Bangladesh's Prioritized Actions 2018-2020

Contents

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Prioritized Actions for Focal Point and in-country stakeholder	Institution/person responsible	Timeline					
		'18	2019				'20
		Q4	Q1	Q2	Q3	Q4	Q1
• Prepare and disseminate directive on how to access and distribute Imprest funds to the health providers and clients in a timely fashion.	**Line Director-CCSDP, DGFP**	**X**					
• Revitalize postpartum FP working group; review and analyze PPFP data and provide feedback to the respective managers	**Line Director-CCSDP, DGFP FP2020 focal points**	**X**	**X**	**X**	**X**	**X**	**X**
• Update costed implementation plan for national FP program to include adolescents, impact to decrease MMR and procurement for contraceptives to fulfill GoB FP2020	**DGFP, USAID and UNFPA**		**X**	**X**	**X**		

commitments to supply NGO and private sectors							
• Add line item with accompanied budget to the operational plan for emergency and discretionary funding to respond to unexpected crises and emergencies	**DGFP**		**X**	**X**			
• Secondary analysis of BDHS 2017-18 with a focus on adolescents.	**USAID and UNFPA**		**X**	**X**	**X**	**X**	
• In service training for service providers to ensure integrated youth friendly services	**DGFP, USAID and UNFPA**		**X**	**X**	**X**	**X**	**X**
• Sensitization of stakeholders and gatekeepers of adolescents and youth on appropriate family planning method-mix and choices	**DGFP, USAID and UNFPA**	**X**	**X**	**X**	**X**	**X**	**X**
• Sensitize private for-profit hospital/clinics owners to make FP services available in all facilities. Social marketing can play a pivotal role in this case	**DGFP, USAID and UNFPA**	**X**	**X**	**X**	**X**	**X**	**X**
• Capacity building of private service providers	**DGFP, USAID and UNFPA**	**X**	**X**	**X**	**X**	**X**	**X**

Prioritized Actions for Secretariat, Core Conveners & Global Partners	**Institution/person responsible**	**Timeline**					
		'18	**2019**				**'20**
		Q4	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
• Application of FP-SDG model in Bangladesh	**FP2020 / HP+**		**X**	**X**	**X**		

Annex 1.
Country Profile: FP2020 Focal Point Team & In-Country Coordination

<table>
<tr><td rowspan="5">List of FP2020
Focal Points</td><td>Government</td><td>Dr. Kazi Mustafa Sarwar,
Director General of Family Planning
Ministry of Health and Family Welfare</td></tr>
<tr><td rowspan="3">Donor</td><td>Dr. Sathya Doraiswamy, UNFPA</td></tr>
<tr><td>Dr. Alia El Mohandes, USAID</td></tr>
<tr><td>Dr. Shehlina Ahmed, DFID</td></tr>
<tr><td>Civil Society</td><td>Dr. Abu Jamil Faisel</td></tr>
<tr><td>Youth</td><td>Ms. Sadia Rahman</td></tr>
<tr><td>FP Stakeholders
(institutional and/or individual)</td><td colspan="2">1. Director, MNC&ARH, DGFP/MOHFW
2. Director, FSDP, DGFP/MOHFW
3. Director, Clinical Contraception Service Delivery Program, DGFP/MOHFW
4. Director, IEM Unit, DGFP/MOHFW
5. Director, Planning, DGFP/MOHFW
6. Director, L&S, DGFP/MOHFW
7. Director, MNCH, DGHS/MOHFW
8. Health Economics Unit, QIS, MOHFW
9. National Institute for Population Research and Training (NIPORT)/GOB
10. Ministry of Women and Children’s Affairs (MOWCA)
11. Ministry of Youths & Sports
12. Marie Stopes Bangladesh
13. JHPIEGO, Bangladesh
14. SERAC, Bangladesh
15. IPAS Bangladesh
16. icddr,b
17. FPAB
18. BAVS
19. BRAC
20. Department of Population Sciences, Dhaka University
21. Urban Primary Health Care Project; MOLGRD
22. Obstetrics and Gynecological Society of Bangladesh (OGSB)
23. Population Council
24. Pathfinder International: Accelerating Universal Access to Family Planning Project/USAID
25. EngenderHealth: Mayer Hashi-II Project/USAID
26. Save the Children: Ma Moni Project/USAID and Community Health Workers Program Performance/USAID
27. Plan International: Advancing Adolescent Health Project/USAID</td></tr>
</table>

