase availability of No-scalpel Vasectomy (NSV) services: These will include a) Utilization of Model Family Planning Clinics in Public Medical College Hospitals, b) Utilization of BAVS Clinics, c) Utilization of Marie Stopes Bangladesh Clinics and Roving Teams, and d) Utilization of MCWCs and UHCs for demand generation and service provision for NSV	LD-CCSDP, PM (SD), PM (QA)	Ongoing within current program	Ongoing within current program	Ongoing within current program	
11.	Action Plan in Urban areas: This will include a) Undertake action plans through effective coordination between the Ministry of Local	LD-CCSDP, PM (SD), PM (QA)	Ongoing within current program	Ongoing within current program	Ongoing within current program	

Sl. #	Activities	Responsibility	Time Line			Remarks
			Immediate	Mid-term	Long term	
	between the Ministry of Local Government and the Ministry of Health and Family Welfare with the aim of ensuring urban health care services, especially family planning, mother and child health care services for the slum, b) Utilization of NGOs working in urban areas, and c) Utilization of service delivery facilities at urban area to enhance LARC & PM services					
12.	Involvement of Private Sectors: The private sectors can play a major role in the provision LARCs & PMs through a) Involving members of the OGSB throughout Bangladesh in providing LARC and PM services in their private clinics in collaboration with SMC, and b) Signing an MOU among DGFP, DGHS and Private Medical College Owners Association to provide PPFP services in private medical college Hospitals. Similarly, an MOU among DGFP, DGHS and Association of Private Hospitals and Clinics to strengthen PPFP services.	Director General, DGFP, LD-CCSDP, PM (SD), PM (QA), and Owners Association of Private Medical College Hospitals and Private Clinics	Ongoing within current program	Ongoing within current program	Ongoing within current program	
13.	Implementation of **Bangladesh National Action Plan for PPFP, Post-MR, and Post-Abortion Care FP** to increase performance on PPFP	DGFP, LD-CCSDP, PM (SD), PM (QA),	Ongoing within current program	Ongoing within current program	Ongoing within current program	
14.	Through DLI-9, 80% of the facilities (District Sadar Hospitals, MCWCs, UHCs and UH&FWCs) will be ready to provide PPFP services in Chattagram and Sylhet Division by 2022. These initiatives would be expanded in rest of the Divisions.	LD-CCSDP, PM (SD), PM (QA), Regional/ District Consultant, FPCS-QIT	Ongoing within current program	Ongoing within current program	Ongoing within current program	
15.	Strengthening record keeping and reporting system for LARC and PM including PPFP services at DGHS and private facilities by providing unified registers to record all FP method related information in a single register and accordingly every month performance report would be sent to CCSDP unit through concerned DDFP office	Directors and Superintendents of DGHS facilities, LD-	Ongoing within current program	Ongoing within current program	Ongoing within current program	

Strengthen Quality of LARC & PM including PPFP Services

16.	For effective supervision and monitoring for quality improvement of LARC & PM including PPFP	LD-CCSDP, PM (SD), PM (QA), Regional/ District Consultant, FPCS-QIT	Ongoing within current program	Ongoing within current program	Ongoing within current program	

