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MID-TERM EVALUATION OF USAID

FAMILY PLANNING SERVICES PROJECT

IN BANGLADESH

(388-0050)

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I. EXECUTIVE SUMMARY

Introduction

The importance of bringing rapid population growth under control has been fully recognized by the government of Bangladesh. It is reflected both in policies and committments affirming the importance of the National Population Control and Family Planning Program as an integral part of its overall development strategy. USAID, as a major contributor of development assistance, has likewise assigned the highest priority to the goal of reducing fertility in its program of development assistance[1]. Implementation of this strategy currently is embodied in the USAID Family Planning Services Project (388-0050) which is the subject of this mid-term evaluation.

Since the inception of the project, a number of significant events have occurred which bear directly or indirectly on the achievement of its goals. A change of government in Dhaka, with the advent of martial law (March 1982), worldwide recession affecting adversely both donors and recipients of foreign aid, a serious lack of counterpart local finance in Bangladesh which has hampered the flow of aid, and a number of changes of key personnel on both sides of the aid relationship are among the factors which call for an assessment of current status and future direction of this project.

Current Demographic Situation

In the absence of more recent national scale surveys on the order of the Impact of Family Planning Survey (1963-69) and the World Fertility Survey for Bangladesh (1975-76), it is not possible to draw firm conclusions regarding progress toward the national goal of replacement level fertility by 1990. The two aforementioned studies yielded conflicting findings, indicating that while annual marital ferility rates declined substantially between the two surveys, cumulative fertility (averaging about four children per woman) did not show any decline. At the same time, favorable changes in attitudes toward and in knowledge about contraception occurred between the two surveys, although compared to the level of contraceptive knowledge and attitudes, the increase in contraception in practice was low.

While studies indicating evidence of a decline in fertility since 1975 may be questioned in terms of sample size and methodological rigor[14], the concensus that some fertility decline is occurring appears justfied by the results of local sample surveys and the evidences of increase in the proportion of ever users. The evaluation team, in the absence of hard data regarding changes in family size, interprets the encouraging contraceptive prevalence surveys of the past two years with considerable caution, and our reservations are expressed in the body of the report. Nevertheless, the prevalence data, coupled with the observed evidence of latent demand for family planning, leads us to believe the prevalence levels can be increased to 30% or above in the current plan period if full implementation of the PCFP Program is pursued vigorously. The political will, donor participation, organizational and administrative adjustments, and programmatic directions required to achieve this objective form the bulk of this evaluation. Additionally, in keeping with the desire, expressed both in Washington and in Dhaka, for attention to be given to the future direction of aid beyond the present project, the team has addressed the measures above and beyond a fully implemented family planning program that will be required to achieve the targeted reduction in fertility.

Scope of Work

The evaluation team was charged with the following purposes:

1) To assess the strategy, inputs, processes and outputs of the current USAID Family Planning Services Project;

2) To recommend feasible and cost-effective interventions to assist the Family Planning Program in Bangladesh to reach a contraceptive prevalence rate (CPR) of effective methods of 30% by 1985. This will require the following:

(a) an assessment of the Bangladesh government's Family Planning Program;
(b) an assessment of USAID and other donor inputs, policies and strategies as they affect the family planning system of the BDG; and
(c) an assessment of NGO family planning activities in relation to the overall family planning effort in Bangladesh.

The Evaluation Team

The team was multi-disciplinary and binational, consisting of the following members:

a. USAID Consultants:
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Specialist in Health (Army)
Director General (Implementation), Population Control Division
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Member, Faculty of Medicine/Academic Council, University of Dhaka
Director General, National Institute of Population Research and Training (NIPORT)
Dhaka, Bangladesh

c. USAID/Washington Representative:

Mr. Dallas Voran
Population Advisor, USAID Washington

Itinerary and Agenda

The evaluation team assembled in Dhaka on August 2, 1982 for a briefing at the USAID/Dhaka mission, to distribute and review pertinent documents, to arrange appointments, and to plan the agenda and itinerary of field observations. A series of visits by the team as a whole followed, both with key government officials involved in the national program, and to selected agencies (both government and NGO) whose activities are pertinent to the Family Planning Services Project. Thereafter, in view of the limited time available for such a formidable assignment, individual and sub-committee visits were made to as many relevant agencies and offices as possible. Also in the interest of limited time, a one day field trip by the whole team to a Thana within easy reach of Dhaka was arranged, with subsequent trips to the Northwestern and Southern areas by sub-divisions of the team, in order to get as wide and representative a view of project activities at the district, thana, and village level as possible. In retrospect, the team feels that the total in-country time of three weeks was inadequate to cover all facets of this extensive and complex project. (It must be noted that the short in-country time occurred through no fault of USAID or the contractor. Rather, it was due to the fact that not all members of the evaluation team were able to free time from their regular activities for a longer assignment.) Nevertheless, it is felt that the major elements of the project were sufficiently examined for the analysis and conclusions reported herein and that its strengths and weaknesses are sufficiently appreciated to warrant the numerous recommendations we have made and to point the direction of future actions.

In the final days of the team's sojourn in Banglasdesh we re-assembled in Dhaka to prepare our preliminary report and recommendations and to discuss our major findings and conclusions with officials of the MOHPC, the Planning Commission, and USAID.

While our findings and conclusions are developed in detail in the body of the report, they may be summarized briefly as follows:

The PCFP Program is conceptually sound and reflects a strong political will, but is increasingly difficult to sustain in the country's present economic situation. Accordingly, a continued need for high levels of aid is anticipated, requiring close collaboration among major donors and fuller utilization of NGOs. Program implementation is hampered by too frequent changes in direction and by shortcomings in organization, administration, logistics and supply management, training, and supervision, which are addressed in a number of our recommendations. Full utilization of the USAID project has been slowed by the same set of problems, but it is nevertheless contributing constructively to the national program. While numerous recommendations are addressed to immediate mid-term problems in various project elements, greater attention must be given to the inclusion in future and follow-on projects to "Beyond Family Planning" measures to create conditions favorable to a more rapid and substantial fertility decline.

Although the team recognizes that its objective was the evaluation of the Family Planning Services Project, in response to an express wish by USAID officials both in Washington and Dhaka, we have attempted to address the larger global issue of US assistance in the population sector in general, in relation to other donors, and into the future beyond the present project. It is in the spirit of this larger task that this report is respectfully submitted.

II. MAJOR RECOMMENDATIONS OF THE MID-TERM EVALUATION

1. The team is pleased to note the increase in family planning acceptance which is apparent from the MIS statistics and the 1981 Prevalence Survey. The team is furthermore impressed with the continuing political support to the population question at the national level. However, fundamental weaknesses in the delivery system remain and there is an urgent need to build up the program at all levels and strengthen its administrative capability. Frequent organizational changes have impeded program implementation. Given the high priority of the population program, we recommend that outstanding organizational issues be addressed with speed and that continuity in direction and management be assured in the future.

2. Problems related to the integration of health and FP/MCH at the thana level and below require immediate attention. USAID should urge the BDG to address these on a priority basis at the national level. These include:

a. resolution of administrative, structural, and financial problems between the Health and FP Divisions which inhibit full realization of integration;
b. establishment of new systems of rewarding performance;
c. provision of equipment and supplies for the integrated services;
d. we strongly recommend that, given the broad range of tasks facing the MOHPC, priorities be set to assure that essential tasks are not neglected.

3. In view of the priority status of the Population Control and Family Planning Program and of the numerous vacancies among fieldworkers, officers, and in the staffs of the training institutes, which clearly inhibit program performance, USAID should urge the BDG to waive the hiring freeze and allow existing vacancies in the program to be filled.

4. USAID should urge the BDG, in keeping with the priority status of the Population Control and Family Planning Program, to allow the Director General of Implementation to retain unspent funds at the end of the financial year in his P.L. account. The BDG should also be requested to review existing financial rules and seek simplified procedures to ensure prompt release and ready flow of these funds in order to improve project implementation. Alternatively, USAID should collaborate with the BDG in devising such mechanisms as a revolving fund to reduce the programmatic bottleneck which arises at the conclusion of the fiscal year.

5. USAID, in collaboration with other donors, should assist the BDG in its institution building process through increased emphasis on the establishment of performance based reward systems for fieldworkers and supervisors in the program and through the development of a greater management training capability in the training and research institutions throughout the country.

6. USAID should propose to the PCFPD and the other donors the formation of a high level task force on training, including government officials and representatives of donor agencies. The purpose of this technical advisory group would be to identify training needs in the program and recommend approaches for meeting them. This would enrich the training program by bringing a variety of perspectives to bear on shared objectives and problems. The resulting sustained focus on training would facilitate timely action and coordination of implementation and funding committments. The recommendations of such a task force may also help to strengthen PCFPD's justifications of budget requests for training.

7. USAID should provide a resident supply and logistics specialist for a minimum of two years to assist the PCFPD to gain control of this essential part of its services program. The full-time presence of such a person will help to ensure a sustained focus on this effort.

8. USAID should assist the PCFPD to revise the Supply Manual to incorporate the full range of MCH/FP supplies and equipment into the supply management system.

9. We recommend that sustained emphasis be placed on the quality of VS services. In order to forestall loss of momentum of the voluntary sterilization program, USAID should make every effort to assist the BDG in meeting the conditions precedent and assure prompt action in reinstating payments once the conditions are satisfactorily fulfilled.

10. USAID and the BDG should collaborate on developing measures that will increase the relative proportion of reversible methods in the national program.

11. Both USAID and the BDG should be encouraged to facilitate the contributions of NGOs to the program and seek creative measures to maximize their performance.

12. USAID should support the government's over-riding priority to provide high quality services for family planning to meet the existing demand and to educate the people to make informed choices as to methods. At the same time further support should be given to the BDG's efforts to create widespread acceptance of the small family norm through the multi-sector projects and adoption of measures "beyond family planning".

13. USAID should place increased emphasis in ensuing mission projects in Bangladesh on effective programs conducive to delaying marriage, increasing birth intervals, and decreasing family size. Such projects, without detracting from the priority of the FPSP, should include funding for:

(1) broadcasting and other media programs which will educate the people in the health risks of early marriage and child bearing before eighteen and from too many or two frequent pregnancies and which could provide specific information on the methods of family planning and the location of services;
(2) assisting BDG in all necessary measures to keep girls in school longer and especially to provide more opportunities for girls to attend secondary schools and to find suitable employment thereafter;
(3) sustained efforts to strengthen all aspects of maternal and child health services, including family planning, and to assist the government in other aspects of the extension of primary health care on the basis of priorities established by BDG in cooperation with an external Health needs assessment.

14. In considering future levels of funding we recommend that the following considerations be given priority attention:

(a) need to diversify the assistance package with greater emphasis on institution building and beyond family planning measures;
(b) the capacity of the BDG to absorb external assistance;
(c) the role of USAID vis-a-vis other donor participation in BDG development;

(d) as yet undetermined changes in the availability of US funding and priorities for assistance among AID recipients;

(e) the need for USAID to collaborate fully with the MOHPC in finding ways to achieve program economies and efficiency.

III. THE NATIONAL POPULATION CONTROL AND FAMILY PLANNING PROGRAM

A. THE POLICY CONTEXT

The Government of Bangladesh adopted a comprehensive population policy in 1976 based on its urgent development needs, its pre-independence and post-independence programs, and the experience of other Asian countries, as well as its own research and the convictions of its leadership.

This policy was further developed in the Second Five Year Plan in the light of changing circumstances and the need to see the population program as an integral part of development. It also gave further attention to measures "beyond family planning", to strategy, and to performance in the 1976-80 period as a basis for identifying necessary changes in the current program if the national goals are to be met.

This restatement of policy confirmed the main lines of the 1976 policy, confirming the high priority to be given to solving this problem and the political support and financial commitment which would be necessary. It also set some specific goals to be achieved in the 1980-85 period, including a crude birth rate of 31.56 per thousand, a crude death rate of 13.78 per thousand, and 37.5% of eligible couples as continued users of contraceptives. The USAID Evaluation Report on US assistance to the Family Planning Programme in 1980 noted that these targets were somewhat unrealistic and recommended that the Ministry of Planning, MOHPC and the Office of the President might consider an overhaul and revision of the growth rate goals, targets for program achievement, and future population size projections. As the MIS system is developed, and the results of the 1981 census become available, as well as results of further demographic research, the Planning Secretariat will undoubtedly make these revisions. During the visit of the current team, both planning officials and MOHPC officials acknowledged that the 1985 targets were unlikely to be met in full, although the 1981 Contraceptive Prevalence Survey gave some reasons for optimism that contraceptive practice might reach 32 or 33% by the end of the plan period.

Other aspects of policy, including the priority given to providing services required to meet existing demands for FP; the emphasis given to sterilization in the method mix; the mobilization of the private sector in terms of medical practitioners; social marketing; the role of voluntary organizations; the question of community involvement; organization of governmental services for service delivery and demand creation; the establishment of linkages with other development programs are all treated in separate sections of this report. The question which remains for the policy overview is the question of priorities.

Priorities among all the policies and strategies laid out in the plan are identified more specifically in the Annual Development Program, which allocates resources for the Ministry of Health and Population and for the development program of other ministries. These are further elaborated in the plans, programs, and projects of these ministries. (See Appendix C for 1982-83 ADP allocations for various sectors).

Findings, Conclusions and Recommendations:

1. Political Will:

As noted in the 1980 program evaluation report[17], the commitment of the Bangladesh Government under President Ziaur Rahman to a policy of population control was strong and unequivocal. The present government under the Leadership of CMLA Lt. General Ershad continues to assign very high priority to population control always in the context of the need to develop the human and material resources of the country, to make it self-reliant, and to improve the living conditions of the people. During the stay of the team in Bangladesh, the CMLA (Lt. General H.M. Ershad) made numerous

references to population and food problems and to raising the productivity of labour in his public speeches. We found evidence of this positive support at top levels, also in the planning commission, in the Annual Development Plan, and in the media. While nearly all the sectors of government have been put on an austerity budget with 20% or more cut from their approved allocations, the population sector has been afforded special treatment.

The limited contacts we have been able to make in other development ministries and in the districts would indicate that this political will is widely understood and appreciated.

RECOMMENDATION: USAID/Dhaka should suggest to BDG that within the framework of the Second Five Year Plan, a two-year population and family planning plan with more specific guidance on priorities and requirements for 1984-85 would be helpful for the ministries concerned, as well as for the external donors.

RECOMMENDATION: USAID should support the Government's over-riding priority to provide high quality services for family planning to meet the existing demand and to educate the people to make informed choices as to methods. At the same time, further support should be given to the BDG's efforts to create widespread acceptance of the small family norm through the multi-sector projects and adoption of measures "beyond family planning".

RECOMMENDATION: AID/Dhaka and the U.S. Embassy should continue to reinforce these evidences of political will in all appropriate contacts with the leadership. It may be suggested to BDG that the message of population control to accelerate achievement of development goals might be supplemented with further emphasis on the benefits of family planning to the health and welfare of the people.

2. Decentralization and Community Participation:

The population policy and strategy as set out in the Second Five Year Plan proposes to involve all local government institutions, voluntary organizations and the people in population activities as an important factor for the success of the program.

The report of the Committee on Administrative Reorganization and Reform constituted by the present government is now available and makes many recommendations for strengthening local government through direct election of Zilla, Thana and Union Parishad Council chairmen, as well as decentralization of administrative authority to the thanas. The CMLA, Lt. General H. M. Ershad, has declared that thana-based administration will start functioning by the end of this year. (See Appendix H for the resolution dealing with implementation of this plan, which was sent to the team after completion of the evaluation trip.)

The team was able to meet a number of chairmen and members of Union Parishads in the course of the field trips and to discuss with them the roles of their councils in gaining support of the people for the Integrated Health and Family Planning program and in helping, as well as monitoring, the activities of the field workers of the Ministry of Health and Population Control. These objectives might be achieved in a number of ways, such as:

(a) activation of broadly constituted family planning committees at union level;
(b) regular reporting by personal contact by the union level officer for Health and Population Control to the Union Parishad Chairman on the number of eligible couples reached and any problems of the workers in the villages of the Union;

(c) special training sessions for Union Parishad and Family Planning Committee members; and
(d) events and awards recognizing high achievement by community members, local voluntary organizations, or government workers.

In addition to the formal institutions, such as the Union Parishad, there are many other recognized organizations of village people for specific purposes, such as cooperative societies for men and for women, mothers clubs, youth clubs, etc., which receive outside support through particular ministries (Agriculture, IRDP, Social Welfare and Women's Affairs, etc.). There also exist numerous local voluntary organizations with both religious and secular origins. In many areas the Swanirvar (self-reliance) Movement has become an important force. Mobilization of these resources to promote people's participation in national programmes for their own welfare is an objective worthy of much greater attention.

RECOMMENDATION: USAID, as a part of its institutional support activities in the follow-on-project, should give encouragement to the government's efforts to decentralize the administration of health and family planning programs in the context of the more general reforms of administration and strengthening of local government in all appropriate ways (such as support for retraining of the administrative cadres at thana level, including orientation for new responsibilities in health and population).

RECOMMENDATION: USAID should coordinate efforts with other donors to strengthen the role of the Union Parishad in relation to field workers in health and population and to increasing community participation of both men's and women's formal and informal organizations in the program. USAID assistance to non-governmental organizations with demonstrated ability to make a contribution in this area should be continued.

The Second Five Year Plan also proposes "appropriate incentive systems at the community level"; and it is understood that the national policy review group has made some recommendations to the government to move forward in this area. It is suggested that USAID/Dhaka (in cooperation with other donors) should respond to any initiatives in this area by providing an analysis of experience in other Asian countries with community incentives and should assist the BDG to develop schemes which will:

(a) encourage all sections of the community to express their basic needs and the ways in which they would like health and family Planning services to be provided;
(b) design a system which will maximize achievement of the goals of the family planning program at the village level and build up social consensus on the small family norm; and
(c) reward communities with development projects benefitting all classes in the village with special concern for the poorest.

3. The Role of Non-Government Organizations:

The contribution of USAID to the non-governmental sector has been analyzed in another section of this report. Here it may be noted that the World Bank and the ADB, as well as some other bilateral donors, have expressed some interest in suppporting NGO efforts in future programs. This will need to be carefully coordinated to ensure that NGO's do not lose some of their special qualities and advantages in rapid expansion. It is also important to ensure BDG/NGO cooperation and coordination at all stages to

reap the maximum benefit from this sector. (See page 40 of this report for analysis of U.S. supported NGO activity.)

4. **"Beyond Family Planning":**

It is widely recognized in Bangladesh as in other Third World countries that provision of services for family planning must be accompanied by massive efforts in other development sectors to meet the basic needs of the people and to provide a climate for social change, including acceptance of the small family norm and of family planning. This concept is central to the policies set out in the Second Five Year Plan for population. The Ministry of Planning has established a Population and Development Section with the help of UNFPA. This section will study the inter-relationships of all the development sectors with population and should be expected in due course to identify the most effective interventions in other development activities to help achieve the internal demographic goals[12].

In the Bangladesh context, the production of food for domestic consumption, as well as agricultural products for export to earn foreign exchange, has been given the highest priority in terms of allocation of revenues. With 88% of the population still in the rural areas and a growing problem of landlessness, measures to combat rural unemployment and underemployment have also demanded a high proportion of investment. USAID has contributed a substantial part of its aid to Bangladesh in these sectors through its projects for agriculture, rural industries, and rural energy. In the areas of social development, the government has set itself goals of Universal Primary Education by 1985, primary health care for all by the year 2000, and has developed less precise goals for raising the status of women through education, training, and employment opportunities, as well as through changes in legislation. In these areas of social development, the IDA/Bank and UNICEF, as well as some bilateral donors, have made more substantial contributions than USAID.

The Second Five Year Plan for population also sets out in some detail the roles that each of the main ministries are to perform as direct contributions to the achievement of the national population goals. These are being implemented through the "multi-sector projects" in Agriculture, Rural Development, Education and Religious Affairs, Labour, Information and Broadcasting, and General Welfare and Women's Affairs.

Findings, Conclusions and Recommendations:
Multi-Sectoral Projects

1. The efforts being made through the multi-sector projects which link other development ministries to the demand side of the family planning program as presently funded and managed are of unequal value. The Ministry of Information and Broadcasting is carrying out projects financed by the Bank, covering radio, television, films, feature writing and publications. Much good work has been done and Bangladesh Radio carries 70 minutes of population and family planning messages six days per week, plus 30 minutes of regional programs in local languages. The information and broadcasting program, as well as the activities of the IEM Section of PCFP are essential support to the service delivery activities - messages must be kept fresh and related to the real needs of the people for information which will help them to move from general awareness to changes in fertility behavior. Judicious integration of health and family planning messages may strengthen the impact of information programs - e.g., a sustained campaign to educate both rural and urban populations on the health risks of early marriage and child-bearing may undergird governmental efforts to raise further the age of marriage (which is rising due to other factors) and to introduce contraception for young couples to delay the first child. These messages need to be a part of the training and practice of all field workers.