	28. Chemonics: Advancing Universal Health Care Project/USAID 29. Social Marketing Company: Marketing Innovations for Sustainable Health Development/USAID 30. Johns Hopkins University: Ujjiban Social and Behavioral Change Communication Project/USAID 31. Macro International: Demographic and Health Surveys/USAID 32. DFID 33. USAID 34. UNFPA 35. Global Affairs Canada (GAC)

CURRENT MECHANISMS FOR IN-COUNTRY COORDINATION of FP work (beyond Focal Points)				
Mechanism	**Convening/ Coordinating body**	**Members**	**Frequency** *(monthly, quarterly, semi-annually, etc.)*	**Notes on efficacy** *(How efficient & effective are these?)*
e.g. Multi-stakeholder consultations	**FP 2020 Bangladesh Country Engagement Working Group**	**All FP stakeholders (public and private sectors)**	**Quarterly**	**Efficient but difficult to convene a meeting**
e.g. FP2020 focal points meeting	**FP 20202 Focal Points Group**	DGFP,USAID, UNFPA, DFID, CSOFP	**As and when required**	**Very active and effective**
DFID, USAID and UNFPA supported	**FP Technical Forum**	**All FP stakeholders including researches, academicians, youths. Govt counterpart are not part of this group.**	**Quarterly**	**New; Not yet very effective**
Development Partners Consortium Meetings	**Development Partners Consortium**	**Agency Representatives or Office Directors of all Health Donors**	**Monthly**	**Very effective**

Please list additional opportunities to improve coordination:

One way of improving coordination is to set up a virtual Group and communicate through e-mail, phone and text SMS.

Annex 2: Identification of Challenges & Prioritization of Actions

Bangladesh's FP2020 Commitments

COMMITMENT 1: Bangladesh will increase its commitment for postpartum family planning by fully implementing its National Postpartum Family Planning Action Plan by training doctors, midwives, nurses and, in part by placing Family Welfare Visitors in each of the 64 district hospitals.

COMMITMENT 2: Bangladesh will introduce a regional service package on family planning in Chittagong, Sylhet and Barisal divisions for hard to reach populations.

COMMITMENT 3: Bangladesh commits to deploy at least two qualified diploma midwives in each of the Upazilla Health Complexes to provide midwife-led continuum of quality reproductive health care by 2021. Midwives will be trained to provide widest range of family planning methods included in their agreed scope of practice in country. Midwives will be trained to provide greater attention to first time young mothers.

COMMITMENT 4: Bangladesh commits to mobilize at least USD 615 million from its development budget for the family planning program implemented by the Directorate General of Family Planning as part of its 4th Health, Population and Nutrition Sector Programme (2017-2021). This is a 67% increase from the allocation in the 3rd Health, Population and Nutrition Sector Programme (2012-2016).

COMMITMENT 5: Bangladesh will fully operationalize its new National Adolescent Health Strategy with special focus of addressing the family planning needs and promoting rights of all adolescents. Adolescents in Bangladesh will have access to widest range of family planning methods possible and special efforts will be made to track adolescent health data. Bangladesh reiterates its commitment to end child marriage.

COMMITMENT 6: Bangladesh will scale up quality improvement measures in family planning programs by establishing Family Planning Clinical Supervision and Quality Improvement teams (FPCST) in each of the 64 districts

COMMITMENT 7: Bangladesh commits to providing free and adequate contraceptives to NGOs, private clinics and hospitals and garment factory clinics with trained FP personnel

COMMITMENT 8: Bangladesh will use technology and programme delivery innovations in family planning

a) In capacity development by providing tablets to field workers including an e-Toolkit and develop eLearning courses and empower them with ICT knowledge and skills
b) In programme delivery by working with marriage registrars to reach newlywed couples with family planning messages and organizing family planning client fairs in hard-to-reach areas.
c) Family planning messages, counselling and advice will also be provided through the national 24/7 call center of the Director General of Health Services

COMMITMENT 9: Bangladesh will include a service provider with reproductive health skills within its rapid response teams and mainstream the minimum initial service package (MISP) for reproductive health in crisis into its emergency response.