Sl. #	Activities	Responsibility	Time Line			Remarks
			Immediate	Mid-term	Long term	
	services, 10 Regional and 54 District **FPCS-QIT in 64 Districts are deployed.** These FPCS-QITs will use QI checklist during their facility visits and provide recommendations and suggestions for quality improvement and if necessary provide hands-on coaching for improvement.					
17.	Ensure constant and sustained attention to the fundamentals of care which include a) Ensuring informed and voluntary decision making in FP program, b) Assuring safety for clinical techniques and procedures, and c) Providing a mechanism for ongoing quality assurance and management. In addition, establish Clients' Rights and Provider's Needs as the Core of LARC & PMs Service Delivery and addressing WHO Quality Dimensions which include: Safe, Effective, Patient centered, Acceptable, Timely, Efficient and Equitable	LD-CCSDP, PM (SD), PM (QA), Regional/ District Consultant, FPCS-QIT	Ongoing within current program	Ongoing within current program	Ongoing within current program	
18.	Ensuring supervision and clinical monitoring: Ten (10) Regional and 54 District Consultant, FPCS-QIT will be utilized for clinical supervision, monitoring and hands on coaching in different service delivery facilities at division, district and upazila level for quality service delivery of LARC & PM including PPFP.	LD-CCSDP, PM (SD), PM (QA) and Regional/ District Consultant, FPCS-QIT	Ongoing within current program	Ongoing within current program	Ongoing within current program	
19.	Use of different types of tools to measure improvements in quality which include a. Client exit interview, b. Provider exit interview, c. Observation checklists for different FP method service provision, d. Facility audits or assessments, e. Review of records, f. Service statistics, and g. Focus group discussion etc.	LD-CCSDP, PM (SD), PM (QA), Regional/ District Consultant, FPCS-QIT	Ongoing within current program	Ongoing within current program	Ongoing within current program	
Initiatives to popularize LARCs among young married couples (aged 15-24 years)						
20.	Implementation of National Plan of Action for National Adolescent Health Strategy 2017-2030: Under this action plan there are 3 objectives which are a) To create an enabling environment for the adolescents to get SRH services at all level, b) To integrate	Director (MCH-Services), LD-CCSDP, PM (SD), PM (QA), Regional/ District Consultant, FPCS-QIT	Ongoing within current program	Ongoing within current program	Ongoing within current program	

Sl. #	Activities	Responsibility	Time Line			Remarks
			Immediate	Mid-term	Long term	
20.	comprehensive sexuality education programs at all academic and training institutions, and c) To improve the SRH status of adolescents by engaging a range of evidence based and effective interventions.					
21.	Increasing adolescent's access to SRH information and services through adolescent friendly health services (AFHS) at MCWCs, UHCs, UH&FWCs and Community Clinics.	Director (MCH-Services), LD-CCSDP, PM (SD), PM (QA), Regional/ District Consultant, FPCS-QIT	Ongoing within current program	Ongoing within current program	Ongoing within current program	
22.	Strengthen counseling and motivation to young married couple for LARC & PM by paid peer volunteers (PPV). Similarly, strengthen counseling and motivation to young married couple to adopt a LARC & PM method through FWAs and FWVs of the public sector and paramedics of NGO facilities.	LD-CCSDP, PM (SD), PM (QA), Regional/ District Consultant, FPCS-QIT	Ongoing within current program	Ongoing within current program	Ongoing within current program	
SBCC Activities to popularize LARC & PM including PPFP Services						
23.	SBCC activities for potential FP clients which include: a) Repeated LARC & PM communication campaigns using mass media and other indigenous source to create awareness, remove myths and misconceptions and generate confidence among potential clients, b) Comprehensive audience-specific/method specific BCC materials that unpack LARC & PM services to the potential clients, c) Active involvement of the male in FP decision-making to reduce discontinuation, and d) IPC and repeated follow-up to build confidence	Director (IEM), LD-CCSDP, PM (SD), PM (QA),	Ongoing within current program	Ongoing within current program	Ongoing within current program	
24.	SBCC activities for community members which include: a) Community discussions to help in deepening the awareness level of the community decision makers and dispelling LARC & PM including PPBTL, PPIUD and PPImplant related myths and misconceptions, b) Utilization of community resources, existing network, and communication channels to assist in increasing the reach of messages, c) Addressing	Director (IEM), LD-CCSDP, PM (SD), PM (QA),	Ongoing within current program	Ongoing within current program	Ongoing within current program	

Sl. #	Activities	Responsibility	Time Line			Remarks
			Immediate	Mid-term	Long term	
	adolescents/youths to empower them to seek and disseminate correct information on reproductive health, and d) Establishing linkages with all relevant actors including NGOs and private sector, to increase the sustainability of the promotion of LARC & PM services					
25.	SBCC activities for service providers which include: a) Developing providers' skills on client-centered counseling and ensuring follow- up of LARC & PM clients to build up their confidence level, and b) Training / orientation to enhance providers' communication capacity	Director (IEM), LD-CCSDP, PM (SD), PM (QA),	Ongoing within current program	Ongoing within current program	Ongoing within current program	