2. The population education program of the Ministry of Education and Religious Affairs (supported by UNFPA) seems of highest importance for longer-run changes in attitude on size of families and acceptance of family planning. The program appears well-conceived and, as noted above, is already reaching a large number of children in age ranges eleven and above. However, it must be remembered that only about one-third of school age children are in school, that drop-out rates are very high in the first three grades, and that only about 25% of the small numbers of secondary school students are girls. The general support for universal primary education, as well as special efforts on female secondary education, are therefore of vital importance to the achievement of the longer term demographic goal (NRR = 1 by 1990).

3. There is some evidence that the multi-sector project for population education for agricultural extension (supported by UNFPA) has inherent problems, since most of these workers are young male graduates, thinly scattered and not in direct contact with poor farmers. The project has concentrated thus far on getting population education into the curriculum of 12 agricultural training institutes which train the extension agents for assignment to union level and also the Central Institute which brings in incumbent agents (about 3,000 are in the field) for short-term refresher training. The introduction of home economics workers is now contemplated (20% of the current class in the Institute is now female) and, eventually, they should be very helpful in training women to be more productive in their food processing and poultry duties, as well as disseminating nutrition education and better child care practices. Working through an expanded system of mothers' clubs and women's cooperatives, they would have the potential to be more effective agents of family planning education than the agricultural extension agents.

4. The Women's Vocational Training Project - a multi-sector project of the Bangladesh Women's Relief and Rehabilitation Foundation, is supported by IDA/World Bank. It is training about 4,800 women in 100 centers under the second project of whom about 10% are those employed in the production workshops of the project and another 360 are involved in cooperative societies organized by the project. Problems of adequate vocational instructors, marketing problems, and many more general problems of supervision, conditions of work, etc. impede the effectiveness of this project.

5. The Labour Welfare Project, carried out by the Ministry of Labour and Manpower with the assistance of the ILO and financing by UNFPA, now covers 21 Labour Welfare Centers, serving about 400,000 worker couples. The labour welfare officers are trained in population and family planning to motivate workers to accept a small family norm and to practice family planning. Services are provided through the Labour Welfare Clinics in the big industries. Some 500 voluntary workers (who are given small incentive payments) also work in the project areas. The response has been good - nearly 60% of the worker couples accepting a family planning method. Training has also been given to trade union executives, mid-level management, and labour officials. Population education has been introduced in work-related training institutes. More recently, ILO has been providing assistance through the Ministry of Local Government, Rural Development and Cooperatives to introduce population education to cooperative leaders; there has been a noticeable increase in family planning practice - field activities are to be expanded to cover 3,000 cooperatives over the next two years.

6. The Mothers' Clubs Projects of the Ministry of Social Welfare and Women's Affairs, supported by the Bank, are also a valuable link between PCFP and the general welfare activities in rural areas. Over 750 such clubs now exist and reach about 22,000 members directly (about 30 members each) and a wider group indirectly. Activities vary, but always include educational activities, nutrition, income - generating activities

and family planning. The International Union for Child Welfare is now cooperating with the Ministry to strengthen the training and supervision, as well as the income-generating activities of these clubs.

7. The Women's Development Cooperatives, which are part of the IRDP of the Government, are not specifically classified as a "multi-sector" project, but as a result of the team's visit to BARD in Comilla, we understood the importance of this program for raising the status of rural women and giving them a real part in development activities[7]. This participation does affect the attitudes of women members (and their circle of family and friends) toward family planning, according to recent statistics.

8. Experimental "Beyond Family Planning" Approaches.

A number of the concepts proposed in this paper, as well as elements in the second FYP designed to reduce "risks" to parents who opt for limiting the number of their children to two or three are likely to be carried out on an experimental basis bythe IDA/World Bank in its third project. These include a bond scheme for parents accepting sterilization and guaranteed employment in off-seasons in public works projects by thana authorities for landless labourers. These experiments are to be carried out in a few thanas only if the proposals of the Bank Representative are accepted. There are also proposals for some experimental projects with community incentive schemes related to the Swanirvar (self-reliance) movement. The third project of the Bank will not be operational before 1984.

The plan for 1981-1985 sets out a large number of possible measures dealing with incentives and disincentives for government workers, as well as legislation for raising the age of marriage, increasing the status of women, and improving the vital registration law. Little action has yet been taken in these areas, but the team understands that the government is awaiting a report of a special policy review committee which will deal with many of these questions. These are certainly matters of national policy and action will not depend on any outside assistance.

The demographic impact of these measures will depend in part on the implementation of the legislation, but perhaps even more on the social changes that will come with education and economic development.

It appears to the team that the area still needing major input and not adequately covered by government investment or external sources lies in the realm of female education at the secondary level. USAID/Dhaka has made a modest intervention by providing stipends of 40 Tk. per month for 1370 secondary school girls in six unions from January, 1982, through an indigenous voluntary organization, the Bangladesh Association for Community Education. The mission has also commissioned a study of the current educational opportunities available to females in Bangladesh in order to assess the potential for a future USAID project development effort.

The latest figures available (through the Bangladesh Bureau of Educational Information and Statistics) show that secondary school enrollment in 1980 (excluding Madrashah schools) was 1,893,059, of which only 25.5% were girls. Even this proportion varies from 24.5% at the 6th grade level to 18.1% at the 10th grade. The 1981 Contraceptive Prevalence Survey indicates a high correlation between the educational levels of women and the use of contraception by currently married women (See Table 1).

While many other factors contribute to the decision to use contraception (urban-rural differences, employment status, and even poverty) and researchers show that the inter-relationships between education and fertility are complex (See Alauddin's review of research[14] on Socio-Economic Determinants of Fertility, pp. 43-48), there is enough evidence from neighboring countries such as Sri Lanka and certain states of India to justify the interest shown by USAID/Dhaka in this area.

At the same time, the mission should encourage research and planning by appropriate governmental institutions on the employment opportunities for educated girls in Bangladesh in the 1990's and beyond. The growth of the social sectors should provide tens of thousands of jobs in medicine, nursing, family planning and other health-related fields, teaching, social welfare services, vocational training for girls, etc. Many tens of thousands more in urban areas will work in private enterprises. The greatest number still living in rural areas will have to find employment in cooperative enterprises or individual activities which will make them economic assets to their families. If the experience of other Asian countries is a guide, a combination of education and income-generating activity will delay the age of marriage and make a positive contribution to reduction of fertility.

The work now undertaken by the Ministry of Planning in the area of "Population and Development" with the help of UNFPA should enable the government to select the most effective interventions to achieve its population targets in future years. Meanwhile, the team hopes that the follow-on project for Population/Family Planning will supplement the IDA/Bank's efforts in primary education by adding sufficient inputs dealing with female secondary education. USAID assistance to the BDG in measures to support education for girls should be planned in close cooperation with the Bank and UNICEF, which are making some $73 million available to the BDG for strengthening primary education.

The possibilities for additional inputs in the extension of primary health care should also be explored. There is little question that family planning services actually delivered are the most effective contribution to maternal and child health. However, the persisting high risks of maternal, infant and child mortality[10] reflect the fact that the delivery system for all health services needs improvement and that the majority of village people still rely on traditional healers and TBA's.[5]

Other donors are providing extensive support for information, education, and motivation activities of the Ministry of Broadcasting, Ministry of Health and Population Control, and other development ministries (through the multi-sectoral projects formed by the Bank and UNFPA). USAID should cooperate closely with the BDG, the Bank and UNFPA to strengthen the relevance and effectiveness of IEM programs to move people from general awareness to changes in fertility behavior.

RECOMMENDATIONS: "Beyond Family Planning"
USAID should place increased emphasis in the ensuing projects in Bangladesh on effective programs conducive to delaying marriage, increasing birth intervals, and decreasing family size. Such projects, without distracting from the priority of the service program, should include funding for:

1. Broadcasting and other media programs which will educate the people in the health risks of early marriage and childbearing before eighteen and too many and too frequent pregnancies, and which will provide specific information on methods of Family Planning and location of services.
2. Assisting BDG in all necessary measures to keep girls in school longer and, especially, to provide more opportunities for girls to attend secondary school and to find suitable employment thereafter;
3. Sustained efforts to strengthen all aspects of maternal and child health services, including family planning, and to assist the government in other aspects of the extension of primary health care on the basis of priorities established by BDG in cooperation with an external Health Needs Assessment.

RECOMMENDATION: USAID should include in the measures it supports for encouraging the adoption of the small family planning norm a significant input

for female secondary education and explore with other donors the full range of measures which show promise of increasing demand and acceptance of girls in secondary schools.

RECOMMENDATION: USAID/Dhaka should be supported in its efforts to incorporate training and employment of women in its broader projects for agricultural production, food-for-work, rural industries and rural energy. Sustained concern for women's cooperatives and vocational training, as well as management training, training for financial and commercial careers, as well as government service, should be encouraged. Private organizations, as well as BDG, should be involved in these efforts.

RECOMMENDATION: Sustained efforts to help the government extend primary health care for all by the year 2000 is of direct concern for the success of the population program. Maternal and child health, including family planning, are of central importance in reducing maternal and child mortality and, therefore should remain the central health focus for USAID and other donors to the population program. Support for other aspects of primary health care should follow a Health Assessment Survey to determine priority beyond the MCH/FP interventions.

B. DONOR PARTICIPATION IN THE BDG PROGRAM:

There are three major donors to the population program of Bangladesh - The International Development Association of the World Bank (including a consortium of five bilateral donors); the UNFPA (including two bilateral donors); and USAID. There are other UN agencies, such as UNICEF, multilateral agencies, such as the Asian Development Bank and the Arab Development Fund, and bilateral donors contributing substantial amounts to the overall development of Bangladesh, which are contributing to health programs or to development projects necessary for the ultimate success of the country in reaching its ambitious population goals. (For an analysis of project aid, donor committment, and financial progress during 1981-82, prepared by the Population Control Division, see Appendix (D).

Findings, Conclusions and Recommendations:

Over the past several years, a remarkably harmonious relationship has grown up among the three major donors to the population program and between them and the government officials concerned. In the last year, fruitful meetings of these, including other members of the Bank Consortium, have been convened by the UNFPA. For the next meeting (August 23, 1982)), the UNFPA has prepared a useful analysis of Donor Assistance to MCH/FP, which is attached to this report as Appendix (E). While there are still differences of emphasis in the programs supported by donors, as indicated in the UNFPA Analysis Appendix, and differences in style, the programs and projects all fit into the overall plan of the government and are quite complementary to each other. There is now enough consultation on future plans to ensure a high degree of complementarity in the next round.

At the same time, a few problems remain which were noted in the 1980 evaluation: There are still a lot of time-consuming missions from the donors (including our own) and no move has yet been made for joint missions or joint feasibility studies. There are still a few unresolved problems in the MCH field in which further consultation with UNICEF seems indicated. The question of the overall ratio of external to domestic allocations for this program requires further attention in the next round of programming.

The analysis provided by UNFPA (see Appendix E) underscores the heavy emphasis in USAID's project on provision of contraceptives and other supplies and equipment, as

well as its contributions to the non-govermental sector. These are essential inputs at the present stage of the program; and all donors, as well as the Government of Bangladesh, appreciate this fact. In the longer run and in accordance with stated policies of the present government, ways must be found to make Bangladesh more self-reliant on the commodity side. The Asian Development Bank has before it a proposal to include a loan of $8,901,000 in its second health loan to BDG for the building up of a second pharmaceutical production unit in Rajshahi, Khulna or Chittagong.[1] As these plans are developed, USAID/Dhaka might explore with GOB and ADB the possibility of compounding oral contraceptives from imported raw materials which suit the acceptability tests for Bangladesh women. Alternatively, the possibilities for American companies to compound their brands in Bangladesh, if in accord with the new drug policy of the BDG, might be explored. In any case, some contribution from domestic resources to contraceptive procurement will have to be considered in ensuing projects, although this may have to be delayed until late in this decade.

It may be timely to bring the government into a more central role in coordination of donor inputs. A least at the time of the Annual Development Programming in the population sector, and at one other time for performance review, it would seem useful for the goverment representative to chair a meeting with all the donors to the program. Such a system existed earlier, but has fallen into disuse.

The common interest of all donors in an effective delivery system for MCH/FP requires that all donors be interested in institutional development of the system (including decentralization of authority and a greater degree of administrative flexibility at all levels). This will require careful coordination to avoid different messages to BDG from the donors.

Finally, on the payment of compensation to acceptors of particular methods of birth control, both permanent and temporary, it will be useful if all donors can agree to support wide access to all methods with the decisions to be made by the clients on the basis of informed choice. Obviously, the question of high standards of service is fundamental to such agreement.

> **RECOMMENDATION:** USAID/Dhaka should continue to cooperate fully with other donors to the BDG population program in joint planning of inputs and reviews with the government of problems arising in implementation of the program.

> **RECOMMENDATION:** USAID/W should seek to promote joint programming missions with UNFPA and the Bank as appropriate, also cooperate in feasibility studies, project design and joint evaluation missions.

Finally, the innovative step of including senior responsible officers of the BDG as members of this evaluation team is noteworthy. Our experience illustrates that such a pattern has the advantages of enhancing accuracy of findings, saving precious time of officials responsible for policy-making and implementation of the PCFP program and also increasing the likelihood of acceptance of the recommendations agreed upon by the participants.

> **RECOMMENDATION:** The inclusion of senior responsible officers of the BDG as members of the evaluation team should be considered for future joint evaluation missions.

The effect of worldwide recession on developing countries, and the problems of inflation and slow economic growth rate in Bangladesh in particular, have been compounded by the inevitable fiscal problems attendant upon the assumption of power by the new government.

To the extent that population control and family planning has retained the high priority afforded to the program by the previous government, it has been less seriously affected than other sectors by new austerity measures. Nevertheless, it shares in the general freeze on hiring new government workers and the severe restriction on travel by government workers. More specifically, budget restrictions have eliminated such projects as ZPG, training of local religious leaders, training of gram sarkars and certain I, E and C activities.

With the advent of the current fiscal year, disbursement delays have arisen, threatening the continuity of the PCFP program. At the close of the '82 FY, all remaining monies had to be surrendered, and whereas regularly allotted government worker salaries are still being paid, at the time of this evaluation no monies have been disbursed since June 30 for payment of part-time workers, dearness and travel allowance for full-time workers, sterilization compensation for either workers or clients, or for other items in the discretionary category.

Since USAID reimburses for project activities only after expenditures have first been met (in taka) by the BDG, the re-imbursement gap is now critical and if not ameliorated quickly, will seriously affect program performance. It has also contributed to a buildup in the USAID pipeline which this team considers an artifact rather than a reflection on the need for continued assistance.

> **RECOMMENDATION:** The present large pipeline balance does not necessarily reflect a diminished capacity on the part of BDG to absorb the level of assistance foreseen in 388-0050. USAID should anticipate a continued high level of assistance for the balance of the project, and a substantial increase in the project to follow based upon the projected increases in the demand for FP services, increased costs of commodities, new requirements arising out of integration of FP with MCH services, and other new program directions.

C. PROGRAM IMPLEMENTATION:

This section of the evaluation report focuses on the MHPC Program, with special emphasis on program trends over the past 24 months.

Findings, Conclusions, and Recommendations:

1. Performance

The last two years have seen an encouraging increase in family planning acceptance. (See Tables 2-4). Acceptance and distribution of all methods are up for the period 1980-1982; and, excepting oral pills, injectables and foam tablet distribution, the year 1981-1982 has seen an increase by comparison with the previous year. However, it must be noted that continuation rates for non-permanent methods are unavailable.

The substantial increase in IUD acceptance in 1981-82 compared with 1980-81 is presumably due to increased access to this method. A total of 3,227 Family Welfare Visitors (whose training includes IUD insertion techniques) are placed to date, but construction of Family Welfare Centres has lagged behind the training of FWV's, with the result that many of them are currently underutilized. While there has been a noticeable acceleration in demand for Cu-T insertion since the implementation of re-imbursement for the provider and client to compensate for economic loss incurred (travel, work loss, etc.), the increase in demand was already evident prior to the institution of the compensation scheme. The evaluation team feels that the compensation for IUD insertion appropriately complements the compensation scheme for sterilization acceptors. Offsetting the economic loss associated with acceptance of a spacing method

should help to avoid possible overemphasis on sterilization by fieldworkers and acceptors alike.

The 1981 Contraceptive Prevalence Survey also provides evidence for the fact that there has been an increase in family planning acceptance. (Table 5) This increase is most noteworthy in the acceptance of Tubectomy. However, some of the evidence from the Contraceptive Prevalence Surveys[2,3] is less reassuring. Acceptance of oral pills and vasectomy has decreased slightly. Furthermore, a substantial portion of the increase in total use rate is explained by an increase in methods with high failure rates: abstinence, safe period and withdrawal. With these observations in mind, the increase in prevalence rate from 12.6% to 18.6% is less reassuring than it originally appears.

The mix of methods targeted in the Second Five Year Plan reflect progressively increasing dependence on voluntary sterilization through 1985. (For a summary of the number and type of facilities providing sterilization services, see Table 6.) While the evaluation team recognizes, and agrees with, the importance of meeting the demonstrable demand for voluntary sterilization, it nevertheless suggests that other factors in the evolution of a fully integrated health and family planning program call for re-assessment of the desired mix of methods. In particular, with indications pointing to the beginning diffusion of family planning awareness and acceptance to younger couples and those with fewer children, reversible methods may be expected to assume a larger role among future contraceptive preferences.

The team observed both a strong dominance of sterilization over alternative methods at service delivery points and a tendency to emphasize sterilization at the expense of time and energy devoted to MCH services which could otherwise be provided by the personnel and facilities at these sites. We regard this overbalance as avoidable, and feel that greater emphasis on integration of services in general, and diversification of contraceptive alternatives in particular, is possible even given the known constraints to rural service delivery.

On a number of occasions the evaluation team was told of widespread client dissatisfaction with "Noriday" and preference for other formulations. Whether this complaint is valid or irrational is beyond the scope of this evaluation. In either case the frequency of such reports suggests a significant deterrent to oral contraceptive acceptance and warrants attention.

RECOMMENDATION: USAID and the BDG should collaborate on developing measures that will increase the relative proportion of reversible methods in the national program.

RECOMMENDATION: Compensation of costs incurred in the referrral and acceptance of IUD contraception should be continued, and Copper T insertion should be made available at all clinical service sites as quickly as possible.

RECOMMENDATION: USAID should encourage AID/W to re-open investigation of alternatives to the current AID provided oral contraceptive formulation.

RECOMMENDATION: Clinical facilities providing only sterilization should be assisted in expanding their range of contraceptive alternatives to include reversible methods.

RECOMMENDATION: USAID should assist in the training of workers for implementation of integrated MCH/FP services in utilization of entry points in the Maternal and Child Health cycle for introduction of child-spacing methods of contraception.

2. Fieldworkers

For a current summary of strength and vacancies in key positions at thana level, see Table 7. Previous evaluations, research findings and several of our discussions with representatives from the BDG and donor agencies have identified inadequate implementation as a central weakness of the program. We have read and were told that the role of the fieldworker has been particularly disappointing. It had been hoped that male and female workers would provide the vital linkage to the rural population, bringing an array of health and family planning services to their doorsteps and facilitating, where appropriate and necessary, access to the more distant service centers. Actual experience with program operations has called these notions into question. The issue here is not only one of quality - whether or not a staff of workers with limited education, training and experience is competent enough to perform a broad range of health, MCH and family planning functions. An even more basic question pertains to quantity of work performed. Does the staff actually spend time making rounds in the village? How much effort do they put into their various functions? Do they actually attempt to develop a relationship of familiarity and trust with their clients, or are their visits mechanical and perfunctory?

The previous USAID evaluation of the BDG program quotes veteran observers as stating that, "fieldworkers simply don't work." Research reports based on surveys from different parts of the country report a frequency of contact between the rural population and the worker that ranges between 40-60% of "no contact". If these reports are accurate, then there are still many eligible couples in the rural areas who are not covered by the services of the health and family planning programs.

In light of these critical previous findings and comments, the evaluation team devoted special attention to the question of the quality and quantity of work performed by the fieldstaff. We attempted to assess whether fieldworkers have indeed a presence in the rural areas and whether their role is perceived as beneficial by the rural population. It must be noted, however, that valid answers to this question are not easily obtained. To ask workers directly how many hours they spend performing their duties is an exercise in futility. In an economic context where a job is a lifeline to security and possibly survival, it is only to be expected that people would try hard to portray themselves in a favorable light and insist that they are diligent and hard working. Even supervisors are likely to be protective of their subordinates in this respect. Since the quality and quantity of the work of the fieldworker is, at least in part, a reflection of the quality and quantity of supervision, we can expect that supervisors will also be inclined to say the work is proceeding according to plans. We, therefore, spent some time during field trips in villages, unaccompanied by program staff, asking villagers in some detail about their contact with health and family planning workers.