Summary of Bangladesh's Costed Implementation Plan (CIP)

Prioritized areas:

Focus Areas	Strategies
Family Planning Service Delivery	• Improve availability of FP services for clients • Strengthening quality assurance (QA) systems for FP services • Strengthening FP Services in hard-to-reach areas and among marginalized groups including urban slums and adolescents • Strengthen FP services to Postpartum, PAC and post-menstrual regulation clients • Strengthen GO/NGO/private sector collaboration
Information, Education and Communication	• Community mobilization through different innovative Social & Behavioral Change Communication (SBCC) activities using social and mass media • Capacity building of service providers, supervisors & managers on client's rights/choice of methods and quality of care • Improve internal MOHFW collaboration between IEM Unit and FP Service Offices
High-Performing Staff	• Knowledge and skill development of the service providers, supervisors and managers through need-based training (including in-service training) • Strengthening capacity of NIPORT, Specialized Centers and Regional Training Centers • Strengthening Technical Cooperation with Development Partners
Procurement and supply chain management of FP commodities	• Continue to streamline FP procurement and supply chain management system • Strengthening product quality assurance and material standardization • Continue to strengthen ICT for detection of supply levels at service delivery points to prevent shortages • Increase number of FP SBCC items in the FP supply chain for ordering and distribution • Ensure adequate FP supplies in supply chain for MOHFW, NGOs, private clinics and hospitals, and garment factories with trained clinic staff
Planning and Management	• Strengthening planning and management skills of managers • Strengthening decentralized planning process • Conducting operations research to support planning • Strengthening reporting, monitoring and evaluation systems
Policy and advocacy	• Strengthening policy environment for implementation of the National FP Program • Advocacy campaign on key FP issues in partnerships with key stakeholders including religious leaders and community influential persons

Step 1. From the above commitment(s) and/or CIP priority area(s) which is your country having the greatest difficulty in making progress on? (*the table below can be extended, if you'd like to cover more than three*)

*Please reference your **2018 commitment self-report questionnaire**, if needed.*

1. **COMMITMENT 1**: Bangladesh will increase its commitment for postpartum family planning by fully implementing its National Postpartum Family Planning Action Plan by training doctors, midwives, nurses and, in part by placing Family Welfare Visitors in each of the 64 district hospitals.
2. **COMMITMENT 4**: Bangladesh commits to mobilize at least USD 615 million from its development budget for the family planning program implemented by the Directorate General of Family Planning as part of its 4th Health, Population and Nutrition Sector Programme (2017-2021). This is a 67% increase from the allocation in the 3rd Health, Population and Nutrition Sector Programme (2012-2016).
3. **COMMITMENT 5**: Bangladesh will fully operationalize its new National Adolescent Health Strategy with special focus of addressing the family planning needs and promoting rights of all adolescents. Adolescents in Bangladesh will have access to widest range of family planning methods possible and special efforts will be made to track adolescent health data. Bangladesh reiterates its commitment to end child marriage.
4. **COMMITMENT 7:** Bangladesh commits to providing free and adequate contraceptives to NGOs, private clinics and hospitals and garment factory clinics with trained FP personnel

Step 2. What progress toward each commitment/CIP priority *(listed in Step 1)* has been made? What efforts have been made?

*Please reference your **2018 commitment self-report questionnaire** (attached) as well as any **available data in country** (e.g. DHS report, materials of the recent Data Consensus Meeting, etc.) as evidence. Additional data summary will be shared by the Secretariat and Track20 in the next few weeks.*

1. **COMMITMENT 1**: Bangladesh will increase its commitment for postpartum family planning by fully implementing its *National Postpartum Family Planning Action Plan* by training doctors, midwives, nurses and, in part by placing Family Welfare Visitors in each of the 64 District Hospitals.

Progress:

The Directorate General of Family Planning (DGFP) has been implementing the *National Postpartum Family Planning Action Plan*, which includes post MR and PAC Family Planning, throughout the country. So far, the MOHFW has provided training to 1562 Family Welfare Visitors (FWVs) and 138 Doctors from all over the country with active involvement of DGFP and support from USAID and UNFPA. In addition, 64 FWVs have been deployed to all District Hospitals in Bangladesh to help ensure that PP contraceptives and Government of Bangladesh funds for provider payments are systematically available. Ten dedicated family planning counsellors have been deployed to 5 District Hospitals and 5 Upazila Health Complexes with support from UNFPA. As the number of deliveries is high in District Hospitals, these initiatives will play a significant role to increase PPFP in the country. Training guidelines, curriculum and facility assessment criteria to identify the facility readiness for PPFP have been developed and approved by DGFP. Through DFID funding, Ipas Bangladesh has been supporting 200 government and private facilities to expand the PPFP services.

2. **COMMITMENT 2**: Bangladesh will introduce a regional service package on family planning in Chittagong, Sylhet and Barisal Divisions for hard-to-reach populations.