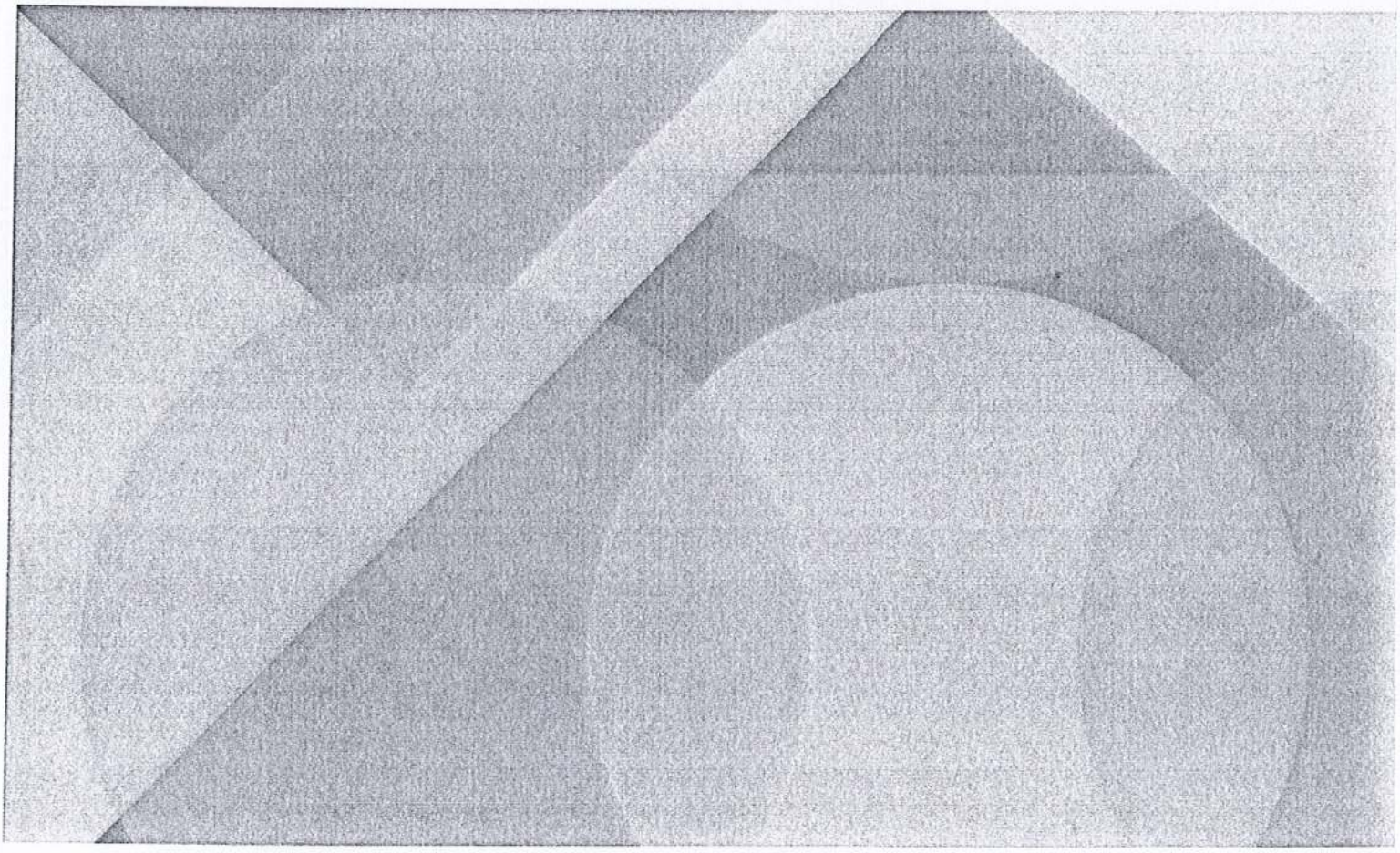
Availability of LARC & PM Contraceptives, MSR and other Logistics

26.	Ensuring availability of LARC & PM contraceptives, MSR and others	Director (L&S), LD-CCSDP, PM (SD), PM (QA),	Ongoing	Ongoing	Ongoing	

Annex :

Improving the Availability of Long-Acting Reversible Contraceptives and Permanent Methods (LARC & PM) Services at Public and Private Health Facilities

WORKING GROUP



Directorate General
of Family Planning

Foreign, Commonwealth
& Development Office

United Nations Population Fund