Based on these field observations, we conclude that, while many problems remain, fieldworkers do have a presence in the village, that there is considerable variance in their work efforts, but that even under the best of circumstances the role of the fieldworker has been narrowly focused. A broad-based primary health care approach remains a distant goal, maternal and child health functions, other than family planning, are largely neglected and, even with family planning, emphasis has been on one particular method: sterilization. While the team observed a reassuring strict observance of voluntarism and compliance with fully informed consent procedures, it nevertheless feels that the dominance of sterilization in the mix of methods is not in the best interests of the program.

1. The team concludes that the narrow focus on sterilization is unfortunate. Sterilization is an important method of family planning and, as such, also a contributing factor to maternal health. However, an overly heavy emphasis on one method violates

the philosophy of the acknowledged cafeteria approach, fails to contribute to spacing and, unless the mean age of sterilization acceptors is low, is limited in its demographic impact. This excessive emphasis will not produce the desired broad-based acceptance of family planning, may lead to sterilization regret and is unwise from a political perspective.

2. The evident focus on new acceptors and lack of emphasis on continuity of contraceptive use must be changed.

3. The focus on family planning to the almost total exclusion of maternal and child care services is also deplorable. The failure to provide a broader range of MCH services does not bode well for the recently announced policy of integration of MCH/Family Planning with other preventive health serivces. We are not trying to imply here that workers can or should be expected to provide the full range of MCH services. We merely wish to emphasize that if workers develop a caring, empathetic attitude toward the well-being of the families they deal with, if they acquire some skill in dealing with minor ailments and are given some medicines for this purpose, and if they begin to act as a referral source for more serious cases, much would be accomplished. Such an approach would mean substantial assistance to the well-being of their clients and would produce important pay-offs for family planning acceptance as well.

4. The low work input of the fieldstaff is a further reason for concern. Research has shown that there is a direct relationship between the frequency of contact between villagers and program staff, on the one hand, and acceptance, on the other. While the quality of the interactions is also critical, one cannot even begin to talk meaningfully about this issue as long as the quantity of work performed remains very low.

5. Our field interviews indicated that, while most villagers appear to know about family planning, the willingness to limit the size of their family is - while perhaps increasing - still not particularly widespread. A major educational task remains to be done. While a family planning program alone cannot bring about the desired change, high quality and accessible family planning services create their own demand. Given this demand-creating aspect of a good family planning program, continued attention to the quality and scope of medical services and family planning domiciliary work remains critical.

6. The narrow focus on sterilization and the limited work inputs of the staff is, at least in part, a function of a narrowly focused set of rewards and sanctions for fieldworkers. The family planning program exercises rewards and sanctions primarily in connection with the recruitment of sterilization cases. Workers receive a small, though significant, referral fee for each sterilization case and are liable to have certain benefits withdrawn if they do not fulfill their targets. While the government has recently introduced a small referral fee for IUDs also, this redresses the imbalance to some extent, but does not address workers' performance in regard to their other duties. We believe that immediate attention should be given to the establishment of a system of rewards that focuses on a broader range of performance criteria than the recruitment of family planning cases. There is currently no recognition for outstanding work apart from the recruitment of certain categories of acceptors. The focus of outreach services might dramatically switch to currently neglected functions, if it came to be understood that such an emphasis receives recognition and support. We recognize that a system of performance-based rewards cannot be easily introduced into a bureaucracy which tends to reward seniority of service.

3. Supervision

We concur with the frequently expressed view that there is an urgent need to strengthen the supervisory system in the program. While there are examples of excellent supervision to be found, the supervisory system is on the whole rather weak. Moreover, the dominant mode of supervision emphasizes mechanical inspection rather than guidance, support, counselling and problem solving. This point has been well documented in an AID supported research study on supervision by Ahmed and Muhuri.

The bureaucratic environment within which this supervisory system exists does not provide any rewards for those who show serious concern for the quality of the work of their subordinates, who facilitate the work of their fieldworkers and exhort them toward greater productivity. The management training capability in the country is also weak.

> **RECOMMENDATION:** USAID, in collaboration with other donors, should assist the BDG in its institution building process through increased emphasis on the establishment of performance-based reward systems for fieldworkers and supervisors in the program and through the development of a greater management training capability in the training and research institutions throughout the country.

4. Organizational Structure

Since the last major USAID evaluation, the BDG Family Planning Program has been reorganized at the thana level to attain a greater degree of integration between health and family planning.[9] In this section of the report, we outline the changes that have occurred and highlight problem areas which still remain.

Family Planning in Bangladesh has been characterized by recurrent reorganizations with a frequently shifting emphasis between vertical and integrated programs. Between 1960 and 1965, the Family Planning Program was administered as a normal function of the existing health services. Over the the next five years, it was organized under a separate, autonomous structure, the National Family Planning Board.[1] In 1972 following independence, family planning was once again integrated with health. As was pointed out by the previous A.I.D. evaluation team, this attempt at integration was afflicted by problems from the beginning.

> "Integration" was planned to occur at the fieldworker level only. Above, separate chains of command and separate sources of salaries remained intact at every level. Carried over from the East Pakistan period, the National Family Planning Board, which had bitterly opposed integration, never became fully reconciled to the decision and was less than wholeheartedly trying to make it work. Equally important, the FWW training had been inadequate - a serious matter, since birth control pills were being introduced into the program for the first time outside the clinical setting.

Vertical Family Planning Program 1975-1981

In 1975, the government decided to return to a vertical structure and divided the MOHPC into a Health Division and a Population and Family Planning Division. MCH was transferred from Health to Family Planning, and a new cadre of family planning workers recruited - Family Welfare Assistants (female) and Family Planning Assistants (male) with an intended ratio of three female and one male worker per union. FWWs were allowed to revert back to their original health activities.

Under this vertical pattern, preventive and curative services and the Family Planning Program had separate organizational identities from the field level to the Ministry. The Health Division was reponsible for preventive and curative services. Family Welfare Workers (FWWs) and Governmental Health Assistants (GHAs) worked in malaria and other preventive health programs under the administrative control of assistant health inspectors at the Union level and health inspectors and the Thana Health Administrator, a physician, at the thana level. Each of the workers was responsible for a range of public health functions, including blood slide collection, distribution of vitamin A Pills, reporting of epidemics and an annual survey of households. Their work area was based on "JLs" (Jurisdiction Lists established for revenue purposes) of which there are approximately 8 per Union. Curative services were provided by the three medical officers at the Thana Health Complex under the technical and administrative supervision of the Thana Health Administrator.

Family Planning and Maternal and Child Health are the responsibility of the Population Control Division. Family Welfare Assistants (3 per Union, each assisted by a part-time dai) and Family Planning Assistants (one per Union) were expected to perform family planning education and information, acceptor recruitment, supply of contraceptives, referral to clinical contraceptive services, follow-up, as well as reporting and record-keeping functions. This fieldstaff functioned under the administrative supervision of the Thana Family Planning Officer. Medical family planning services were performed by the Family Welfare Visitor at the Family Welfare Centre (union level) and by the Thana Medical Officer for MCH and Family Planning, who also provided technical supervision to the FWV. (Fig. 1)

This administrative and role separation between Family Planning and MCH, on the one hand, and other preventive and curative services, on the other, was continued at higher administrative levels. In Family Planning, the chain of command moved upward from the TFPO to the Subdivisional Family Planning Officer, the Deputy Director of Family Planning, Divisional Director of Family Planning to the PCFP Divisional National Headquarters. In health, the Thana Health Administrator reported to the Civil Surgeon, who in turn was linked through the Deputy Director of Health at the Divisional level to the Director General, Health, in Dhaka.

Here we would like to point to an interesting distinction in the organization of the Health Division and Population Control Division at the national level. While the Health Division follows the traditional pattern of differentiating between the secretariat, or policy wing and the directorate, or implementation arm, these two wings were merged in the PCFP Division in June, 1979. (See Figure 2) The purpose of this rather unusual merger was to maximize the utilization of scarce manpower, to avoid duplication of work in administration, accounts and common services and, also, to improve efficiency of the action programs. The Secretariat posts retained the Secretariat designations and functions; directorate posts continued to hold their respective designations and functions. It was intended that, where necessary, the Directorate officers would be assigned to discharge Secretariat duties, but this was not implemented. One of the outcomes of the merger has been to introduce an unclear chain of command and a lack of coordination at the highest level of the implementation wing. These problems need to be resolved.

Integration of Health and Family Planning at the Thana and Below:

In January, 1980, the government announced a further reorganization merging health and family planning delivery systems at the thana and Union levels for both outreach and static services. Above the thana level, the Health and the Population Control Divisions would continue to function as separate organizational entities within the Ministry of Health and Population Control. The reasons for this integration of all curative and preventive programs at the thana level were stated in terms of a need:

1) to provide an integrated package of health and family planning services to the client population;
2) to improve coordination and supervision between health and family planning personnel and to establish a unified command at the thana level;
3) to provide advancement prospects for fieldstaff and field supervisors;
4) to avoid duplication of physical facilities;
5) to involve medical doctors at the thana level more directly in family planning; and
6) reduce the work area of the field staff.

After lengthy discussions of the integration proposal by a specially constituted interministerial committee, final proposals were prepared by the Population Control Division and approved by the President in September, 1981. (Figure 3) The delay in approving the integration scheme resulted from the complicated personnel changes implied in the merger of health and family planning staff. Approval included acceptance of the following conditions:

1. Redesignation of posts to incorporate Health and Family Planning in the nomenclature.

2. Reassignment of areas of work among Health and Family Planning Workers.

3. Formation of BCS sub-cadre for the personnel of Population Control Division (DG to TFPO).

4. Filling up of 50% posts of Medical Colleges, Hospitals and Health Institutions of equivalent rank by TFPOs.

5. Allowing higher pay-scale (TK. 370/ - 745/ -) to Health Inspectors and filling up of 13% vacant posts of TFPO by Health Inspectors.

6. Selection Grade to FWAs on completion of 10 years of service and reservation of quota for them in the training programme of FWV, MA, Nurses.

7. Creation of posts of HI, AHI, and Field Workers.

8. Selection Grade (TK 325-610/-) to 2250 FPAs and their absorption as AHI whose pay-scale is Tk. 325-610/-.

9. Fixed TA/DA to H & FP fieldworkers.

10. THA to accord administrative and financial sanction and TFPO to act as Drawing and Disbursing Officer.

11. Administrative control and ACR of HI and AHI by TFPO.

12. Special report (to be annexed with ACR) about TFPO and MO (H & FP) by THA.

13. Certificate of satisfactory performance form.

14. Other recommendations approved by the Interministerial Review Committee regarding office accomodation of TFPO at THC, of HI/AHI at TTDC, training of field workers, formation of Joint Task Force, etc.

15. Joint Task Force to review progress, issues and problems and make recommendations for consideration by the Interministerial Review Committee.

We have quoted these conditions in full to give an indication of the complexity of the personnel decisions that were part of the integration scheme. While these conditions seem to provide improvements in the conditions of employment of many categories of workers, they did not resolve many of the issues involved in the merger of Health and Family Planning at the thana level. The difficulties which arose after the announcement are, however, more than just the consequence of unresolved personnel matters. The integration decision brought to a head a fundamental conflict between two different departments, each with its own officers and staff, budget, loyalties and professional commitment. Family Planning workers have interpreted the integration decision as a loss of control and as an attempt by physicians to monopolize all aspects of preventive and curative care within the Ministry of Health and Population Control. Staff from the Health side, on the other hand, have viewed with resentment the opportunities for promotion which they felt were more readily available for Family Planning staff. The Bangladesh Medical Association and the Thana Family Planning Officers' Association have taken opposite stands on the issue; and immediately following the integration decision, Family Planning fieldworkers went on strike for one month and a half. Frustration of the Family Planning workers was also related to the fact that the establishment of a Family Planning cadre has not been implemented. A Joint Task Force on Integration of Health and Family Planning at the thana level continues to review the progress in implementing the integration decision.

Organization of the Integrated Thana Health and Family Planning Programs:

Under the integration scheme multipurpose outreach workers will provide a range of health and family planning services to the population in their work areas. This multi-purpose worker carries the new designation of Health and Family Planning Worker, which is to apply uniformly to FWAs, GHAs, FWWs, FPAs. These workers are supposed to function as part of a team consisting of a teamleader, a Dai, and one Health and Family Planning worker.

Each of these teams is to be supervised by an Assistant Health and Family Planning Inspector (50% of whom are promoted FPAs), the Health and Family Planning Inspector, and the Thana Family Planning Officer, who in turn is reponsible to the THA. Clinical services are provided by 4 MOs, one of whom is in charge of supervising the FWV. (See Fig. 4)

Implementation of Integration:

A reorganization involving basic restructuring of work roles, reclassification of positions, as well as changes in authority relationships cannot be implemented in a short period of time.

Fieldworker Training:

Fieldworkers have received their first round of crash training designed to familiarize them with the integrated approach and their new role requirements. Training is currently in its second phase during which fieldworkers are acquainted with the broad range of health and family planning messages for which they will be responsible. The team observed during field visits that trainees were eager to acquire new skills. This was especially true of some of the Family Welfare Assistants who see a definite need to expand their skills to new areas. However, the training requirements implied in the creation of multi-purpose health workers are immense. It is unlikely that a fieldstaff which has not been very effective in performing a narrow set of functions will, after training courses of no more than a few days, have acquired the knowledge, skill and motivation that would transform them into successful multi-purpose workers.

Establishment of Teams:

During field visits the evaluation team also observed that in many thanas teams have been formally constituted. We were not in a position to assess whether and with what effectiveness these teams have actually begun to function in the field. In general, it was our impression, however, that the team concept and the array of 'integrated' designations are still relatively novel to thana level supervisors and staff. This suggests that fieldworkers would also still be rather unfamiliar with their new working patterns.

Continued Structural Impediments to Integration:

A number of structural contradictions and administrative problems remain unresolved. As currently constituted the organization of the Ministry of Health and Population Control is characterized by structural differentiation between Health and Family Planning at the national, divisional, district and subdivisional level, and functional integration at the thana level and below. (Fig. 4) That there should be confusion and uncertainty as to how the separate chains of authority are to be joined at the thana level is not surprising. Given that the Thana Health Administrator, whose parent department is Health, is the Chief Administrator at the thana, the Population Control and Family Planning Divison has, formally speaking, lost its direct line of control to the TFPO and the fieldstaff. While, in practice, such loss of control may not have occurred, the contradictions between organizational differentiation at the higher and functional integration at the lower level are bound to produce continued frustration and conflict. A particularly vivid example of these contradictions can be seen in the training program for integration which is currently organized by NIPORT. There has been continued difficulty in getting Thana Health Administrators to attend this training. The PCFP Division must depend on the Health Division to call the THA for training; such cooperation has not occurred.

Unresolved Conditions of Service:

Many of the issues pertaining to the conditions of service of Family Planning staff and officers remain to be settled. Some of the original conditions of integration, especially those pertaining to the encadrement of Family Planning officers, have not been implemented. However, an important step in the direction of providing security of service for Family Planning workers has been the decision of the BDG to declare the Population Control Division as a permanent organization. (March 13, 1982)

Separate Budgets for Health and Family Planning:

It should also be realized that in spite of the integration at the thana level, Health and Family Planning budgets will remain quite separate. Thus, there will still be a difference between 'health' and 'family planning' workers, even at the thana level, in that some workers of the same designation will be paid from the Family Planning budget and others from the Health budget. While the original intention was to have the THFPO as the Drawing and Disbursing Officer for all fieldstaff, it was our observation that, in practice, the THFPO tends to pay staff on the Family Planning budget and the THA the staff on the Health budget. Similarly, Thana Medical Officers have all received the added designation 'health and family planning' and should participate in the delivery of medical family planning services. However, one of these doctors is on deputation to Family Planning and, in that capacity, in charge of the supervision of the FWV.

Summary of Integration Issues:

This brief history and analysis should indicate that the integration of Health and Family Planning Programs at the thana level is a very substantial organizational undertaking. It involves much more than just the training of workers and the establishment of new work teams. Rather, integration is a process of institutional restructuring which touches upon basic interests, loyalties and professional commitments of the two departments involved. It is not yet complete and will, in all likelihood, continue to absorb the energies of officials at all levels for some time to come. USAID has taken a neutral position on the question of integration, but argued that continued changes in direction are likely to be dysfunctional for program productivity. The evaluation team shares the view that continuity in organizational structure is highly desirable, but recognizes at the same time that additional changes may be necessary in order to resolve outstanding problems ensuing from the decision to integrate Health and Family Planning at the thana level.

While foreign donors cannot assist in the resolution of these internal problems, the team recommends that AID provide creative assistance in the area of fieldworker training. It would seem important to explore what aspects of training toward multipurpose health work might receive priority. Since it is quite unrealistic to expect that trainees can learn 27 messages in two weeks and acquire the skills to implement them, it would seem appropriate to emphasize in any followup training a more limited and basic set of health messages and skills. Moreover, since the task of affecting the health care behavior of villagers is an exceedingly difficult one, it is essential that the training be appropriate and relevant to rural conditions. We believe that this is an area where innovative approaches should have major pay-offs.

More generally, we conclude that integration has imposed an additional burden on an already overloaded, and over-extended bureaucracy. Integration has added new and very extensive requirements for training and created the very serious administrative problems that are implied in the merger of the two departments at the thana level. In other words to already complicated and extensive tasks, further work has been added which is to be implemented by an organization that is characterized by a weak administrative capability. This is disturbing. We strongly believe that given the broad range of tasks facing the MOHPC priorities be set to assure that essential tasks are not neglected.

RECOMMENDATION: The team is pleased to note the increase in family planning acceptance which is apparent from the MIS statistics and the 1981 Prevalence Survey. The team is furthermore impressed with the continuing political support to the population question at the national level. However, fundamental weaknesses

in the delivery system remain and there is an urgent need to build up the program at all levels and strengthen its administrative capability. Frequent organizational changes have impeded program implementation. Given the high priority of the population program, we recommend that outstanding organizational issues be addressed with speed and that continuity in direction and management be assured in the future.

RECOMMENDATION: Problems related to the integration of health and FP/MCH at the thana level and below require immediate attention. USAID should urge the BDG to address these on a priority basis at the national level. These include:

a. resolution of administrative, structural and financial problems between the Health and F.P. Divisions which inhibit full realization of integration.
b. establishment of new systems of rewarding performance;
c. provision of equipment and supplies for the integrated services;
d. we strongly recommend that, given the broad range of tasks facing the MOHPC, priorities be set to assure that essential tasks are not neglected.

Physical Facilities and Staffing

Shortages in physical facilities and staffing vacancies are two major problem areas. Thana Health Complexes and Family Welfare Centres are the main facilities where clinical family planning services are provided. At present, 312 out of 470 thanas have Thana Health Complexes. By 1985, 53 additional THCs are scheduled for completion. Out of 4,352 Unions, 357 have Family Welfare Centres; 343 additional ones are to be completed by June, 1983. There have been delays in attaining construction goals in the past; this pattern is likely to continue, although the World Bank representative (The Bank is the major donor to this aspect of the program) and the Directors of Program Implementation agreed that the pace of construction is stepping up significantly. (See Table 5 for the numbers and types of facilities providing sterilization services.)

Since 1979, a hiring freeze has been in effect throughout the BDG. The Family Planning Program has suffered considerably from its inability to fill vacancies at all levels. In the Fieldstaff category there are critical vacancies for Dais, Family Welfare Assistants and Family Planning Assistants. (Table 6) No real shortages exist in the Family Welfare Visitor category. In fact, since the training of FWVs has proceeded faster than the completion of FWCs, there is currently an oversupply of FWVs. The shortages in Fieldstaff, especially for Dais and FWAs are critical. Given that the BDG Family Planning Program is essentially a woman's program, these workers are the cornerstone of the outreach strategy. While the mere filling of vacancies is no guarantee that good outreach work will be done, these staff shortages are an important problem for the program. Critical vacancies also exist among TFPOs and Medical Officers on deputation to the Family Planning Program.

RECOMMENDATION: In view of the priority status of the PCFP Program and of the numerous vacancies among field workers, officers and in the staffs of the training institutes which clearly inhibit program performance, USAID should urge the BDG to waive the hiring freeze and allow existing vacancies in the program to be filled.

RECOMMENDATION: We recommend that USAID in collaboration with other donors urge the BDG to facilitate completion of construction of the physical infrastructure.

Supply Management

No Family Planning Services program is possible without supplies and equipment. If they are not well-managed, the program suffers, people are deprived of reliable services, and the benefits from enormous investments of resources are diminished. Therefore, program managers at every level must give supply management a high priority among their many concerns as a necessary condition for an effective, efficient program.

USAID is a major supplier of commodities to the Bangladesh Family Planning Program. The USAID Project Administrators have an obligation to ensure that maximum benefit is realized from this investment of public funds. This is basic to good management. It is also a statutory requirement. It is the team's judgment that USAID should supply a full-time supply and logistics consultant to help satisfy its accountability requirements. For a detailed evaluation of the supply management system, with recommendations for this important aspect of the program, see Section IV. A. of this report.