Progress:

The DGFP is placing special emphasis in 3 divisions which are lagging behind compared to the other divisions. We took following steps to extend services to the hard-to-reach population.
Capacity Building:

1. Training on “Long acting reversible contraceptive and permanent methods (LARC & PM)” were provided to a total of 250 DGHS, DGFP and NGO doctors.
2. Training on Postpartum Family Planning was provided to 260 FWVs.

Demand Generation:

1. Recently, 753 additional paid peer volunteers were recruited to perform house-to-house visits. The 874 previously recruited volunteers are continuing their services. At present, the total number of paid peer volunteers is 1,627.
2. A total of 26 orientation workshops on “Long acting reversible contraceptive and permanent method (LARC & PM)” were conducted.
3. PPFP orientation workshops were conducted in 42 districts and sub-districts level.
4. For religious leaders, 18 LARC & PM workshops were conducted, using the booklet, “Family Planning in the Light of Islam”.
5. NGO services: At present, 18 BAVS clinics are providing LARC & PM services in urban areas.
6. To improve monitoring and supervision of family planning program, the Field Service Unit, DGFP/MOHFW has recruited 10 family planning facilitators with financial assistance from the UNFPA.

7. The CCSDP and FSD, DGFP/MOHFW and the IEC Unit are discussing the specifric expansion of family planning BCC materials that are and should be available through the logistics system to increase distribution with support from USAID.

3. **COMMITMENT 3**: Bangladesh commits to deploy at least two qualified diploma midwives in each of the Upazila Health Complexes to provide midwife-led continuum of quality reproductive health care by 2021. Midwives will be trained to provide widest range of family planning methods included

in their agreed scope of practice in country. Midwives will be trained to provide greater attention to first time young mothers.

Progress:

- Newly recruited 1,150 midwives has deployed in Upazila Health Complexes throughout the country.
- 10 midwives were trained on clinical contraception, including postpartum family planning, among those who were recruited as FP counselors in GAC supported districts.
- Another 25 midwives were trained on clinical contraception, including postpartum family planning from Sweden supported districts
- Newly graduated 310 midwives were given competency based training on comprehensive reproductive health, which includes FP, MR, PAC, STI and health sector response to GVB.
- DFID has been supporting national midwifery program in faculty development and clinical mentorship of newly graduated midwives.

4. **COMMITMENT 4**: Bangladesh commits to mobilize at least USD 615 million from its development budget for the family planning program implemented by the Directorate General of Family Planning as part of its 4th Health, Population and Nutrition Sector Programme (2017-2021). This is a 67% increase from the allocation in the 3rd Health, Population and Nutrition Sector Programme (2012-2016).

Progress:

- During current health sector plan, HPNSP [2017-22] substantial increment of resources for FP interventions has been made by the government. Resources for FP interventions under DGFP amounts US$ 627.12 million which is almost 67% higher than the previous sector programme budget. In addition to that, local level resource mobilization from the local govt. and community leaders are also increasing
- The total Annual Development Program (ADP) utilization for seven Operational Plans (OPs) in the 4th HPNSP for the FY 2017-18 is provided in the table below. It shows the expenditure by all seven OPs against both the allocation for FY 2017-18 and the funds released.

	2017-18 (RADP)	Expenditure (July 2017 to June 2018	% of utilization
Total	325.35	289.35	89%

- 4.5 million GFF money are being utilized for facility readiness to strengthen postpartum Family Planning services through trained human resources, equipment and contraceptives and supplies, quality improvement, SBCC and updated MIS.
- As part of the health sector program, DFID will contribute USD 2.5 million in the national family planning program.
- As part of the national family planning program, USAID will contribute approximately USD 22.0 milion in project support annually and the UNFPA will contribute approximately USD 1.0 million annually.

5. **COMMITMENT 5: Bangladesh will fully operationalize its new National Adolescent Health Strategy with special focus of addressing the family planning needs and promoting rights of all adolescents. Adolescents in Bangladesh will have access to widest range of family planning methods possible and special efforts will be made to track adolescent health data. Bangladesh reiterates its commitment to end child marriage.**

Progress:
Newly endorsed adolescent health strategy is being implemented in 27 districts. 5.1 MCH Services Unit of DGFP is implementing adolescent friendly health services (AFHS) through 64 Mother and Child Welfare Centers (MCWC) and 339 Union health and family welfare centers (UH&FWC) by providing training to service providers (Doctors, FWVs and SACMOs). DGFP is also strengthening those facilities with supply of necessary logistics and IEC materials ensuring AFHS as well as family planning information to all adolescents and family planning methods to married adolescents. DGFP is also collaborating with UNICEF through ADOHEARTS project to prevent child marriage. In Rangpur District, in collaboration with two local NGOs and the MOHFW, USAID is funding the Advancing Adolescent Health Project which has established AFHS in 73 MOHFW facilities and trained the staff in how to provide AFHS. From January to March 2018 alone, more than 8,000 adolescents were referred for services, with 82% actually receiving services. More than 100,000 girls and boys age 10-19 have completed or are completing a series of 4 to 8 life skills training sessions. More than 32,000 adolescent girls, boys, parents and community gate keepers have signed a pledge to delay marriage.