D. INSTITUTIONAL DEVELOPMENT NEEDS - A SYSTEMS VIEW:

That acceptance of family planning is increasing in Bangladesh is apparent, not only from MIS statistics and the Contraceptive Prevalence Survey. There is a widespread impression among those who visit the field that social acceptance of family planning has incresed considerably. Fieldstaff and other observers have referred to a change in attitude and an increased openness in discussing the subject of family planning in the village. No-one we met has expressed doubts that there still is unmet demand; in fact, the general consensus seems to be that it is realistic to expect that prevalence will increase to 30 - 35% through "family planning" alone.

The team shares the view that prevalence can be increased with the help of a vigorous family planning program. However, if the fundamental weaknesses of the BDG delivery system continue, the expected prevalence rates will not be reached in the next few years. USAID, in its assistance strategy has - at least implicitly - taken the approach that with sufficient inputs (commodities, compensation payments) the program should be able to reach its goals, or at least, that assistance directed at institution building is largely the business of other donors. This position should be reconsidered.

While inputs are obviously essential, the institutional processes by which resources are utilized are equally, if not more, important. The BDG program still does not have the administrative capability to make the best use of the human and physical resources at its disposal. We have listed a sizeable number of problems that have been encountered in the program. Each of these problem areas is important in and of itself, but what is more important still is that they are inter-related, i.e. systemic in nature. They reflect the institutional weaknesses of the Health and Family Planning Departments, which, in turn, are constrained by the larger bureaucratic context within which they exist. While some of these larger bureaucratic constraints are intractable, there is scope for institution building and the development of an increased managerial capability.

> **RECOMMENDATION:** We recommend that USAID direct a greater portion of its assistance toward improvement in managerial capability. A number of the specific recommendations which we have made in other sections of this report - establishment of reward systems, decentralization, improvements in management training capabilities, community participation - would contribute toward such institution-building efforts.

IV. USAID PROJECT 388:0050:

A. COMMODITIES:

USAID's projected commodity contributions in the first two years (FY 1981 and 1982) of the Family Planning Services Project (No. 388-0050) total over $14 million, comprised of the following:

Oral pills and condoms (centrally procured)	$ 9,699,000
Other contraceptives	$ 2,658,000
Clinical supplies and equipment	$ 1,150,000
Locally procured commodites (sarees, lungis)	$ 1,148,000
	$14,655,000

The System:

In 1976, the PCFPD adopted a system of contraceptive supply accountability and reporting, developed with the help of an AID-supplied consultant. District and Thana Family Planning Officers and storekeepers were trained in the Supply Manual procedures. Over the next several years, with the concerted efforts of the PCFPD administrators and supply personnel, a resident UNFPA logistics advisor, USAID staff and periodic consultant services, a flow of reasonably accurate commodity data was available to program managers on a monthly basis.

The Supply Manual prescribes a straightforward, logical system. Simply stated, if involves adding, subtracting, counting, recording and reporting. It records receipt of contraceptives through Chittagong port, their movement through the Dhaka Central Warehouse and regional warehouses to District and thana-level stores, and from there to field workers and clinics.

The reporting chain begins with the field and clinic workers' monthly reports to the thanas of contraceptive receipts, distribution, and end-of-month balances. Aggregated at the thana, these data are forwarded to the district, together with the thana store's receipts, issuances, and remaining balances. The same information for the district stores, with the figures from each thana, are sent to national level by the district officers. In this way, program administrators receive current information on the kinds, amounts, and location of contraceptives at every level.

The system helps to pinpoint implementation problems; it gives early warning of supply shortages and overstocking, and it provides a reliable data base for projecting future requirements and initiating procurement actions. However, it fills these functions only if every worker, every clinic, and every thana and district administrator reports accurately, completely and promptly, and only if all the concerned level officers receive the reports and know how to analyze and use them.

Findings, Conclusions and Recommendations:

1. One result of the disruption which followed the reversion to integrated health and MCH/FP services two years ago was widespread and protracted neglect of supply reporting. Reportedly, it is only in the several months preceding this evaluation that improvements are noted in reporting of contraceptive distribution and stock balances. This is attributed, in part, to recent key personnel changes and the resulting evidence of top-level interest in the supply system. In addition, a USAID Foreign Service National employee has worked intensively with district and thana officers to elicit reports and to improve their quality. While this helps to fill the adminstrative data vacuum, USAID recognizes that it is a stop-gap measure. The ultimate responsibility for making the system work remains with the PCFPD.

RECOMMENDATION: USAID should encourage the PCFPD to use any means available to make it clear to each person in the supply chain that supply management is of central, not peripheral, importance.

2. Many of the persons who received training when the supply manual was introduced have been transferred to other duties or have left the program. Most of their replacements have not been trained in the operation of the system.

RECOMMENDATION: USAID should assist the PCFPD to develop the capability to routinely train newly posted personnel at the start of their assignments. This training should include the rationale, procedures and importance of the system and development of skills in recording, reporting, resupplying and storing.

RECOMMENDATION: USAID should urge NIPORT to include adequate supply system training in the syllabi for initial and refresher training of administrative, clinic and field staff.

3. Storekeeper duties at thana level are assigned to one of several Thana Family Planning Assistants (TFPAs). TFPAs are subject to routine rotation to other positions, in accordance with BDG personnel policies. It is common for TFPA's with storekeeping experience to be assigned other duties on rotation and for their replacements to be inexperienced in storekeeping. Reportedly, persons designated, "Storekeeper" are not subject to regular transfers.

RECOMMENDATION: USAID should urge PCFPD to seek approval to redesignate one of the TFPA positions as "Storekeeper".

4. Large quantities of supplies of increasing numbers of items pass through the district stores. One storekeeper and one loader are the only sanctioned positions to handle this heavy workload. Furthermore, the storekeeper cannot entrust the key to the stores to anyone else when he is absent from duty; no one has access to the stores until he returns.

RECOMMENDATION: USAID should propose to the PCFPD that they consider establishing the additional post of Assistant District Storekeeper in each district.

5. The supply system was originally designed to manage the commodities in the program at that time: two kinds of oral pills, condoms, three sizes of IUDs, and foam. Now the program needs to procure, use, control and account for a greatly expanded list of commodities: many items of MCH- and sterilization-related supplies, nonexpendable equipment, administrative forms and office supplies, and publications for which there is a recurrent need. The team was told that receipt and issuance of these items are being recorded in a pre-independence ledger system. But reports of supply locations and stock balances are not required or received in Dhaka. This situation has several serious consequences:

a. Maldistribution among the districts cannot be detected in time to avoid interruption of services locally.
b. The Procurement Officer cannot anticipate impending stock-outs. From time to time this leads to the necessity of costly airlifts of imported items.
c. A great deal of control is lost. Since many of the items concerned have resale value, it is important that program managers gain greater control, not only to ensure that resources are applied properly towards achievement of program objectives, but also to merit the confidence of the people served by the program, other BDG agencies, and the donors.

RECOMMENDATION: USAID should assist the PCFPD to revise the Supply Manual to incorporate the full range of MCH/FP supplies and equipment into the supply management system.

6. There is a shortage of adequate storage facilities. The Central Warehouse in Dhaka, constructed with UNFPA assistance, is excellent. The warehouse at the port of entry, Chittagong, is rented and reportedly will have to be given up. A proposal to build a regional warehouse in Chittagong, to have been funded by UNFPA, has been turned down by the Executive Committee of the National Economic Council. Plans to construct the remaining two regional warehouses in Khulna and Bogra have been approved, but funding has not been located. District stores, mostly rented buildings, vary greatly in their capacity and quality. The long-standing dearth of storage capacity at thana level will have been solved if and when there is general compliance with the ministry order that the thana MCH/FP office, including stores, should be accomodated in the Thana Health Complex. To-date, compliance has been uneven.

RECOMMENDATION: USAID and the other major donor agenies should meet with PCFPD to plan a permanent solution for adequate regional storage facilities.

RECOMMENDATION: USAID should encourage PCFPD to budget adequate funds to hire suitable buildings at district headquarters where government owned buildings are not available, and to request notification of compliance from the Thana Health Administrators and Thana Health and Family Planning Officers to the order that the MCH/FP office should be moved into the THC.

7. PCFPD's commodity transport capability consists of ten trucks contributed by UNFPA in 1980-81 and five trucks and three pickups imported by UNFPA in 1975-76. It is difficult and costly to keep the older vehicles in running order.

The vehicle repair and maintenance facility, established under UNFPA's Transport and Equipment Maintenances Organization (TEMO) project, was planned during the initial integrated program period to service both Health and Family Planinng vehicles. Since the abandonment of the integration attempt in 1975 it is considered to belong to the Health Division. Although there is reported to be an agreement between the two divisions at Ministry level that TEMO will repair PCFPD vehicles on a reimbursable basis, in practice, TEMO personnel give preference to servicing the large Health fleet. We believe this situation will prevail until such time as the personnel concerned no longer identify with one or the other of the two existing divisions.

There is no PCFPD or donor plan to replace the PCFPD vehicles. Planning should begin now for a long-term solution to the problem of transporting contraceptives and MCH and surgical supplies and equipment.

RECOMMENDATION: USAID should assist the PCFPD in assessing the relative merits of long-range options for adequate transport capability. These might include:

a) contracting with a commercial trucking firm (or the Social Marketing Project) for distribution to the districts and the accessible thanas;
b) retaining a PCFPD fleet, including periodic replacement of vehicles;
c) using the Health Division transport system. (Information available to the team is that the Health Supply System - storage, distribution, accounting, reporting - is weak and that the MCH/FP program would be handicapped if its supplies were incorporated into the medical stores system. There was no opportunity, however, to enquire into Health's transport capability.)

8. The program is handicapped by uneven performance of the procurement function. There are several contributing factors:

a) Unreliable, incomplete information on in-country stock levels and offtake rates;

b) Widely varying lead-time requirements among donors and among commodity items;

c) Unpredictable time requirements for the interval approval procedures in the several BDG agencies involved, in the case of commodity requests to donors; and

d) turnover of procurement personnel and lack of a qualifications requirement for posting of a procurement position.

RECOMMENDATION: USAID and the other donors should prepare a flow chart display giving detailed information for the scheduling of each step of the procurement process for each commodity and each donor. PCFPD may add similar information for the steps involved in local procurement. USAID should reinforce this information with timely reminders to the key persons involved in the processes of requirements development and proposal submission.

9. **Overall Conclusion:**

The problems cited are difficult and complex, but they are shortcomings which can be corrected if they are accorded high enough priority. With intensive, sustained work, it should be possible to develop a supply and logistics system which serves the program well and of which PCFPD administrators can be proud. The team was informed that the services of the UNFPA-supplied Supply and Logistics Advisor will come to an end in mid-1983. With USAID's large annual investment in program commodities go statutory and regulatory accountability and management requirements. It is incumbent upon USAID to participate directly with the BDG in making the needed improvement possible.

RECOMMENDATION: USAID should provide a resident supply and logistics specialist for a minimum of two years to assist the PCFPD to gain control of this essential part of its services program. The full-time presence of such a person will help to ensure a sustained focus on this effort.

B. LOCAL COSTS OF VOLUNTARY STERILIZATION PROGRAM

1. The Surveillance Program.

The Second Five Year Plan called for improvement in the quality of voluntary sterilization services and institution of competent technical supervision and surveillance. The importance of this provision was highlighted by the recognition of apparent high mortality associated with voluntary sterilization cases, including two identified clusters of deaths in 1979 and early 1980. The ensuing evaluations of this problem, and actions arising out of these studies are detailed in the 1980 USAID evaluation report. They are reflected in the FPSP project paper in "Conditions Precedent to Disbursement", which include (a) a comprehensive plan for a voluntary sterilization surveillance system, and (b) completion of a standardized informed consent form by all acceptors of VS financed in whole or in part by AID funds. Further assurances of voluntarism in the sterilization program were incorporated into specific covenants embodied in the Project Authorization dealing with payment of costs incurred by acceptors and costs of medical and support services paid to medical and field workers. These were promulgated after careful review of AID guidelines specified in PD-70.

Findings, Conclusions and Recommendations:

Concern for voluntarism and strict compliance with the terms set forth in the Project Paper are fully shared by the Bangladesh officials and medical personnel encountered in this evaluation. Consent forms have been printed and distributed to the service centers, a revised protocol for analgesia and local anesthesia has been adopted, and training of physicians in the anesthesia protocol and management of emergencies has begun. A comprehensive manual for sterilization operations has been printed and distributed. The retraining of doctors in the ten government centers, the BAVS, Mohammedpur, and Chittagong Medical Center is in progress. While this evaluation obviously cannot be construed as tantamount to a surveillance exercise, it was nevertheless observed in our field visits to a number of service points where sterilizations were being performed that consent forms were being properly completed, the new anesthesia protocol observed, emergency drugs and equipment on hand, and clients appropriately monitored. While some reports of individual physician resistance to the new protocol persist, most of those questioned by the evaluation team expressed a preference for the new regimen, and a sampling of medical opinion, both in government and NGO centers, indicates a growing consensus in its favor as more doctors are trained in the proper management of the less heavily sedated patient.

Comments on trends in mortality related to sterilization must be regarded as tentative pending full implementation of the formal surveillance program. Nevertheless, all indications are that mortality has been substantially reduced since the earlier reports of unacceptably high death rates. A study by A. P. Satterthwaite, Dr. Shafiqur Rahman and Dr. Mahmuda Begum[16] reported 23 deaths in 185,583 operations performed from 1 July, 1980 to 15 April 1981 - a mortality rate of 12.4 per 100,000 cases (all 23 deaths were in Tubectomy cases, with no deaths reported among 17,320 cases of vasectomy in that period). For the period from January 1 to June 30, 1982, although the surveillance system is as yet admittedly incomplete, the best available information gleaned from field reports indicates a total of 8 known VS related fatalities out of 204,370 VS performed, according to the WHO surveillance office, and a probable 9 cases known to the USAID medical advisor. While investigation of these on a case by case basis awaits complete implementation of the surveillance team, at least one of these cases is believed to be related to anesthesia (with the "old" anesthesia protocol employed).

USAID assumed funding for local costs of VS following cessation of UNFPA funding in the spring of 1981. Full payment was made for costs incurred from 15 April 1981 through 14 January 1982 on the basis of a Mission decision that the surveillance plan met the requirements of the conditions precedent. From 15 January 1982 through 14 April 1982, reimbursement was reduced to 87% to adjust for incomplete distribution of consent forms. Following satisfactory compliance with this requirement (with the aid of the Social Marketing Project) reimbursement was again restored to 100% from 15 January 1982 through 14 April 1982. Since that time no further reimbursements have been made, and USAID has notified the BDG that reimbursement will be restored only when the complete surveillance team is posted and fully operational.

The BDG, with assistance from SIDA (Sweden) and WHO, has now approved the appointment of four expatriate physicians from a list of six nominated by WHO. One, Dr. Kierski (an OB/GYN specialist from Poland) is already in Dhaka. The others are currently awaiting WHO clearance before proceeding to Dhaka for posting. Likewise, the four Bangladeshi local consultants have been selected from 29 applicants, and their names have been referred to the Secretary, Population Control Divison, for approval and issuance of appointment letters.

While these actions represent encouraging progress toward implementation of the Sterilization Surveillance Project, certain obstacles still have to be overcome before reimbursement of local costs for VS by USAID can be reinstated.

The full implementation of the designation of the Assistant Director of MCH/FP in each district as the person responsible for the surveillance reporting system is not likely to occur until the full surveillance team is operational. Likewise, certain logistic problems, including provision for necessary travel by the surveillance team, are still unresolved. It is essential that these requirements be met in order that the reimbursement process may be reinstated, since the interim funds for local costs advanced by the Director General of Implementation will soon be exhausted.

RECOMMENDATION: The Evaluation Team recommends that sustained emphasis be placed on the quality of Voluntary Sterilization services. In order to forestall loss of momentum fo the voluntary sterilization program, USAID should make every effort to assist the BDG in meeting the conditions precedent and reinstate payment of local costs as soon as the conditions are satisfactorily fulfilled.

2. Physician Training for V.S.

Despite the publication of an excellent Manual for Sterilization Procedures in May, 1981[8], given the rate of turnover of physicians in government service, it is expected that training/retraining in VS will be a continuing program requirement. Doctors assigned as family planning medical officers at thana level for a period of three years often get assigned to other duties early. This rapid turnover has training implications because the available replacement doctors, usually new graduates, often have not had enough training in sterilization techniques, in the use of the recommended anesthesia regimen, or in the management of emergencies and the use of life-saving equipment.

Findings, Conclusions and Recommendations:

Physician training has been severely hampered by lack of funds, since the BDG has no provision for meeting transport costs of physicians to and from the designated training sites and their living expenses during the training exercise. Attempts by the DG of Implementation to meet this problem, either within the government or in discussions with donor agencies (FPIA, IPAVS) have to-date been unsuccessful.

In view of the high demand for VS and its dominant role in the mix of contraceptive methods for the foreseeable future, the evaluation team feels that additional measures need to be taken to ensure a steady supply of properly qualified physicians for this aspect of the program. The medical colleges, for example, despite the development of the model clinics, still do not provide for the acquisition of surgical skills in the undergraduate medical curriculum. Likewise, during the internship year, while young physicians gain some experience in assisting at surgical procedures, they still do not have an adequate opportunity to acquire proficiency in such procedures as vasectomy or tubectomy.

RECOMMENDATIONS: USAID should encourage the division of PCFP to collaborate with the Health Division (which now has jurisdiction over the model clinics) to utilize the model clinics of the teaching hospitals for training of medical students and interns in VS techniques.

RECOMMENDATION: USAID should assist the BDG in finding suitable funding to implement the re-training of physicians. Among available options, the possibility of amending the project agreement to enable transfer of funds, currently not utilized for out of country training, to help meet local costs for in-country physician training in VS should be considered.

3. Mechanism of Local Cost Reimbursement

Findings, Conclusions and Recommendations:

Spot payment in taka of compensation in voluntary sterilization services is on a case by case basis. A serious problem arises at the beginning of the financial year when no funds remain in the personal ledger (P.L.) account of the Director General of Implementation for payment of compensation costs to clients. All unutilized funds lapse at the end of the financial year and must be surrendered, with ensuing delay before the next quarterly funds are released. This delay (which has extended this year from 1 July through the period of this evaluation) threatens the continuity of the Voluntary Sterilization Program.

> **RECOMMENDATION:** USAID should urge the BDG, in keeping with the priority status of the Population Control and Family Planning Program, to allow the Director General of Implementation to retain unspent funds at the end of the financial year in his P.L. account. The BDG should also be requested to review existing financial rules and seek simplified procedures to ensure prompt release and ready flow of these funds in order to improve project implementation. Alternatively, USAID should collaborate with the BDG in devising such mechanisms as a revolving fund to reduce the programmatic bottleneck which arises at the conclusion of the fiscal year.

C. TRAINING:

A large, complex program such as Bangladesh's requires training of large numbers of people in a variety of subject areas and skills. Responsibility for the training function of the program is now consolidated in the Training Unit of the National Institute of Population Research and Training (NIPORT). The sanctioned professional staff positions consist of a Director, an Assistant Director, four Senior Instructors, and two Instructors. The Training Unit itself conducts training of trainers and management and supervision training of mid-level officers. It ensures that other training courses and events are carried out; for example, the technical training of physicians, the paramedical Family Welfare Visitors, and Traditional Birth Attendants; the district training teams' training of MCH/FP and Health field workers; workers in other ministries' population programs; and policy and management workshops for senior officers of the Health and Population Control Ministry and other multisectoral and nongovernmental personnel. Two long-term expatriate training specialists financed under the UNFPA program are working with NIPORT on training of trainers and management of the training function.

Many of the shortcomings of the program are traceable to inadequacies of past training which, in turn, derived from prevalent misconceptions about the nature of training. It is useful to recall some of these widely held assumptions in order to understand the environment in which the Training Unit works, to appreciate the progress which has been made, and to get a notion of the work still to be done.

> Assumption: Any person with higher education and a position of authority can be a trainer; the higher the education and the position, the better trainer the person is.
>
> Until recently, little effort was devoted to developing (and keeping) a team of skilled trainers. Without an understanding of the highly specialized skills needed for training, an executive could confidently order large cadres of personnel to be trained on a crash basis by the trickle-down approach: central-level officers train district level who train thana level who train the field workers. The

approximately 18,000 FWAs and FPAs were trained in this way when they were recruited.

Assumption: A new recruit needs to be told what he or she needs to know and what to do. When that has been done, the person is trained.
Skills training - how to use the knowledge imparted - has been seriously neglected. The concept of on-going training on the job is not yet firmly established nor the need for it sufficiently recognized.

Findings, Conclusions and Recommendations:

1. **In-Country Training:**

a. Organization

(1) The team observed improvements which have occurred in the past two or three years which give reason for hope that there is movement in the direction of quality training.

(a) Twenty-three district training teams have been created and are at work training the population and health field workers. The World Bank and UNFPA have assisted the Government in this effort. The Training Officer and the Senior FWV positions are filled; the third position for a Home Economist is still vacant. Establishment of district training teams for field-level training avoids to some extent the dilution of quality inherent in the trickle-down approach, at least for this part of the total training program.
(b) An effort is underway to give additional training to instructors of the Family Welfare Visitor Training Institutes. USAID is funding technical assistance through its grant to CARE-MEDICO. Training in practical skills has long been a weak part of the 18-month FWV course, partly because of the instructors' generally low skills level and also because of the shortage of case material in the clinical settings near the FWVTIs. A recent promising development is an increase in points for the practical training which count towards a passing grade. Reportedly, both instructors and students are showing greater motivation to seek field placements where the students can get the required minimum number of deliveries and IUD insertions.
(c) Staffing problems of the Training Unit, which plagued it in the first few years after it began operating in 1977, are greatly improved. However, two Senior Instructor positions were still vacant at the time of our visit.
(d) Another important reason for encouragement is the understanding, maturity, and confidence the program leaders and the Training Unit have shown in recognizing a need for and being able to use effectively the technical help available under the USAID and UNFPA projects.

b. Fieldworker Training:

The fieldworker training in progress at the time of the evaluation is aimed at giving MCH/FP training to the Health personnel and health training to the MCH/FP staff. In a two-week period, the workers were to be prepared to deliver 28 messages in their assigned communities. Two of the days were devoted to field practice in getting community involvement.

So much material in so brief a period constitutes overload. The dearth of skills development content is a serious deficiency. It is inevitable, the team believes, that there will be an immediate need for sustained on-the-job follow-on training. Potential opportunities for continuing training exist in the program - during the workers' monthly visits to thana headquarters to receive their salaries and contraceptive resupplies, and through increased emphasis on the staff development component of supervision. For the latter, the supervisors should receive training or orientation on the content of the field workers' course. To the best of our knowledge, this is not planned.

In the follow-on field worker training, it would be desirable to begin by focusing on the half-dozen most important of the workers' tasks until the required knowledge and skills have been mastered. The balance of the 28 tasks can be added gradually, over time. Existing training resources consist of the thana officers and FWVs, the district training teams, and the equipment for videotaping learning sessions led by specially gifted and knowledgeable individuals.

> **RECOMMENDATION:** USAID should encourage PCFPD to plan and carry out an orderly plan for continuing field worker training. USAID should explore the possibility of using funds budgeted in the project for MCH materials to develop instructional materials. These should be designed to have utility for self-instruction, group learning, and field reference.

Although the staffing of the Training Unit has been improved, there is still no guarantee that trained, experienced trainers will not be transferred to unrelated positions. It is difficult to develop a relatively stable training team.

> **RECOMMENDATION:** USAID and the other donors should encourage the PCFPD to design and get approval for a way of giving suitable advancement opportunities to personnel who require specialized skills, such as training.

2. Training Abroad

a. Bangladesh and Indonesia are cooperating in a program for training Bangladeshi THFPOs in Indonesia. With the imposition of martial law, this series was suspended; PCFPD officials expect that it will be resumed. Aimed at improving local program administration, the training emphasizes working with the existing social structure to get maximum community participation.

One of the training exercises in Indonesia requires the THFPOs to design an innovative activity which could be carried out in their respective work areas. A high-ranking PCFPD official reported that when he asked some thana officers about their plans to implement the projects they had designed in Indonesia, they responded that the circumstances in which the Indonesian program operates are quite different from the situation in Bangladeshi communities. The implication is that the thana officers thought the projects they had planned during training had a better chance of working in Indonesia than they would have in Bangladesh. There are admitted risks in generalizing from such anecdotes. However, the THFPO's reported reaction could be expected. Cross-cultural adaptation of social program approaches is notoriously difficult for persons not experienced in moving between cultures.

> **RECOMMENDATION:** USAID should ensure that enough attention is given to helping the trainees to identify the principles at work in the Indonesian program; to separate the principles from the culture-bound specifics; to formulate them in generalized, universally applicable statements; and to rehearse how they could be applied in Bangladesh. The training organization in Indonesia bears major

responsibility for ensuring that this process takes place. The PCFPD and USAID should assist during predeparture and reentry discussions with the trainee groups.

b. USAID's assistance project includes a provision for financing short-term training and long-term academic study (at no higher than Master's level) in the U.S. or third countries. The Martial Law Administration reportedly scrutinizes overseas training proposals rigorously and approves fewer than had been the case in earlier years. The team believes that money used for training and education is well-invested, in general, and that this aspect of the project should be continued.

At the time of the evaluation, USAID was about to begin a potentially useful follow-up study of former participants in the pre- and post-independence periods to determine the proportion whose present employment is related to the training objectives. The team noted that most of the officers in key positions of responsibility, especially among the technical cadre, had received academic training abroad under prior USAID projects.

Training is central to the quality of the program, to its cost-effectiveness, and to the service users' perceptions of the program. The training requirement of the Bangladesh program are large and varied. Accordingly, both the BDG and USAID must consider every opportunity to enhance the quality and effectiveness of training.

RECOMMENDATION: USAID should propose to the PCFPD and the other donors the formation of a high level "task force" on training, including government officials and representatives of donor agencies. The purpose of this technical advisory group would be to monitor the program to identify training needs and to recommend approaches for meeting those needs. This would enrich the training program by bringing a variety of perspectives to bear on shared objectives and problems. The resulting sustained focus on training would facilitate timely actions and coordination of implementation and funding commitments. The recommendations of such a group may also help to strengthen PCFPD's justifications of budget requests for training.

D. CONTRACEPTIVE PREVALENCE STUDIES

In the absence of a complete vital registration system periodic contraceptive prevalence surveys provide valuable data from which inferences can be drawn regarding fertility trends as well as program performance. Emphasis on prevalence data, both for target setting and program performance evaluation, was evident in the recommendations ensuing from the 1980 USAID evaluation.

Findings, Conclusions and Recommendations:

A Management Information System was established as a unit of the Population Control Division of the MOHPC in 1980. It's antecedent was the former "Research and Evaluation Unit". While many problems involving incomplete reporting and inaccuracy of data remain, the system is, nevertheless, acquiring increasing sophistication as its experience accumulates. Its reporting cell provides a weekly sterilization report (with about 2% of thana's not yet reporting), and a monthly Family Planning report, to which MCH data has just begun to be added. The computerized monthly report also now provides data on the family planning performance of NGO's. The Population Control Division conducted the USAID supported Contraceptive Prevalence Survey of 1981. (Appendix F), which provides extensive information on demographic and social characterics of the population, as well as data on contraceptive knowledge and current use.

In addition to the reporting cell, the monitoring system of the target setting cell provides a useful channel of information between the Director General of

Implementation and the District officers, allowing for prompt inspection and corrective action wherever indicated on the basis of quarterly performance data.

Both the MIS staff and the USAID personnel concerned with the study have drawn attention to sources of conflicting data which call for further refinement of the CPS methodology, which of necessity relies on assumptions regarding contraceptive use which may be inaccurate. Some clues to possible sources of error have been provided by comparison of CPS data with PCFP data on distribution of contraceptives. An added check on reliability of distribution data was done by comparing distribution figures reported to PCFP division in the monthly district distribution report with those reported by fieldworkers in performance reports to the Thana FP Office and, thence, to the MIS unit via the District FP Office. This study was done from January 1982 to April 1982 by Mr. Sk. Ali Noor, with the assistance of Mr. Harun-al Rashid (USAID/Dhaka). In the case of oral contraceptives, the results indicated that distribution data and CPS data are essentially consistent. However, in the case of condom distribution, significant inconsistencies in condom distribution among fieldworkers were uncovered, and assumptions regarding the relationship between distribution and use are highly questionable. While the study produced some useful insights into fieldworkers' practices, the real resolution of this problem will not be forthcoming until completion of a current CIDA supported anthropological study of actual use in 4 selected thanas, which is currently in progress.

RECOMMENDATION: USAID should continue support and technical assistance to the Population Control Division in undertaking Contraceptive Prevalence Surveys in order to help the planning and programming process.

E. OPERATIONS RESEARCH

Reference to demographic and family planning studies in Bangladesh is made earlier in this report. The following findings of this evaluation refer to USAID supported studies of policy implementation with operational implications for the PCFP program.

Findings, Conclusions and Recommendations:

A summary of Operations Research Projects through August 1980 was appended to the 1981 Program Evaluation Report. For an update of projects completed through May 1982, see Appendix (G).

Since May 1982, no further Operations Research Projects have been completed. A study of the IUD compensation scheme was approved by BDG and is underway. A study of the effect of non-monetary incentives for high performance of individual fieldworkers was proposed in June 1982 and has been approved, but to-date no requests for proposals have been forthcoming. A study of the feasibility of using parttime vs. fulltime workers in the PCFP Program has been proposed, but is not yet approved by the BDG.

A mechanism for advertisement of requests for proposals (RFP) and review of proposals by a standing Operations Research Steering and Technical Review Committee (STRC) was established in July 1981.* Its intent was to assure wide dissemination of RFP's and clear definition of criteria for appropriate topics, according to the objectives of the Operations Research Project. However, this laudable effort appears to be thwarted at present by long delays in dissemination of RFP's, in moving proposals through the technical review process, and in securing government approval of projects. The net result is that the potential contribution of Operations Research to programmatic decision-making is not presently being realized, and this year's activity will fall far short of the $200,000 budgeted for such research.

Operations research is of critical importance. The population field has been characterized by a tendency to search for new directions and policy solutions. Given the many frustrations encountered with organized family planning programs, the general willingness to move toward 'new solutions' is perhaps not surprising. Yet, new approaches are bound to produce further disappointments unless they are built upon a careful analysis of the reasons for past failures.[5] The apparent slowdown in operations research output deprives the program of such useful analysis. (For a detailed discussion of research needs in this area see Simmons, et.al. "The Relevance of Programmatic Factors for Population Analysis" [13].)

RECOMMENDATION: We recommend that USAID continue to pursue opportunites for funding useful projects in this area. Special emphasis should be given to projects which focus on a detailed analysis of the implementation process of health and family planning programs, including contraceptive prevalence surveys. There should be emphasis on the study of family planning programs in their total context, from the people for whom they are designed to the highest level of policy-making. Emphasis should be on how the program is actually functioning and on an assessment of the organizational factors that determine overall program accomplishments or existing variations in performance. A cost-benefit analysis of family planning in Bangladesh should also receive high priority.

F. LOCAL FAMILY PLANNING

The Local Family Planning Project provides resources for funding innovative activities at the District level and below, which are to be designed and implemented by local personnel. The procedures, criteria, and guidelines for these activities had not yet been circulated at the time of our evaluation.

The majority of proposals under this project must originate from the Government Health and Family Planning Program personnel who have participated in the Indonesian Training Program. This subproject is modelled after the Indonesian Program, which, in collaboration with AID, had developed a mechanism that permitted fast, flexible movement of resources to provincial and rural activity where there was high probability that they would be used effectively.

Findings, Conclusions and Recommendations

The team considers this project a very creative innovation with great potential for providing local flexibility and encouragement of much needed initiative at the operational level. Its aims fit the highly emphasized spirit of decentralization of the current administration. However, because of its innovative nature, it requires careful nurturing and protection from cumbersome bureaucratic routines and excessive centralization which it attempts to circumvent.

Implementation of this project has been delayed because of clarifications that had to be sought over relatively minor details of procedure.

RECOMMENDATION: We urge USAID and the Director of the Local Family Planning Project to finalize the project and to provide maximum support to this project to assure that its innovative qualities and its potential for rewarding local initiative will not be lost.

G. SUPPORT OF NON-GOVERNMENT ORGANIZATIONS

A more detailed evaluation of USAID-funded non-governmental Family Planning activities in Bangladesh was conducted by a separate consultant (K. Minor) from June 1

to July 6, 1982.[15] In the introduction to her report, the consultant notes that it addresses primarily the opinions and concerns of the NGO's, noting that the present evaluation team would have further opportunities to evaluate the BDG's perspective on NGO activity.

The reader is thus referred to the above consultation report for details of individual USAID supported NGO projects, their modus operandi, their funding mechanisms, and operational features. The following comments are addressed, accordingly, to the degree to which NGO outputs in the aggregate fulfill the objectives set forth in the FPSP, observations on BDG/NGO cooperation, and certain common problems of logistics and supply.

Findings, Conclusions and Recommendations

1. Outputs

Attempts to quantify the NGO's contribution to the National Population Control and Family Planning Program in terms of percent of total prevalence, as called for in the FPSP logical framework matrix, are frustrated by many factors. Although the annual contraceptive prevalence survey is beginning this year to collect NGO data, comparative prevalence figures using standard definitions and criteria are not yet available. Moreover, service statistics of government clinics do not generally reflect referrals from NGO project workers.

Despite the problems in attribution, however, the evaluation team feels that the empirical evidence from available reports, coupled with our own field observations and interviews, warrants the conclusion that the criterion of 10% of prevalence attributed to NGO activity has been met. The fact that NGO's account for the bulk of service delivery in the urban areas, where over 10% of the population reside and where the population with attributes conducive to family planning acceptance is concentrated, supports this conclusion. It is further supported by the aggregate of acceptor data reported by the individual projects, despite their variation in reporting patterns. The evaluation team commends the NGO Program Consultant who preceded this evaluation for facilitating the consensus and commitment by NGO's to implement a common reporting system in the course of her June 1982 consultation.* (Reference to K. Minor report in appendix)

2. BDG - NGO Cooperation

It has been understood from the start that the NGO's projects are intended to complement the BDG government rather than function merely as an "extension" of government service delivery. Despite certain conflicts in expectations of one another by BDG and NGO representatives and complaints of bureaucratic delays and frustrations that seem inevitable in a "partnership" venture of this magnitude, the evaluation team is convinced that the MOH/FP is supportive of the NGO component of the total national effort. Recognizing that some 163 private organizations are operating in Bangladesh, it is understandable that full government notification and approval of NGO projects is required and that their activities in family planning be confined generally to the urban areas. The evaluation team notes, however, that NGO's are more than just service providers. They are valuable sources of innovation and experimentation with new methods, approaches, or policies before they become nationwide in application. This is one of the reasons for allowing them to extend into rural areas with BDG approval (e.g. the experiments of BFPA with strictly local voluntary bodies and with traditional healers). The MOHPC has demonstrated flexibility with respect to certain private sector organizations whose projects include a rural component (such as BFPA, SMP). USAID has proposed that AID/NGO grantees provide service to district and sub-division

towns. This, along with other possibilities for extension of NGO coverage encountered in the course of our field visits, warrants further discussion among the BDG, USAID, and individual NGO's.

3. Central vs. Bilateral Funding of NGO Projects

Centrally funded grants provide funds for the population intermediary agencies to develop and maintain adequate management and technical staffs to implement their international subgrant programs. Primary responsibility for monitoring and backstopping their subgrantees belongs to the intermediaries. Management of the grants and of the world wide projects is assigned to the AID/W Contract Management Office and the Office of Population, respectively. USAIDs monitor the implementation of any subgrant activities in their countries to the degree they judge necessary.

In bilaterally funded NGO grants, negotiation and management of the grant agreements and monitoring of the project activities are the responsibility of mission staff. In those mission grants to international headquarters agencies (in the Bangladesh case, for example, to IPAVS in New York and The Pathfinder Fund in Boston), the mission "purchases" the grantees' managerial and technical competence which is sustained by those agencies' central grants. This reduces the mission's workload somewhat. But, in general, direct mission funding of NGO projects increases technical, executive and controller staff requirements - an important factor in weighing the comparative advantages of the alternate funding mechanisms.

Findings, Conclusions and Recommendations

To the extent that further increase in contraceptive prevalence is expected, and expansion of BDG resources cannot realistically be expected to meet the demand in the immediate future, the need for increased USAID funding of NGO projects needs to be considered in the discussion of future funding requirements. Moreover, increased future activity in the "Beyond Family Planning" area of developing wider acceptance of the small family norm should certainly draw upon the experience of NGO's with particular expertise in this area. Such activity will require close collaboration between the BDG, USAID, and the NGO's concerned. The evaluation team commends the USAID/Dhaka staff for the dedication and quality of its back-stopping activities and technical assistance to the NGO projects it currently supports. Additionally, however, the standard-setting, technical assistance, and management training provided by central bodies, of which Bangladesh organizations are members, (e.g. IPAVS and IPPF) are still important aspects of improving services and expanding management capacity beyond that which can be provided by the staff of USAID/Dhaka.

4. Problems of Logistics and Supply

The questions raised by the prior consultant are valid, and were echoed in the course of our field visits. They call for timely and workable actions which are detailed in the overall discussion of logistics and supply issues elsewhere in this evaluation report. (See pg. 29)

RECOMMENDATION: Both USAID and the BDG should be encouraged to facilitate the contribution of NGO's to the program and seek creative measures to maximize their performance.

RECOMMENDATION: The mechanism for Mission funding of local NGO projects should be preserved and utilized to the extent of USAID's capacity to monitor and provide technical assistance to such grantees.

5. Cost Analysis of Major NGO Programs

For data obtained and analyzed subsequent to the team's visit to Bangladesh, see Appendix I.

H. CONCLUSION: 1984 AND BEYOND

It is abundantly clear from this mid-term evaluation that continued substantial donor assistance will be required for the foreseeable future if Bangladesh is to achieve its development and demographic goals. The major themes emerging from the evaluation represent this team's view of the desired directions USAID assistance should take for the remainder of the current project and the follow-on projects to succeed it. They are:

1. A close collaborative relationship with other major donors.
2. Continued support for the full implementation of the present program aimed at meeting fully the existing demand with high quality service.
3. Emphasis on strengthening institutional capability in the organizational, administrative and management aspects of the service delivery system.
4. Increased emphasis on support of "Beyond Family Planning" measures conducive to delaying marriages, increasing birth intervals, and decreasing family size.
5. Encouragement of full utilization of the contribution of multi-sectoral projects and non-government organizations to the National Family Planning effort.

Given the constraints on economic forecasting in the current climate of worldwide recession, suggestions regarding future funding requirements of USAID assistance are clearly beyond the scope of this evaluation. The increasing acceptance of Family Planning, the expanding pool of potential acceptors in the childbearing ages, the evidences of yet unmet demands for services, and the continuing rises in the costs of commodities critical to the program all point, however, toward increased funding requirements, the responsibility for which cannot yet be assumed by the BDG.

RECOMMENDATION: In considering future levels of funding we recommend that the following considerations be given priority attention:

a. Need to diversify the assistance package with greater emphasis on institution building and beyond family planning measures;
b. The capacity of the BDG to absorb external assistance;
c. The role of USAID vis-a-vis other donor participation in BDG development;
d. As yet undetermined changes in the availability of US funding and priorities for assistance among AID recipients;
e. The need for USAID to collaborate fully with the MOHPC in finding ways to achieve program economies and efficiency.

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FIGURES

1. Thana Level Organization of Health and Family Planning prior to integration.

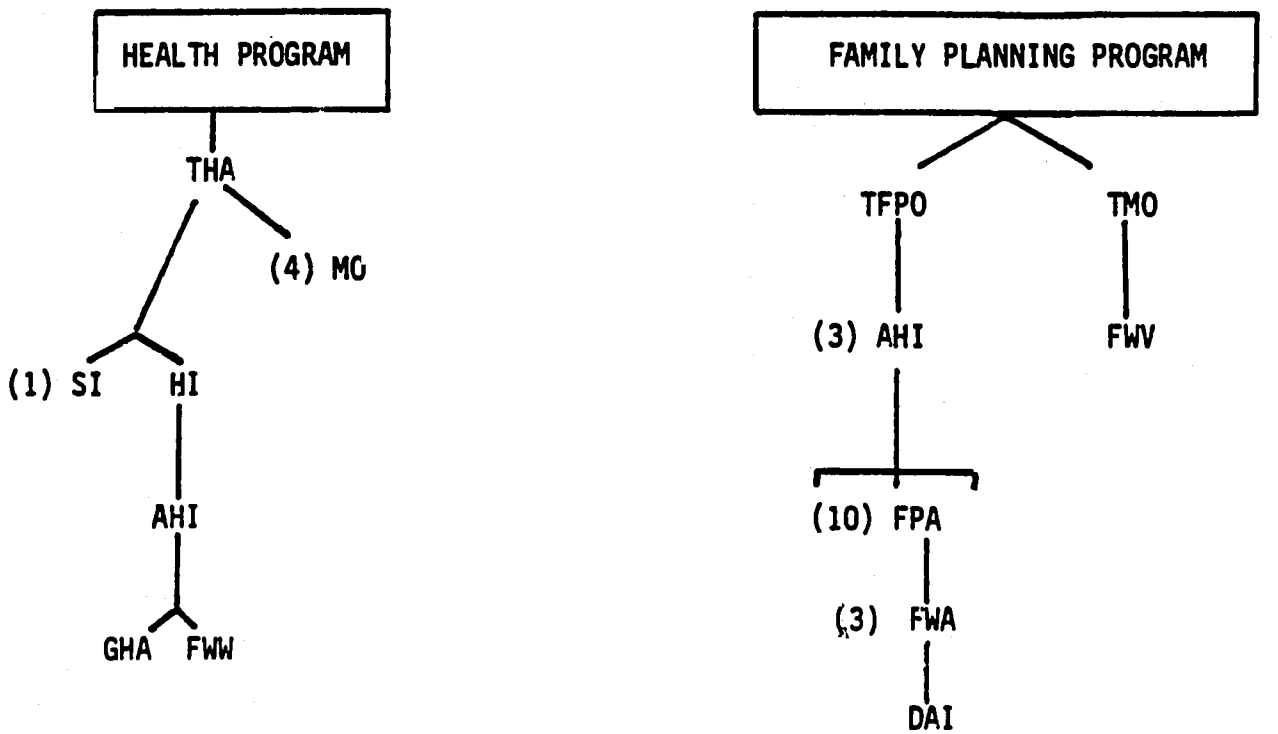
2. Organizational Structure of Ministry of Health and Population Control. (Major Posts in PCFP and Health Divisions at NHQ only).