6. **COMMITMENT 6**: Bangladesh will scale up quality improvement measures in family planning programs by establishing Family Planning Clinical Supervision and Quality Improvement Teams (FPCS-QIT) in each of the 64 districts.

Progress:

DGFP has already scaled up Family Planning Clinical Supervision and Quality Improvement Teams (FPCS-QIT) in all 64 districts of the country. In addition to previous 10 regional consultants, 54 District consultants have been recruited for clinical supervision and monitoring for quality improvement of LARC & PM and MCH services. 64 senior staff nurses were also recruited as FPCS-QIT members.

7. **COMMITMENT 7**: Bangladesh commits to providing free and adequate contraceptives to NGOs, private clinics and hospitals and garment factory clinics with trained FP personnel.

Progress:

With an aim to increase contraceptive users among the garment workers, the FPFSD unit through its operational plan has trained service providers of 108 readymade garments factories. The training is followed by free distribution of contraceptives to the respective garment clinics. DGFP is already providing contraceptives to NGOs free of cost. A total 229 local and national NGOs are providing FP-MCRAH services in urban and rural areas.

8. COMMITMENT 8: Bangladesh will use technology and programme delivery innovations in family planning

8.1. In capacity development by providing tablets to field workers including an e-Toolkit and develop eLearning courses and empower them with ICT knowledge and skills

8.2. In programme delivery by working with marriage registrars to reach newlywed couples with family planning messages and organizing family planning client fairs in hard-to-reach areas.

8.3. Family planning messages, counselling and advice will also be provided through the national 24/7 call center of the Directorate General of Family Planning and Health Services.

Progress:

8.1. The IEM Unit of DGFP has taken initiatives to develop the capacity of Managers and field workers to empower them with ICT knowledge and skills. During 2017-18, under the IEC operational plan, a training program on the e-Toolkit which contains BCC messages and videos about family planning, maternal and child health, nutrition and the eLearning course is being implemented in 7 districts for district and upazila managers (9 batches) as well as field workers (37 batches).

To digitalize the field level activities, DGFP will supply 5,868 tablets in 10 districts with fund from USAID. This is in progress now. Another purchase of 624 tablets is in the evaluation stage by the DGFP.

8.2. The IEM Unit has organized Poribar Sommelon (Family Gathering) to advocate on FP and MCH and adolescents services at upazila level (66 programs). Satisfied clients of FP users were present at these programs to advocate the importance of family planning in maintaining a happy family.

The IEM Unit has initiated work with marriage register to address newlywed couples to disseminate messages on FP-MCH. A handbook on premarital counselling has been developed to orient field workers to provide information to newlywed couples in collaboration with marriage registers.

The FPFSD operational plan has implemented a pilot program in Brahmanbaria District to reduce adolescent pregnancy and to ensure delayed pregnancy among newlywed couples. In the piloting activity for marriage registers, religious leaders and community level service providers were added to conduct awareness rising activities along with distributing gift boxes on the wedding day containing IEC materials and contraceptives.

8.3 A 24/7 call center of the Directorate General of Family Planning is functional to provide virtual FP information and services. Besides this, FP-MCH information is also provided through the DGHS call center.

8.4 The IEM Unit continues to maintain an up-to-date digital archive of all MOHFW approved BCC materials.

8.5 CCSDP unit has continue to organize LARC&PM client fairs in hard to reach areas for increasing its coverage.

9. **COMMITMENT 9**: Bangladesh will include a service provider with reproductive health skills within its rapid response teams and mainstream the minimum initial service package (MISP) for reproductive health in crisis into its emergency response

Progress:

- 250 Service providers have been trained on minimum initial service package for reproductive health.
- 120 midwives were trained on reproductive health as rapid response team member at facility level.

Step 3. What are the key challenges or blockages faced when trying to accelerate progress towards the above selected commitments? Where does there seem to be resistance? What are the root causes of those *challenges and blockages*?