3. Organization of Ministry of Health and Population Control from National Headquarters to Thana Level.

4. Organizational Structure of the Integrated Thana Health and Family Planning Programme.

5. Organizational Structure of the Population Control and Family Planning Division.

Figure 1: Thana level organization of Health and Family Planning prior to integration.



FPA = Family Planning Assistant
FWA = Family Welfare Assistant
THA = Thana Health Administrator
SI = Sanitation Inspector
HI = Health Inspector
AHI = Assistant Health Inspector

TFPO = Thana Family Planning Officer
TMO = Thana Medical Officer
GHA = Government Health Worker
FWW = Family Welfare Worker
FWV = Family Welfare Visitor

Figure 2: Organizational structure of Ministry of Health and Population Control
(Major posts in PCFP and Health Divisions at NHQ only)

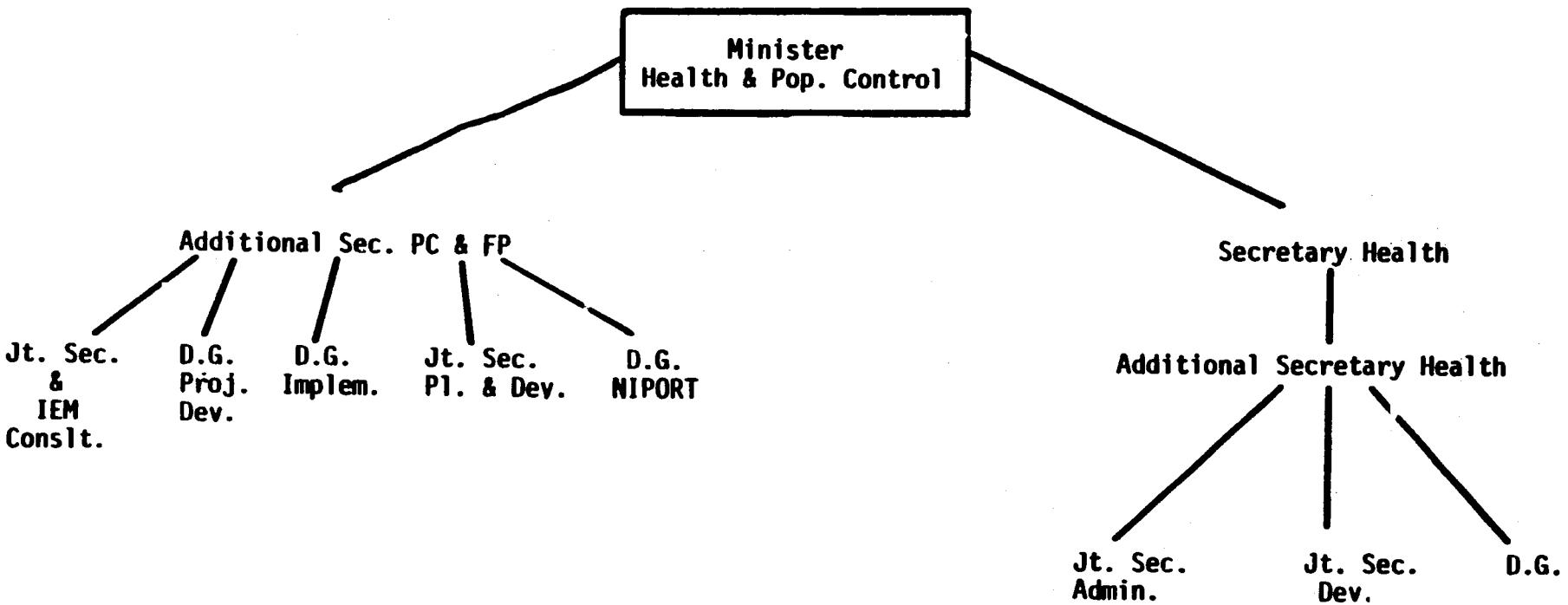
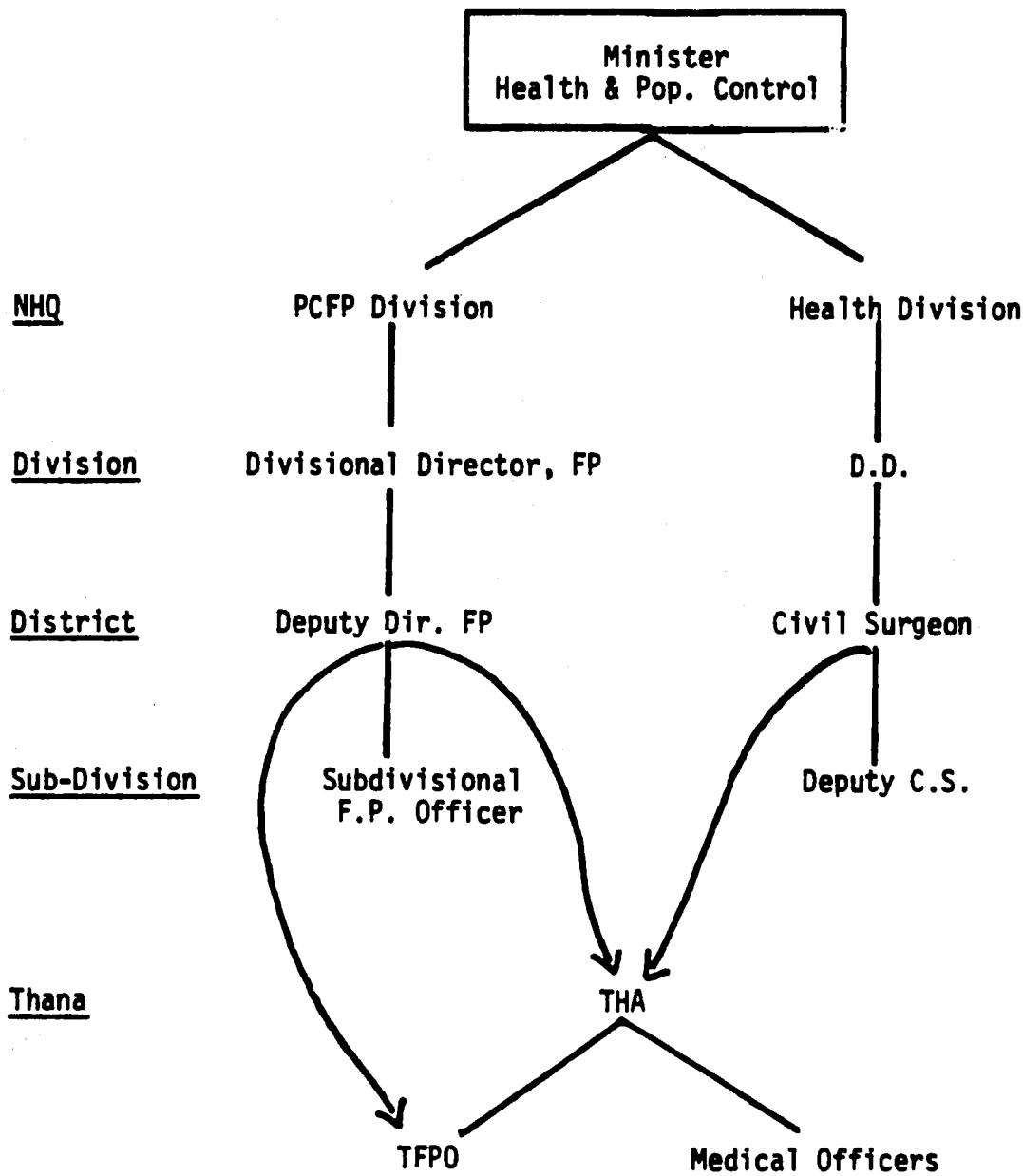


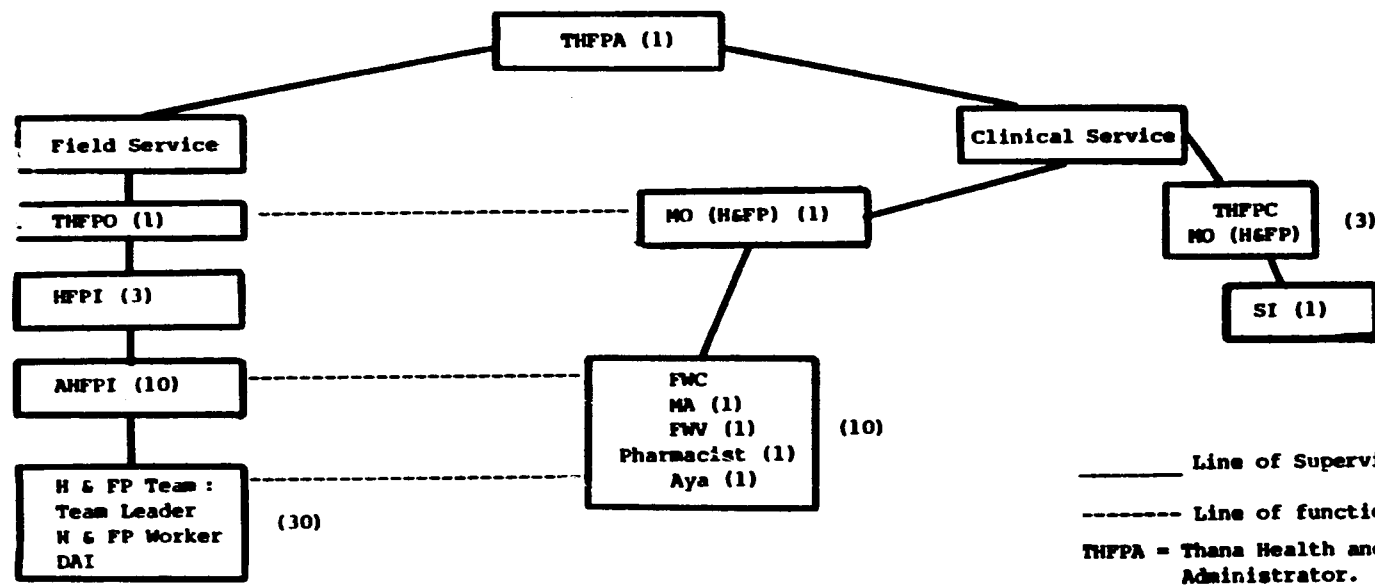
Figure 3: Organization of Ministry of Health and Population Control from National Headquarters to Thana Level (1981 ---)



Integrated Health and Family Planning Programme:

1. Oral Rehydration Solution
2. Parasite Control
3. Family Planning
4. Malaria Control
5. Immunization
6. MCH
7. Health Education

FIGURE 4: ORGANIZATIONAL STRUCTURE OF THE INTEGRATED THANA HEALTH AND FAMILY PLANNING PROGRAMME

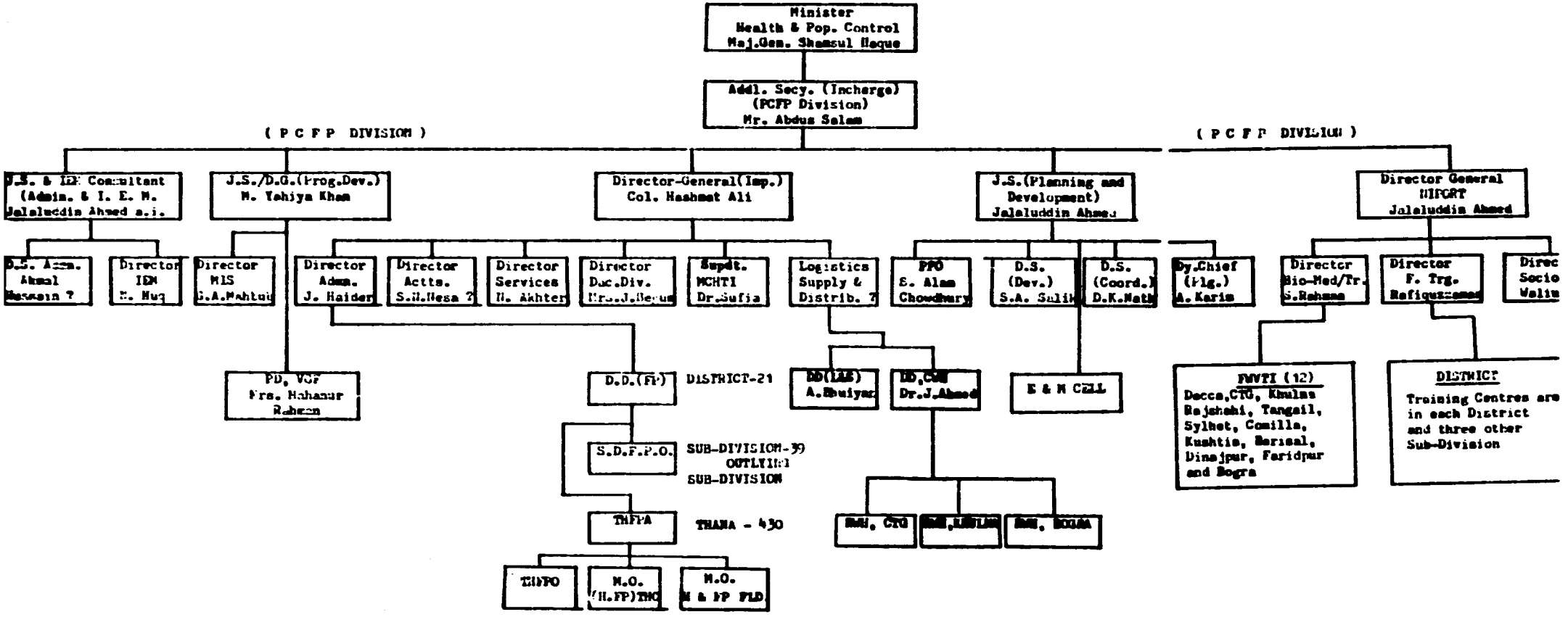


_____ Line of Supervision & Control

-------- Line of functional coordination

THFPA = Thana Health and Family Planning Administrator.
MO(H&FP) = Medical Officer, Health and Family Planning.
THFPO = Thana Health and Family Planning Officer.
SI = Sanitary Inspector.
HFPI = Health and Family Planning Inspector
AHFPI = Asst. Health and Family Planning Inspector.
MA = Medical Assistant
FWV = Family Welfare Visitor
H&FP Worker = Health and Family Planning Worker

Figure 5. ORGANIZATIONAL STRUCTURE OF POPULATION CONTROL AND FAMILY PLANNING DIVISION



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TABLES

1. Percentage of Currently Married Women under 50 Years of Age using Contraception by Broad Categories of Methods and by Education.

2. Yearwise Performance of Different Contraceptive Methods, 1979-1982.

3. Monthly Performance of Sterilization, IUD, Oral Pills and Condoms, 1980-1982.

4. Monthly Performance of M.R., Injectables, Emko and Foaming Tablets, 1980-1982.

5. Percentage of Currently Married Women Under 50 Years of Age using Contraception by Method, Bangladesh, 1975, 1979, and 1981.

6. Number and Type of Facilities providing Sterilization Services.

7. Key Positions at Thana Level - Sanctioned/Actual Strength and Vacancies.

TABLE 1

PERCENTAGE OF CURRENTLY MARRIED WOMEN UNDER 50 YEARS OF AGE USING CONTRACEPTION BY BROAD CATEGORIES[1] OF METHODS AND BY EDUCATION

EDUCATIONAL LEVEL	NUMBER OF CURRENTLY MARRIED WOMEN (WEIGHTED)	USERS BY CATEGORIES OF METHODS			TOTAL USERS	NON-USERS
		MODERN METHODS		TRADI-TIONAL METHODS		
		PERMA-NENT	TEMPO-RARY			
NEVER ATTENDED SCHOOL	4284	4.9	3.7	6.3	14.9	85.1
LESS THAN PRIMARY LEVEL	1122	4.3	8.1	8.5	20.9	79.1
COMPLETED PRIMARY LEVEL	452	5.3	9.1	10.6	25.0	75.0
CLASS VI-VII	186	5.9	13.7	16.4	36.0	64.0
CLASS VIII-IX	143	3.6	21.3	15.0	39.9	60.1
SSC AND HSC	95	2.1	35.8	16.8	54.7	45.3
DEGREE AND ABOVE	12	2.4	39.3	21.6	63.3	36.7
NOT STATED	11	-	5.2	26.1	31.3	68.7
ALL	6306[a]	4.8	6.1	7.7	18.6	81.4

[1] Tubectomy and vasectomy are included in Modern Permanent category; all other Modern Methods in Modern Temporary category; and all traditional methods in Traditional Method category.

[a] Weighted total adds to 6305 instead of 6306 due to rounding after weighting.

Source: 1981 CPS

Table 2: Yearwise Performance of Different Contraceptive Methods, 1979-82.

Year	Steriliz.	IUD	Oral Pill in Cycles	Condoms in pieces	M.R.	Injectibles	Emko	Foaming Tablets
1978-79	106,424	22,631	7,120,550	57,541,476	4,412	11,028	39,051	----
1979-80	198,782	21,801	6,227,651	58,380,612	10,479	26,026	39,127	----
1980-81	258,492	41,629	8,103,384	87,039,183	28,041	112,024	59,804	5,001,943
1981-82	302,028	82,918	7,722,788	92,837,464	42,427	82,006	64,226	4,106,370

Table 3 : Monthly Performance of Sterilization, IUD, Oral Pills and Condoms 1980-82

Months	Sterilization		IUD		Oral Pill in pieces		Condom in pieces	
	1980-81	1981-82	1980-81	1981-82	1980-81	1981-82	1980-81	1981-82
July	14,827	10,383	1,677	3,102	661,507	584,658	6,389,048	6,990,093
August	19,853	16,744	2,478	4,363	798,011	696,419	7,688,837	7,181,453
September	29,031	17,731	2,027	3,840	586,151	581,560	5,984,324	7,248,388
October	24,056	28,953	2,404	5,297	626,495	620,744	8,274,744	9,266,263
November	15,069	17,948	3,014	6,638	765,964	729,221	8,744,549	8,226,908
December	15,286	9,748	3,211	3,873	729,516	335,529	6,013,090	4,764,201
January	23,015	22,266	3,810	7,872	709,247	672,277	8,326,189	8,165,817
February	27,253	33,644	3,993	8,744	674,845	703,076	6,955,893	7,780,736
March	21,852	38,111	4,871	8,296	676,662	671,513	7,872,114	7,321,643
April	24,527	36,926	4,988	9,626	613,741	673,381	6,588,060	7,458,437
May	22,921	35,555	4,842	11;300	605,987	755,514	6,972,636	9,295,614
June	19,802	34,019	4,319	9,967	655,258	698,896	7,229,699	9,137,911
Total	258,492	302,028	41,629	82,918	8,103,384	7,722,788	87,039,183	92,837,464

Table 4 : Monthly Performance of M.R., Injectibles, Emko and Foaming Tablets 1980-82

Months	M.R.		Injectibles		Emko		Foaming Tablets	
	1980-81	1981-82	1980-81	1981-82	1980-81	1981-82	1980-81	1981-82
July	1,567	2,333	7,460	8,172	3,315	4,692	564,287	443,806
August	2,382	3,222	8,286	8,485	5,967	5,565	490,012	421,897
September	1,737	2,551	7,404	6,910	3,805	4,406	423,437	388,917
October	1,403	3,134	8,751	7,846	3,509	4,836	361,336	384,421
November	1,767	3,138	9,465	6,604	4,750	5,026	456,270	448,732
December	2,127	1,813	8,063	4,126	5,047	2,793	352,517	213,941
January	2,501	3,384	10,563	7,409	5,345	4,952	335,568	313,964
February	2,657	3,885	10,215	6,900	4,649	4,984	315,544	276,460
March	3,105	4,810	10,579	7,169	8,260	5,625	364,749	260,374
April	2,992	4,803	10,793	5,132	6,138	6,051	417,284	290,096
May	2,762	4,941	9,990	5,958	4,581	8,545	475,563	355,747
June	3,041	4,413	10,455	7,295	4,440	6,751	445,376	308,015
Total	28,041	42,427	112,024	82,006	59,804	64,226	5,001,943	4,106,370

TABLE 5

PERCENTAGE OF CURRENTLY MARRIED WOMEN UNDER
50 YEARS OF AGE USING CONTRACEPTION
BY METHOD, BANGLADESH
1975, 1979 and 1981

METHOD	BFS[1] 1975	CPS YEAR 1979[2]	CPS YEAR 1981
ORAL PILL	2.7	3.6	3.5
CONDOM	0.7	1.5	1.6
IUD	0.5	0.2	0.4
TUBECTOMY	0.3	2.4	4.0
VASECTOMY	0.5	0.9	0.8
INJECTION	-	0.2	0.4
VAGINAL METHOD	-[a]	0.1	0.3
ABSTINENCE	1.1	0.8	1.2
SAFE PERIOD	1.0	2.2	3.9
WITHDRAWAL	0.6	0.2	1.8
OTHER	0.3	0.6	0.7
TOTAL USE RATE	7.7	12.7	18.6

[1]Source: BFS - Bangladesh Fertility Survey, 1975.
(Data derived from Table 2.4.5. and Table 4.4.1)

[2]Source: CPS - Contraceptive Prevalence Survey, 1979.