3.1. KEY CHALLENGES AND BLOCKAGES (e.g. operational, technical, political)
Commitment # 1
• **Challenge 1:** Efforts by stakeholders to operationalize the National PPFP Action Plan have been limited to date. • **Challenge 2:** The two wings of MOHFW, namely the DGFP and DGHS, do not fully engage themselves in the implementation of National PPFP Action Plan. • **Challenge 3:** MOHFW involvement to steer the implementation of the National PPFP Action Plan is lacking. • **Challenge 4:** The DGHS lacks sufficient contraceptive supplies for PPFP services. The DGHS and DGFP both lack sufficient number of trained FP providers. • **Challenge 5:** Lack of capacity building and facility readiness.
Commitment # 4
• **Challenge 1:** Budget allocation is not a challenge because the GoB has approved allocated operational plan budget; getting secondary administrative/financial expenditure approval from line ministry (MOH&FW) for disbursement of budgetary line elements specifically for procurement, training, workshop, recruitment etc. usually takes long time (2 to 3 months). It causes delay in implementation within the fiscal year with a potential loss of funding if activities spill over up to the following year. • **Challenge 2:** Although the MOHFW has the responsibility and can authorize total budget planning and expenditures, the capacity to respond to emergency and contingency

situations as they developed beyond the explicit operational plans with immediate and adequate funding.

- **Challenge 3:** Progress in the allocation and disbursement of Imprest fund to DGHS facilities and service providers. Operationalizing the disbursement to all facilities on a timely basis needs to be fully established.

Commitment # 5

- **Challenge 1:** Operationalizing the National Adolescent Health Strategy to be integrated into the different ministries including Youth & Sports, Women and Children Affairs and MOH&FW, LGRD
- **Challenge 2:** The roles and responsibilities of the different stakeholders are not clear in the Action Plan developed for the implementation of the National Adolescent Health Strategy.
- **Challenge 3:** Availability and access to unified youth friendly messages that address different age groups (10-14; 15-19; 20-24; 25-29; 30-34) do not fulfill needs.

Commitment # 7

- **Challenge 1:** Unavailability of FP services, including PPFP, in most of the private Medical College Hospitals and the private for-profit hospitals and clinics.
- **Challenge 2:** Weak regulatory mechanism; private for-profit sector is less accountable to offer FP services.
- **Challenge 3:** Service providers in the private for-profit sector are not well trained in family planning.

3.2. ROOT CAUSES PER CHALLENGE LISTED ABOVE

(i.e. What are the root causes of the challenges faced in accelerating progress towards the listed commitments? Please reference the guidance note below.

Step 3.2. Guidance note: *This step can be done through asking 5 "why questions"*

5 WHY questions: *an iterative interrogative technique used to explore the cause-and-effect relationships underlying a particular challenge. The primary goal of the technique is to determine the root cause of a challenge or problem by repeating the question "Why?" Each answer forms the basis of the next question. Here is an example:*

- *Community based health workers (CBWs) are not yet in place at the district level (the challenge)*
  a. *Why? - CBWs have not received a basic training yet (First why)*
  b. *Why? - District health offices have not yet received the updated training manual from the central level (Second why)*
  c. *Why? - Budget cuts for the training department at the Ministry delayed training manual development at the central level (Third why)*
  d. *Why? - Health minister was not successful in budget negotiation with the Ministry of Finance for this fiscal year (Fourth why)*
  e. *Why? – According to feedback, supporting documents for budget negotiation were not sufficient (e.g. policy briefs, visualized data summary) to allow the Health Minister to show the impact and urgency of the program (Fifth why, a root cause)*

Commitment # 1

Challenges	Root causes
● **Challenge 1:** Efforts by stakeholders to operationalize the National PPFP Action Plan have been limited to date. ● **Challenge 2:** The two wings of MOHFW, namely the DGFP and DGHS, do not fully engage themselves in the implementation of National PPFP Action Plan. ● **Challenge 3:** MOHFW involvement to steer the implementation of the National PPFP Action Plan is lacking. ● **Challenge 4:** The DGHS lacks sufficient contraceptive supplies for PPFP services. The DGHS and DGFP both lack sufficient number of trained FP providers. ● **Challenge 5:** Lack of capacity building and facility readiness.	● Historical responsibility of DGFP to do FP, not the DGHS. Lack of coordination and pro-activeness among DGFP and DGHS in functionalizing PPFP action plan. ● Coordination mechanism has not been developed to overcome years of separation between the two DGs. ● Frequent turnover of senior officials hamper strategic directions in implementing PPFP action plan. ● Contraceptives are not available in the labor room or OT due to lack of commitment and coordination. ● Absence of a comprehensive policy for capacity building of the providers and ensuring site to be ready to provide family planning services.