[a]This method is included in 'OTHER'.

Table 6: Number and Type of Facilities Providing Sterilization Services

Type of Facility	
Thana Health Complex	312
Family Welfare Centres	357
Sub-Divisional Hospitals	35
District Hospitals	13
Medical College Hospitals	8
Maternal and Child Welfare Centres	86
BAVS	25
Bangladesh Family Planning Association	10
Christian Health Care Project	23
Railway Hospitals	12
Others (Mohammadpur Clinic/ Satellite Clinic/ICDDR.B. Concerned Women/Coalition Clinic	9
Total Number of Facilities	890

Table 7 Key Positions at Thana Level-
Sanctioned/Actual Strength and Vacancies

Position	Sanctioned Strength	Actual Strength	Vacant Positions
Thana Family Planing Officer	488	409	79
Medical Officer (H/FP)	418	326	92
Family Planning Assistant	4500	4091	409
Family Welfare Assistant	13500	12148	1352
Family Welfare Visitor	3231	3215	16
Dai	15500	11944	3556

APPENDICES

A. INSTITUTIONS AND OFFICIALS VISITED.

B. GLOSSARY OF ACRONYMS USED IN REPORT.

C. ANNUAL DEVELOPMENT PROGRAMME ALLOCATIONS FOR 1982 - 83.

D. ANALYSIS OF PROJECT AID, DONOR COMMITTMENT AND FINANCIAL PROGRESS DURING 1981-82.

E. UNFPA REPORT OF DONORS ASSISTANCE TO MCH/FP PROGRAMMES IN BANGLADESH.

F. BANGLADESH CONTRACEPTIVE PREVALENCE SURVEY, 1981. (TABLES)

G. OPERATIONS RESEARCH PROJECTS COMPLETED SINCE THE 1980 PROGRAM EVALUATION.

H. REORGANIZATION OF THANA ADMINISTRATION, NOVEMBER 7, 1982.

APPENDIX A

INSTITUTIONS AND OFFICIALS VISITED BY THE EVALUATION TEAM

I. DACCA

1. Bangladesh Government, Ministry of Health and Population Control:

Major General Shamsul Huq, Minister

a. Health Division, MOHPC

M. Siddiqur Rahman, Secretary
M.A. Raza, Deputy Secretary
Dr. A.I. Begum, Chief, Planning

b. Population Control and Family Planning Division

Abdus Salam, Additional Secretary
Jalaluddin Ahmed, Joint Secretary
Col. Hashmat Ali, Director General, Implementation
Syed Jahangeer Haider, Director, Administration
Azizul Haque Bhuiya, Deputy Director, Logistics and Supply
Nargis Akhter, Director, MCH/FP Services
Dr. Jahir Uddin Ahmed, Warehouse Manager/Deputy Director, Central Warehouse, Mohaqhali, Dacca.
Saeeda Najmunnessa, Director, Accounts (current charge)

Program Development

M. Yahia Khan, Director General
Gole Afruz Mahbub, Director, MIS

National Institute for Population Research and Training

Mr. A.K.M. Rafiquzzaman, Director (Training)
Dr. S. Waliullah, Director (Social Science Demographic Research Unit)
Dr. Shafiqur Rahman, Director (Biomedical Research Unit)
Mr. A.F.M. Salim, Senior Instructor

Information, Education, Motivation

M.D. Najmul Huq, Director

2. Bangladesh Government, Planning Commission

M. Mofizur Rahman, Member
Atiqur Rahman Khan, Chief, Population Section

3. USAID/Dacca

Wm. Joslin, Acting Mission Director
Charles Gurney, Chief, Population and Health

Suzanne Olds, Deputy Chief, Population and Health
Dr. Carol Carpenter-Yaman, Asst. Population Advisor
Dr. John Naponick, Medical Advisor, Population and Health.
Sk. Ali Noor, Population Program Analyst
Sk. Al Rashid,
Louisa Gomes, Nutrition Advisor
Shanti Conly, NGO Coordinator
Dr. H.S. Plunkett, Program Officer (Evaluation)

4. **United Nations Fund for Population Assistance**

Bal Gopal K.C., Deputy Resident Representative
Dr. Warren Robinson, Advisor, Population and Development Project

5. **International Bank for Reconstruction and Development**

Dr. K.A. Pisharoti, Population Specialist

6. **UNICEF**

Joseph Sclafani, Senior Program Coordinator
Joe Judd, Senior Program Planning Officer
Matnew Gomes

7. **WHO**

Dr. Zvonko J. Sestak, Resident Representative
Dr. Kierski, V.S. Surveillance Team
Dr. Salahuddin, V.S. Surveillance Team

8. **Multisectoral Projects**

Mrs. Rebecca Hasan, Women's Vocational Training for Population Education and Control.
M.A. Mannan, Introduction of Population Education in Formal School System.
Saifur Rahman Chowdhury, Projects under Ministry of Education and Broadcasting.
Mrs. Ellen Sattar, UNFPA Advisor on Population Education, Ministry of Education.
Abdus Sakoor, Deputy Secretary, Ministry of Agriculture.

9. **Non-Government Organizations**

a. **Bangladesh Family Planning Association**

Mr. A.M.A. Kabir, President
Mr. Md. Mozammel Hoque, Executive Director
Mr. Md. Maizuddin, Honorary Secretary General
Mr. Kazi Anisur Rahman, Honorary Treasurer
Mrs. Mahenur Rahman, Joint Secretary
Mr. Badruddin Ahmed, Publicity Secretary
Mrs. Momtaz Hossain, Social Welfare Secretary
Dr. Syed A.K.M. Hafizur Rahman, Member NEC
Mrs. Meherun Nessa Khatun, Member NEC & President, Dacca

District Branch.
Mr. Mizanur Rahman, Director Operations
Mr. Sadequr Rahim, Director Finance

b. **Bangladesh Association for Voluntary Sterilization**

Dr. Azzizur Rahman, President

c. **Population Services International: Social Marketing Project**

S. Anwar Ali, Project Director
A.A.M. Anwar, Manager, Development
G. Sarwar Khan, Marketing Manager

d. **The Pathfinder Fund, Dacca**

Dr. A. Subhan Choudhury, Country Representative

e. **CARE, Bangladesh**

Dr. L. Marum, FWV Training Project Officer

II. **FIELD VISITS:**

1. **Kaliakoir Thana, Dacca Districts (Entire Evaluation Team)**

M.D. Akhtaruzzaman Khan, Deputy Director, Family Planning, Dacca District.
Family Welfare Center Staff
International Child Welfare Union Project Staff

2. **Field visit 8-10 August, Comilla and Noakhali Districts by Jalaluddin Ahmed, Julia Henderson, Dallas Voran, and Nizam U. Ahmed**

Noakhali District Headquarters
Dr. Sarder Serajul Hoque, Civil Surgeon
Mr. N.I. Mridha, Deputy Director (FP)
Mr. A.M. Idris, Assistant Director (Genl & IEM)
Dr. A. Dias, Assistant Director (FP)
Mr. D.B. Bose, Superintendent/FP
Mr. Sheik Mohiuddin, Storekeeper/FP
Mr. Jawher Lal Das, Program Assistant, UNFPA/Dacca (TEMO)
Field Worker Trainees (FWAs, FWWs, GHAs)
Mr. A.Z.M. Abedur Razzaque, Training Officer

Feni Subdivision, Noakhali District
Mr. Anwarul Islam, Deputy Commissioner, Noakhali District
Mr. Nurul Amin, Subdivisional Officer
Mr. A.K.M. Abdur Rashid, THFPO, Feni, and SDFPO-in-Charge, Feni
Mr. G.M. Saleh Uddin, District Extension Officer (Agriculture)

Comilla District Headquarters
Dr. Habibur Rahman, Deputy Director (FP)
Mr. Abdul Ghafoor, Assistant Director (FP)
Mr. M. Shafiuddin, District Training Officer

Field Worker Trainees (FWAs, FWWs, GHAs)
Dr. Dipti Rani Saha, Lecturer, FWV Training Institute
FWV Trainees
Mr. Gulam Mostafa, Director/Secretary-in-Charge, Kotwali Thana Central Cooperative Association (KTCCA)
Ms. Hosnara Begum, Supervisor, Women's Program, KTCCA
Ms. Marium Begum, Lady Health Visitor, Rural Health and Nutrition Project (KTCCA)
Mr. Razul Karim, Instructor, Bangladesh Academy for Rural Development

Bejoypur Union, Kotwali Thana, Comilla
Mr. Ershad Mia, Chairman, Union Council
Union Council Members

3. **Field Visit in Pabna and Rajshahi Districts, August 8-10, by Col. Hashmat Ali, D. Minkler, R. Simmons and L. Gomes.**

Pabna District
Dr. Shah Md. Islam, Civil Surgeon
Mr. T. Hassain Choudury, Deputy Director, F.P.
Dr. Nazrul Islam, Additional Civil Surgeon
Mr. Sharafat Ali, Assistant Director, Gen & IEM
Dr. Saber Ali, Assistant Director, MCH & FP
Thana Health Complex, Athgokia
Azimpur Village (home visits)
Dughazi Union Development Committee
BAVS Clinic, Pabna

Rajshahi District
Dr. Abul Hussain, Civil Surgeon
Mr. Joyenuddin Bhuijan, Deputy Director, FP
Dr. Rafique Akther, Additional Civil Surgeon
Dr. Ahmed Hussain, Assistant Director (MCH & FP)
Dr. Ashraf Hussain Sarder, Assistant Director, (Gen. & IEM)
Col. Ahmed, Superintendent, Rajshahi Medical College Teaching Hospital
Faculty Members, Dept. of OB/GYN, Community Medicine.
Dr. Fazilatun Nesha, Principal, Rajshahi FWVTI, and faculty.
Model Clinic, Rajshahi Med. College Teaching Hospital
Natore Maternal and Child Welfare Clinic.
Phutia Thana Health Complex
Charghat Thana Health Center
Monigram Family Welfare Center (FPA's, FWA's)
BAVS Rajshahi:
Dr. Fazul Haq, President
Prof. K.C. Choudhury, Project Director
BFPA
Pathfinder Project, Mrs. M. Ahmed, Director
Concerned Women for Family Planning, Tillotoma Project:
Prof. J. Khattun
Meeting with members of Sericulture Industry Board

APPENDIX B
GLOSSARY OF ACRONYMS USED IN THE REPORT

ADB:	Asian Development Bank
ADP:	Annual Development Plan
AHI:	Assistant Health Inspector
BDG:	Bangladesh Government
BCS:	Bangladesh Civil Service
CMLA:	Chief Marshal Law Administrator
CPS:	Contraceptive Prevalence Survey
DA:	Dearness Allowance
FPSP:	Family Planning Services Project
FPA:	Family Planning Assistant
FWA:	Family Welfare Assistant
FWV:	Family Welfare Visitor
FWW:	Family Welfare Worker
FYP:	Five Year Plan
GHA:	Governmental Health Assistant
HI:	Health Inspector
IRDP:	Intensive Rural Development Project
MA:	Medical Assistant
MO:	Medical Officer
MOHFP:	Medical Officer, Health and Family Planning
MOHPC:	Ministry of Health and Population Control
NGO:	Non-government Organizations
PCFP:	Population Control and Family Planning
PCFPD:	Population Control and Family Planning Division

PD-70:	USAID Policy Directive #70
SMP:	Steering and Technical Review Committee
STRC:	Steering and Technical Review Committee
TA:	Travel Allowance
TEMO:	Transport and Equipment Maintenance Organization
TFPO:	Thana Family Planning Officer
THA:	Thana Health Administrator
THC:	Thana Health Complex
THFPO:	Thana Health and Family Planning Officer.

APPENDIX C

ANNUAL DEVELOPMENT PROGRAMME
1982-1983

The foreward chapter of the ADP states - "Agriculture production, especially foodgrain production and population control has topped the list of priority sectors in the ADP. Energy and primary and technical/vocational education are the priority programmes."

ALLOCATIONS FOR VARIOUS SECTORS in 1981-82 and 1982-83 ADPs:

SECTOR	FY 1982-83 (in Taka 000)	% of ADP Core Budget
Agriculture	3,928,164	14.54
	(3,679,192)	(17.42)
Industry	3,086,296	11.43
	(2,840,501)	(13.45)
Health	685,600	2.54
	(487,748)	(2.31)
Population Control	783,800	2.90
	(764,400)	(3.62)
Education & Religion	1,070,313	3.96
	(726,570)	(3.44)
Social Welfare, Women	127,084	.47
Affairs & Youth Develop.	(57,260)	(.27)
Labour & Manpower	204,927	.75
	(182,527)	(.86)

Total ADP = Tk 27,000,021,000

Total Core = Tk 21,111,564,000

Note: Figures in parenthesis are the allocations from Core Budget

APPENDIX D

POPULATION CONTROL DIVISION

An Analysis of Project Aid, Donor Commitment and Financial Progress during 1981 - 1982

This section will deal with three aspects as indicated in the headline mentioned above.

First: The growth of ADP allocation since 1972-73 (base-year) may be seen at Table I, which gives the following indications.

a. The quantam of project aid received through ADP mechanism and its relative position with GOB contribution to the programme. On average 56.4% project aid allocated throughout the period 1972-73 to 1981-82.

b. The rising trend in ADP allocation for Population Sector in relation to the size of the national ADP allocation. From 1% allocation out of national ADP in 1972-73 (base-year) it rose up to 3.1% in 1981-82.

c. The percentage of increase in ADP was 16.8% over the base-year i.e. 1972-73 (Tk. 5.00 crore in 1972-73 to Tk. 84.28 crore in 1981-82).

Second: Donor-wise commitment since 1975 may be seen at Table II. The major donors/aid-giving agencies are the following:

a. IDA with its Co-financiers: (up to December '83)	US$140 million committed
b. UNFPA: (up to June '85)	US$35.10 million committed
c. USAID (up to December '83)	US$67.44 million committed

Third: Project-wise financial progress during 1981-82 may be seen at Table III. This indicates revised project-wise ADP allocation, released amount and expenditure incurred during the financial year.

STATUS OF
FOREIGN ASSISTANCE TO
POPULATION CONTROL PROGRAMME OF
BANGLADESH

The allocation of foreign assistance (project aid) is nearly 56% on average (since 1972-72 to 1981-82). The quantum of GOB contribution is about 44% on the average. The utilization of GOB contribution is nearly 95%, whereas, that of project aid is about 70%. The reason is the following:

Project Aid: Commodity assistance/technical assistance which is about 50% of the total foreign assistance is reflected in ADP without strictly assessing the commitment. This figure is more or less a notional figure. Such being the case, the quantum of project aid in total might look on the higher side comparative to GOB contribution, yet in actual practice (from utilization point of view) GOB contribution is on the higher side.

The reason for increasing GOB contribution is more than one:

Government has committed revenue budget to meet the cost of Population Control Programme. Figures for last 3 years are as follows:

1980-81 - Tk. 12.28 crore - utilized (purchase of helicopter included)
1981-82 - Tk. 11.24 crore - utilized
1982-83 - Tk. 11.33 crore - being utilized

If this is added with development budget allocation the following will emerge:

	GOB(Dev.)	GOB (Revenue)	TOTAL	
1980-81	28.31	12.28	40.59	
1981-82	31.28	11.24	42.52	in crore Taka
1982-83	25.82	11.33	37.15	
			(likely to be revised)	

On average the position of GOB contribution and foreign assistance is almost equal. The discrepency in utilization of project aid (in commodity/technical assistance) is a factor that has lead to the equity in contribution.

TABLE I

Comparative Statement of ADP Allocation for Population Control and Family Planning Programme (including multi-sectoral projects)

(in crore taka)

Year	Taka GOB	Proj. Aid Total	Total Alloc. (Col. 2 & 3)	% of Nat'l ADP	% of Increase over base year	NOTE
(1)	(2)	(3)	(4)	(5)	(6)	(7)
1972-73 (base year)	3.00	2.00	5.00	1	(base year)	On average 56% is foreign assistance/project aid: 44% is GOB contribution.
1973-74	4.00	3.00	7.00	1	40	
1974-75	4.74	3.00	7.74	1	54	
1975-76	8.44	11.15	19.57	2	292	
1976-77	15.71	5.93	21.64	2	333	
1977-78	17.22	14.78	32.00	2.5	540	
1978-79	19.02	27.72	46.74	3	834.80	
1979-80	22.025	37.245	59.27	3	2100	
1980-81	28.31	41.33	69.64	3	1393	
1981-82	31.28	53.00	84.28	3.1	1680	
TOTALS:	153.751	199.15*	352.90			

Source: ADP - Planning Commission

Compiled/Consolidated by: Planning Cell, Population Control Division (May, 1982)

* On average 50% is in reimbursible Tk. (PA TK).

TABLE II

FOREIGN ASSISTANCE FOR PCFP PROGRAMME SINCE 1975 (approximate):

A. WORLD BANK: First Population Project Cr. No. 533-BD. Effective from 1976 to 1980 (Dec.) - extended up to Dec. 1982.

1.	IDA	US $ 15.00 million	(soft-loan)	
2.	Australia	US $ 2.32 million	(grant)	Co-financiers
3.	CIDA (Canada)	US $ 1.75 million	(grant)	Co-financiers
4.	KFW (FRG)	US $ 6.58 million	(grant)	Co-financiers
5.	NORAD (Norway)	US $ 8.03 million	(grant)	Co-financiers
6.	SIDA (Sweden)	US $ 3.00 million	(grant)	Co-financiers
7.	ODM (UK)	US $ 2.52 million	(grant)	Co-financiers

B. WORLD BANK: Second Population and Family Health Project Dr. No. 921-BD. Effective from April 1980 up to Dec. 1983

1.	IDA	US $ 32.00 million	(soft-loan)	
2.	Australia	US $ 4.04 million	(grant)	Co-financiers
3.	CIDA (Canada)	US $ 5.02 million	(grant)	Co-financiers
4.	KFW (FRG)	US $ 18.20 million	(grant)	Co-financiers
5.	Netherlands	US $ 7.94 million	(grant)	Co-financiers
6.	NORAD (Norway)	US $ 20.00 million	(grant)	Co-financiers
7.	SIDA (Sweden)	US $ 7.27 million	(grant)	Co-financiers
8.	Not yet committed	US $ 3.97 million	(grant)	Co-financiers

C. BILATERAL AGREEMENTS

1.	SIDA	SKr. 3.50 million	(grant for procurement of autoclaves)
2.	W. Germany	US $ 1.26 million	(grant)
3.	Asian Dev. Bank	US $ 0.2 million	(grant)
4.	UNICEF	US $ 1.59 million	(grant)
5.	Japan	US $ 0.9 million	(grant)
6.	DANIDA	US $ 1.00 million	(grant)

D. UNFPA

1. First country project up to 1980 - US $ 10.50 million
2. Second country project up to June 1985 - US $ 25.00 million

E. USAID

1.	Up to 1980	US $ 15.70 million
2.	1980 - 1985	US $ 51.74 million

TABLE III

		AMOUNT	TOTAL UTILIZATION	% ACHIEVED
A.	Total allocation for Population Control Division	Tk.7669.00 lac	5541.12	72.25%
B.	Total released amount (incl. PA FE) for Population Control Division	Tk.6886.20 lac	5541.12	80.46%
C.	Released GOB Tk.	Tk.2426.25 lac (out of 2901.80 allocation)	1674.00	68.99%
C.	Released PA Tk. (Reimbursed)	Tk.2653.45 lac	2226.62	83.91%

APPENDIX E
(RESTRICTED USE)

DONOR'S ASSISTANCE TO MCH/FP PROGRAMME IN BANGLADESH

UNFPA/Dacca
13 August 1982

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Best Available Document

Assistance from the Donors to MCH/FP Programme
in Bangladesh

I. Introduction

Following the discussions at the first donors' meeting held on 22 March 1982 at UNFPA Office/Dacca, we have prepared this report on the basis of the information received from the following donors, namely, World Bank [a/], USAID, UNICEF, WHO, UNDP and UNFPA which are providing support to the MCH and Family Planning Programme in Bangladesh. This report covers:

(a) an overall picture of the donors' assistance to the MCH and Family Planning Programme in Bangladesh;

(b) specific assistance provided by each donor in MCH and Family Planning Programme; and

(c) highlights on some of the common problems faced by different donors in the implementation of the MCH and Family Planning Programme in Bangladesh.