● Commitment # 4

Challenges	Root causes

• **Challenge 1:** Budget allocation is not a challenge because the GoB has approved allocated operational plan budget; getting secondary administrative/financial expenditure approval from line ministry (MOH&FW) for disbursement of budgetary line elements specifically for procurement, training, workshop, recruitment etc. sometime takes long time (2 to 3 months). It causes delay in implementation within the fiscal year with a potential loss of funding if activities spillover up to the following year. • **Challenge 2:** Although the MOHFW has the responsibility and can authorize total budget planning and expenditures, the capacity to respond to emergency and contingency situations as they developed beyond the explicit operational plans with immediate and adequate funding. • **Challenge 3:** Progress in the allocation and disbursement of Imprest fund to DGHS facilities and service providers. Operationalizing the disbursement to all facilities on a timely basis needs to be fully established.		• Implementing line managers are not well empowered to take decision for larger procurement, training, workshop, recruitment etc. • Policies of sector wide program money management is complex and fear of audit observation delays the planned activity implementation in some cases. • The MOHFW cannot change processes that are implemented/required by the Ministry of Finance.
Commitment # 5		
Challenges	⇦	**Root causes**
• **Challenge 1:** Operationalizing the National Adolescent Health Strategy to be integrated into the different ministries including Youth & Sports, Women and Children Affairs and MOH&FW, LGRD		• Data on adolescents specifically young adolescents (10-14 years) are missing in the national survey like DHS, MICS. • Service providers and gatekeepers are not well prepared or trained to

• **Challenge 2:** The roles and responsibilities of the different stakeholders are not clear in the Action Plan developed for the implementation of the National Adolescent Health Strategy. • **Challenge 3:** Availability and access to unified youth friendly messages that address different age groups (10-14; 15-19; 20-24; 25-29; 30-34) do not fulfill needs.		disseminate appropriate information and services. • Strong cultural and religious barriers exist to providing FP messages to adolescents and youth prior to marriage or sexual contact.
• Commitment # 7		
Challenges		**Root causes**
• **Challenge 1:** Unavailability of FP services, including PPFP, in most of the private Medical College Hospitals and the private for-profit hospitals and clinics. • **Challenge 2:** Weak regulatory mechanism; private for-profit sector is less accountable to offer FP services. • **Challenge 3:** Service providers in the private for-profit sector are not well trained in family planning.	⇦	• Unwillingness of private for-profit hospital owners is the major obstacle to offer FP services. Inadequate commitment in terms of corporate social responsibility (CSR) to the nation; only profit oriented. • Absence of FP representative in the Regulatory body for licensing. • Poor management and lack of commitment of both authorities and providers.

Step 4. What actions are required to tackle the root causes (in 3.2 above) for the identified challenges? Where does the greatest opportunity stand to influence the system, overcome resistance and accelerate changes?

4.1. What is needed in order to tackle the root causes for the identified challenges/blockages (listed in 3.2 above)? Based on your assumptions about what could work well and what will not, think about all possible actions/interventions.	
Commitment # 1	
Root causes	**Actions/interventions to be taken**

• Historical responsibility of DGFP to do FP, not the DGHS. Lack of coordination and pro-activeness among DGFP and DGHS in functionalizing PPFP action plan. • Coordination mechanism has not been developed to overcome years of separation between the two DGs. • Frequent turnover of senior officials hamper strategic directions in implementing PPFP action plan. • Contraceptives are not available in the labor room or OT due to lack of commitment and coordination. • Absence of a comprehensive policy for capacity building of the providers and ensuring site to be ready to provide family planning services.	• Regular meeting at different levels be undertaken to review ground level situation. Also need a directive from the Ministry of Health and Family Welfare to both DGs to actively participate in a coordinated manner. Provide more information and data to both DGs. Speed up technical assistance (TA) to the two DGs to address implementation barriers; availability of contraceptives and imprest funds and trained providers. • Prepare and disseminate directive on how to access and distribute Imprest funds to the health providers and clients in a timely fashion. • Something innovative using ICT could be developed to set up an effective coordination mechanism. Intensify the advocacy from the Development Partners Group to the Ministry of Health and Family Welfare to require coordination. Provide technical assistance to get it setup. • Strategic thinking and planning workshops be conducted for senior level officials of MOHFW, DGFP and DGHS. • A national policy could be framed for building up the capacity of different providers using the principle of Continued Medical Education (CME) and that would include ensuring site readiness. A new FP project includes a component to help NIPORT develop a FP certification program for FP providers. The MOHFW is currently expanding an HR iMIS to track staff training; specific types of FP training can be included.
Commitment # 4	
Root causes	**Actions/interventions to be taken**
• Implementing line managers are not well empowered to take decision for larger procurement, training, workshop, recruitment etc.	• The practice of using Data for Decision Making (DDM) has to be institutionalized up to ministry level • Update costed implementation plan for national FP program to include adolescents, impact to

• Policies of sector wide program money management is complex and fear of audit observation delays the planned activity implementation in some cases. • The MOHFW cannot change processes that are implemented/required by the Ministry of Finance.	decrease MMR and procurement for contraceptives to fulfill GoB FP2020 commitments to supply NGO and private sectors • Application of FP-SDG model in Bangladesh • Add line item with accompanied budget to the operational plan for emergency and discretionary funding to respond to unexpected crises and emergencies.
Commitment # 5	
Root causes	**Actions/interventions to be taken**
• Data on adolescents specifically young adolescents (10-14 years) are missing in the national survey like DHS, MICS. • Service providers and gatekeepers are not well prepared or trained to disseminate appropriate information and services. • Strong cultural and religious barriers exist to providing FP messages to adolescents and youth prior to marriage or sexual contact.	• Secondary analysis of BDHS 2017-18 with a focus on adolescents. • In service training for service providers to ensure integrated youth friendly services addressing all age groups as defined by GoB at all level of facilities and communities. • Sensitization of adolescents and youth on appropriate family planning method-mix and choices through varied outlets using latest digital technologies and social behavior. communication and change best practices. • Sensitization of stakeholders and gatekeepers of adolescents and youth on appropriate family planning method-mix and choices through varied outlets using latest digital technologies and social behavior communication and change best practices.
Commitment # 7	
Root causes	**Actions/interventions to be taken**

• Unwillingness of private hospital owners is the major obstacle to offer FP services. Inadequate commitment (CSR) to the nation; only profit oriented. • Absence of FP representative in the Regulatory body for licensing. • Poor management and lack of commitment of both authorities and providers.	• Sensitize private for-profit hospital/clinics owners to make FP services available in all facilities. Social marketing can play a pivotal role in this case. • Revise/Include FP representative in the Regulatory body. • DGFP and DGHS should plan for capacity building of private providers and ensure adequate supply of contraceptives wherever necessary.
4.3. How can all focal points and other stakeholders best leverage their influence to support these interventions to accelerate progress? (Refer back to the stakeholder list above)	
For all of the Actions/Interventions mentioned above to address the Root Causes, the Focal Points are well poised and placed to influence implementation.	
4.4. To what extent are these interventions focused on the following three themes of the workshop? Please list those that you would like to discuss/learn more (from other countries' experiences and/or technical partners) at the October workshop.	
1. Strengthening leadership / improving political will	• Regular and frequent discussion at the highest level of MOHFW has to be undertaken to bring changes in policies. • The practice of using Data for Decision Making (DDM) has to be institutionalized at all levels. • Something innovative using ICT could be developed to set up an effective coordination mechanism. • Leadership, strategic thinking and planning workshop/ training be conducted for senior level officials of MOHFW, DGFP and DGHS. • A SBCC campaign using all types of social and mass media, and community based events, focused on SBCC will be quickly planned and implemented to increase awareness among pregnant women of the need for PPFP and

	increase their demand for it. Multiple USAID family planning projects are having internal discussions on such a plan to take to the MOHFW. ● A national policy be framed for building up the capacity of different providers using the principle of Continued Medical Education (CME) to create a FP Provider Certification program and that would include ensuring site readiness.
2. FP financing	● Prepare and disseminate directive on how to access and distribute Imprest funds to the health providers and clients in a timely fashion. ● Add line item with accompanied budget to the operational plan for emergency and discretionary funding to respond to unexpected crises and emergencies.
3. Reaching youth and adolescents **a. Adolescents** **b. Youth**	● In service training for service providers to ensure integrated youth friendly services addressing all age groups as defined by GoB at all level of facilities and communities. ● Sensitization of adolescents and youth on appropriate family planning method-mix and choices through varied outlets using latest digital technologies and social behavior communication and change best practices. ● Sensitization of stakeholders and gatekeepers of adolescents and youth on appropriate family planning method-mix and choices through varied outlets using latest digital technologies and social behavior communication and change best practices.