It is hoped that the information contained in this report will help:

(i) to achieve better coordination among the various donors in the implementation of MCH/FP programme in Bangladesh; and

(ii) to promote better understanding by sharing views among the donors on MCH and Family Planning programme in Bangladesh which we hope will help to achieve positive results in the population control programme of the GOB.

II. Overview of Donors Assistance

Several major donor countries and multilateral agencies are currently providing assistance to the MCH/FP programme in Bangladesh. Out of the multilateral/bilateral donors the World Bank [1/] tops the list followed by USAID and UNFPA. The total amount of assistance for the ongoing MCH/FP programme in Bangladesh from various multi/bilateral donors is estimated at

a/ Including cofinanciers (SIDA/NORAD/CIDA/FRG/ODM/Australia/The Netherlands)

1/ In fact it is the International Development Assistance (IDA), an affiliate of World Bank which is providing assistance

US$ 162.4 million (See Table 1 on page 7). World Bank supported programme is also cofinanced by the following bilateral donors viz. CIDA, NORAD, ODM, FRG, Australia, SIDA and the Netherlands.

The breakdown of assistance provided by the various donors is given in Table 3 on page 9 . According to the available information 63.0% of the World Bank assistance is for construction, 20.3% for budgetary support and 8.7% for supplies and equipment. On the other hand USAID assistance is mainly for - supplies and equipment (56.4%) and support to NGOs (39.5%). About 38% of the total UNFPA assistance is allocated for supplies and equipment followed by construction/renovation of rural health dispensaries, MCWCs etc. (21.6%) for which multibi fund is yet to be committed. The balance of UNFPA assistance goes for budgetary support (20.6%), training and fellowships (6.5%) and advisory services (6.5%). UNICEF assistance to MCH/FP programme is mostly for training and fellowships (72.7%) followed by supplies and equipment (27.3%). WHO's assistance is mainly for advisory services (59.8%) followed by other supportive services and overhead costs (37.3%). UNDP is providing assistance to the MA training programme for which 46.8% of the resources are for advisory services, 29.1% for supplies and equipment and 24.1% for training and fellowship. Out of the total donors' inputs to MCH/FP programme in Bangladesh almost 46% has been allocated for construction activities, 20.8% for supplies and equipment and 16.0% for budgetary support (See Table 3 on page 9).

III. Breakdown for Assistance by Category

Construction Programme

Among the donors the World Bank has the largest programme to support construction activities (See Table 3(a) on page 10). World Bank assistance during 1st and 2nd Population/Family Health project covers construction of 700 FWCs, 27 THCs, 9 FWVTIs and 19 Health and Family Planning Training Institutes in 19 districts. The total assistance envisaged in the World Bank project for construction programme is about US$ 98 million which is 60.3% of the total World Bank assistance (1st and 2nd project).

Next to World Bank, UNFPA has made provisions for renovation of 800 RHCs, 83 MCWCs and 2 warehouses at Dacca and Chittagong under multibi funding. However, UNFPA has not yet mobilized multibi fund for the construction programme partly because the GOB has not agreed to utilize bilateral fund for the construction programme under multibi arrangement.

Budgetary Support

World Bank and UNFPA are the two main donors which provide budgetary support to the different category of GOB personnel (See Table 3(c) on page 12). World Bank support covers FWAs (upto 6,500) and other GOB staff of the Evaluation Unit of the Planning Commission whereas UNFPA provides budgetary support to NIPORT, FWVTIs, MATS and MCH/FP field workers (2,800). UNFPA has also provision to support field staff of the Divisional Training Centres and Central Warehouse of the PCFP Division. UNICEF is also providing budgetary support for the TBA project staff (Project Director, Accountant, Clerk-cum-Typist and Messenger).

Supplies and Equipment

USAID tops the list among the donors in providing contraceptives to the Family Planning Programme in Bangladesh. The entire requirement of pills and condoms for family planning programme in Bangladesh is met out of USAID assistance. Next comes World Bank which meets the total requirement of DDS kits in the country. After USAID and World Bank, UNFPA is the third donor which provides supplies and equipment to the MCH/FP programme in Bangladesh. UNFPA assistance include FWC equipment sets, MCH kits, midwifery kits, sterilization drugs and supplies, MR kits, injectables and other consummables for MCH/FP programme (See Table 3(c)). UNICEF provides TBA kits under the TBA training programme which is an important programme for the success of MCH programme in Bangladesh. UNDP and WHO also provide limited quantity of supplies and equipment for MCH/FP programme.

Training and Fellowship

USAID is providing assistance for the training of field workers and programme managers through its grants to NGOs (CARE, IPAVS etc.). See Table 3(d) on page 13 . It also supports 3 (three) weeks training of THFPOs and other middle level officials in Indonesia. USAID also supports both short and long-term fellowships in USA and third country for FP officials.

UNFPA provides support for long-term fellowship in the field of management training for NIPORT officials. UNFPA has also made provisions for incountry training for FWVTI, NIPSOM and MATS officials. UNICEF supports incountry training of MAs and TBAs. World Bank supports incountry training of field workers and overseas training for officials of Health Information Unit, MIS and MATs. UNDP under its support to MA training programme has made provisions for overseas training for the Project Director and other staff (See Table 3(d) on page 13).

Expatriate Advisory Services

World Bank is providing advisory services to the Health Information Unit, Health Education Bureau and to the FWVTIs. UNFPA has been providing services of MCH/FP advisor which is a long-term post. No other donor is providing advisory services in MCH/FP field in Bangladesh. WHO is providing services of four expatriate advisors in the field of sterilization programme which is being funded by SIDA under the World Bank second project. UNDP has provided advisory services for MAs training programme as well as consultancies in Public Health Nursing, Sanitation etc. USAID is providing technical support through CARE for FWVTIs trainers training programme under which the services of two Nurse advisors, one educational specialist and one public health physician are made available.

Out of the total amount of assistance being provided to the MCH/FP programme in Bangladesh only 1.9% or US$ 4.28 million will be spent on expatriate advisory services (See Table 3 on page 9). This is very relevant specially when GOB is pressing to further reduce the number of expatriate advisors in MCH/FP programme in Bangladesh.

IV. Issues and Constraints

The following is a list of some of the major constraints/impediments pointed out by the donors in the implementation of the MCH/FP programme in Bangladesh. These items are classified under the following four major headings:

(1) problems relating to the implementing machinery/ capacity of the host government;

(2) shortage of manpower and facilities;

(3) unsatisfactory performance of field workers; and

(4) others.

(1) Problems on GOB side

(a) frequent transfer of officials (UNICEF)

(b) varied responsibilities of Project Director apart from the main project (UNICEF)

(c) delay in completion of civil works (700 FWCs etc.) and consequently slow disbursement of funds (WB);

(d) administrative delays in appointment of staff, fund release, procurement of equipment and insufficient project coordination (WB);

(e) delays due to rationalization of Plan expenditure (WB);

(f) poor programme planning and priority settings, which contribute to lack of clear understanding on the integration and programme organization strategy (USAID);

(g) over centralization of decision making and minimal delegation to the field, which results in poor supervision and non-flexibility of delivery approaches (USAID).

Table 1: Donor's Assistance to MCH/FP Programme

(In Million US$)

Donor	Allocation	Percentage (%)	Duration
WORLD BANK	126.6 a/	(61.2%)	1975 - 1983
USAID	44.0	(26.0%)	1981 - 1983
UNFPA	18.5	(10.9%)	1979 - mid 1985
UNICEF	1.39	(0.8%)	1980 - 1982
WHO	1.02	(0.6%)	1982 - 1985
UNDP	0.79	(0.5%)	1977 - 1982
TOTAL:	169.4	(100.0%)	

a/ For MCH/FP only:

Ist Project : US$ 33.6 million

2nd Project : US$ 93.0 million

TOTAL : US$ 126.6 million for MCH/FP

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(2) Shortage of Manpower and Facilities

(a) post lying vacant at NIPORT, FWVTIs and Central Warehouse (UNFPA);

(b) lack of manpower and supervision (UNICEF)

(c) lack of pathology laboratories in rural areas (WHO).

(3) Unsatisfactory Performance of Field Workers

(a) very poor performance of the MAs (UNDP);

(b) fragmented and incomplete reporting (WHO);

(c) delays in reporting deaths which do not allow on-the-spot assessment on the causes of deaths (WHO).

(4) Others

(a) weak system for the monitoring of supply needs in the field (UNFPA);

(b) lack of effective implementation of the integrated health and family planning programme (UNFPA);

(c) poorly functioning logistics systems (USAID)

Table 2 : Project Title and Objectives

Donor	Project Number and Title	Location	Objectives
UNDP	BGD/73/072: Training of MAs	4 MATS at: 1) Noakhali 2) Faridpur 3) Kushtia 4) Bogra	a) To assist in strengthening of four MA schools for the training of Medical Assistants (MAs) who will provide health care in rural areas particularly at the union level, and b) To prepare appropriate training programmes for the training schools.
UNFPA	BGD/79/P04: Expansion of Integrated MCH/FP Services and Support to PCFP Dte.	Nationwide through PCFP Directorate	a) To provide technical, budgetary and commodity support to the GOB's MCH/FP programme including assistance to the voluntary sterilization and logistics components of the programme. b) To assist the GOB through NIPORT, FWTIs and NIPSOM in the development and institutionalization of capabilities for the training of field workers and mid-level officers, and c) To support ICDDR,B in conducting research-cum-integrated MCH/FP project in Matlab and Teknaf Thanas.
	BGD/79/P01: Population Manpower Dev.	1) NIPORT, Dacca 2) FWTIs (12)	
	BGD/79/P11: Family Health Manpower Dev.	1) NIPSOM, Dacca 2) MATS	
	BGD/79/P12: Matlab MCH/FP Project and Support to One Extn. Area	1) Matlab Thana (Comilla) and 2) Teknaf Thana (Chittagong)	
UNICEF	Training of TBAs	Nationwide	To reduce the incidence of maternal and neo-natal mortality through providing TBAs with the knowledge skills required to conduct: a) safe delivery, b) help pregnant mothers to attend referral medical centres, and c) train TBAs in the basic MCH & FP subjects so that they may motivate the mothers to accept FP method.
	Training of MAs	4 MATS at: 1) Noakhali 2) Faridpur 3) Kushtia 4) Bogra	To produce an intermediate level of medical personnel who will manage the rural health problems through Family Welfare Centres (FWCs) at union level.

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Table 2 : Project Title and Objectives (cont'd)

Donor	Project Number and Title	Location	Objectives
USAID	388-0050: Family Planning Services Project	Nationwide	To expand FP services through the GOB and NGOs by providing assistance: a) to improve the quality of the voluntary sterilization services; b) to provide contraceptives and other commodities; c) to conduct operations research on service delivery topics and measure changes in contraceptive prevalence, and d) to provide training to improve the service delivery system (for TFPOs, FP project managers, FWV trainers, etc.)
WHO	BAN/MCH/005: Sterilization Surveillance Team	One expatriate consultant in each of the four divisions (Dacca, Chittagong, Khulna and Rajshahi)	To help GOB in improving the quality of the sterilization programme.
World Bank	553 BD: 1st Population/Family Health Project	Nationwide	a) To assist the GOB in establishing a health delivery system to meet the existing demand for FP services and to expand the capacity for training; and b) To assist health and FP manpower delivery programme.
	921 BD: 2nd Population/Family Health Project	Nationwide	To reduce fertility and mortality by: a) strengthening the FP service and health care delivery system, b) expanding and improving the quality of training of health and FP manpower, c) extending the IEM activities of the first project, and d) strengthening evaluation and research capacities.

Table 3 : Breakdown of Assistance to MCH/FP Programme 1/

(In million US$)

Donor \ Items		Construction	Budgetary Support	Supplies & Equipment	Training/ Fellowships	Advisory Services(Expatriate)	Others	Total	Remarks
World Bank	I	31.7 (69.5%)	7.7(16.9%)	3.3(7.2%)	-	0.7 (1.6%)	2.2 (4.8%)	45.6 (100.0%) 2/	1st Population/Family Health Project (1975-1982) - (IDA plus CIDA, NORAD, ODM, FRG, Australia, SIDA)
	II	66.3 (60.3%)	23.9 (21.7%)	10.2 (9.3%)	0.7 (0.6%)	1.5 (1.4%)	7.4 (6.7%)	110.0 (100.0%) 3/	2nd Population/Family Health Project (1979-1983) - (IDA plus CIDA, NORAD, SIDA, FRG, Australia and the Netherlands)
	I+II	98.0 (63.0%)	31.6 (20.3%)	13.5 (8.7%)	0.7 (0.4%)	2.2 (1.4%)	9.6 (6.2%)	155.6 (100.0%) 4/	
USAID		-	-	24.8(56.4%)	1.8 (4.1%)	-	17.4(39.5%) 5/	44.0 (100.0%)	Project 388-0050 (1981-83) plus unspent balance from project 388-0001 (1977-80) available for 1981 and 1982
UNFPA		4.0 (21.6%)	3.8 (20.6%)	7.0(37.8%)	1.2 (6.5%)	1.1 (6.5%)	1.4(7.6%)	18.5 (100.0%)	Covering 4 projects: BGD/79/P01 (July 1979-June 1985) BGD/79/P04 (Jan. 1982-June 1985) BGD/79/P11 (July 1980-June 1985) BGD/79/P12 (July 1980-June 1985) (Including multibi assistance by Dutch and Danish Government for BGD/79/P01 and BGD/79/P04)
UNICEF		-	N/A	0.38(27.3%)	1.01(72.7%)	-	-	1.39 (100.0%)	Covering 2 projects (1980-1982)
WHO		-	-	0.03(29%)	-	0.61 (59.8%)	0.38(37.3%) 6/	1.02 (100.0%)	Project BAN/MCH/005 (1982-1985) (Funded by SIDA under World Bank 2nd Pop./Family Health Project)
UNDP		-	-	0.23 (29.1%)	0.39(26.1%)	0.37 (46.8%)	-	0.79 (100.0%)	Project BGD/73/072 (1977-1982) Dutch Government cost-sharing
TOTAL		102.0(46.1%)	35.4 (16.0%)	45.94(20.8%)	4.9 (2.2%)	4.28 (1.9%)	28.78(13.0%)	221.3 (100.0%)	

(For foot note please see next page)

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Table 3(b): Budgetary Support to MCH/FP Programme

Items \ Donors	WORLD BANK: 1st Population/F M Project	WORLD BANK: 2nd Population/FM Project	U N F P A	UNICEF	WHO	UNDP	USAID
Salary of the FWB Personnel	FP Field Workers,a/ Project Program Officer and Office staff Staff of Evaluation Unit, Planning Commision, Three level operating Staff a/ Under 2nd Project, 6500 FWs in 80/81 to 4500 in 82/83		**NIPORT** 1 Director General 3 Directors 15 Sr.Instructor & Sr.Res.Assocts 6 Jr.Instructor & Jr.Res.Assocts Honoraria to part-time teachers National Consultants 16 Divisional Training Officers Misc. Admin. Support Staff **FWTIs(11)** 11 Principals 33 Lecturers 110 Field Trainers 11 Nursing, Midwifery Instructors 2 National Consultants Misc. Support staff **MATS** 1 Project Director Guest Lecturers Misc. Support staff **MCH/FP Staff** 1 Deputy Director MCH 2 Assistant Director MCH 40 Supervisors [illegible] FWVs 200 FPAs 1800 FWAs Misc. Support staff	**TBA** 1) Project Director 2) Accountant-cum-Cashier 3) Clerk-cum-Typist 4) Messenger	None	None	FW Faculty Training (through Grant to CARE)

Contd...../

TABLE 3(b): Budgetary Support to MCH/FP Programme (Contd....)

Items \ Donors	WORLD BANK		U N F P A	UNICEF	WHO	UNDP	USAID
	1st Population/ FM Project	2nd Population/ FM Project					
Office rent	(by co-financer only)	Field Workers Training Institutions	1) NIHORT Annex and hotels 2) Divisional Training Centres 3) FWTIs	None	Office space	None	None
Maintenance cost		FWTIs 19 FWA Training Centres 4 Model FP Clinics	NIHORT 4 Divisional Training Centres FWTIs NIPSOM Central Warehouse, PCFP	None	Project travel	One Expert Vehicle	None

Table 3(c): Supplies and Equipment to MCH/FP Programme

Item / Donor	Medical kits/ clinical supplies & Equip.	Contraceptives: IUDs	Contraceptives: Oral Pills	Contraceptives: Condoms	Contraceptives: Depo Provera/ Noristerat	Contraceptives: Emkofoam/ Neo Sampoon	Educational/ Trng. Materials and Equipment	Office Supplies & Equip.	Warehouse Equipment	Vehicles	Others
WORLD BANK	Yes 1/						Yes	Yes		Yes	
USAID	Yes	Yes	Yes	Yes		Yes	Yes				Yes 2/
UNFPA	Yes 3/	Yes			Yes		Yes	Yes	Yes	Yes 4/	
UNICEF	Yes 5/						Yes	Yes	Yes 6/		
WHO								Yes		Yes	
UNDP							Yes			Yes	Yes 7/

1/ DOS kits (US$ 4 million, Second P/FH Project)

2/ Printing of manuals

3/ FWC equipment (1905 sets), MCH kits (1235 kits), Midwifery kits (1385 kits), IUD kits (1135 kits), Sterilization drugs and supplies, MR kits (42300 kits) and consumables for MCH

4/ 21 Trucks, 2 Minco Buses, 3 motorcycles and 25 bicycles

5/ TBA kits (15,200 kits)

6/ Cold room

7/ Laboratory chemicals and testing materials

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Table 3(d): Training/Fellowship and Study Tours in MCH/FP Programme

Type of Assistance / Donors		USAID	UNFPA	UNICEF	WORLD BANK 1st P/FH Project	WORLD BANK 2nd P/FH Project	UNDP
Training	Long Term	a) Field workers and managers of sub-projects training (by grants to NGOs) b) FWVs faculty trainers (by grant to CARE) c) Government doctors training (by grant to IPAVS)	Nil	**MAs training** 1,200 persons for 24 months at NATS	Nil	Nil	**MAs Training In-country** For 3 years
	Short Term	**TBA Officers training** 120 persons per year (30 persons x 5 groups) for 3 weeks in Indonesia	**Training of Trainers** a) 1 trainer for 8 weeks at NIPORT b) 6 NATS Junior Lecturers/Tutors for 30 days at NATS **Introduction of Field Training Programme** 1 person for 6 days at NIPSOM **FP Methods and Integrated Health/FP training** 1 Physician trainer for 5 days and 4 physicians for 3 days at NIPSOM **Logistics Procedures training** 3 warehouse managers and storekeepers at PCFPD	**TBA Trainers (FWVs)** 1,000 persons for 15 days/3 days at FWVTIs **TBA training** 15,000 persons for 3 months at UFPCs	**Field Workers** 3,700 persons (FWAs etc.)	**FWVs refresher Training**	Nil

Table 3(d): Training/Fellowship and Study Tours in MCH/FP Programme (Continued)

Donors / Type of assistance		USAID	UNFPA	UNICEF	WORLD BANK: 1st P/FH Project	WORLD BANK: 2nd P/FH project	UNDP
Fellowship	Long term	**Academic fellowship** 2-3 person for 18 months each in the USA and the third country	**For MA degree in training/management/population** 60 m/m of overseas training for 3 persons from NIPORT	Nil	**For Population Programme Officers** 12 m/m	Nil	**Superintendent and Lecturer of MATS** 22 m/m
	Short term	**Academic fellowship** 10-15 persons for 3-6 months in the USA and the third country	Nil	Nil	Nil	**Public Health Fellows** 12 m/m for 4 persons at MATS **For Health Information Unit** 20 persons for 4 wks.	Nil
Study Tour		Nil	**For management level staff of NIPORT and FWTIs** 25 tours for 1 month	Nil	**For religious leaders(Ulemas)** In other Muslim countries	**Study Tour fellows** 16 m/m for 8 pers. **For Women's Coops.** 20 staff for 4 wks. **For Women's Rehabilitation and Welfare Foundation** 7 officials for 4 weeks **For Health Education Bureau and HIS** 39 m/m for 13 officials **For Mothers' Club** 22 officials for 6 weeks.	**For Project Director (MA Project)** 1 m/m **For CTA & Joint Secretary** In India, Thailand, and Papua New Guinea

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Table 3(c): Expatriate Advisory Services to MCH/FP Programme

Donor		Expatriate Advisory Services	Incumbent (Experts/Advisors)
WORLD BANK	1st P/FH Project	Total 70 m/m (approximately) for: 1) Evaluation of FP Programme 2) Service Statistics 3) Training	
	2nd P/FH Project	Total 72 m/m for: 1) Health Information Unit (36 m/m) 2) Health Education Bureau (12 m/m) 3) FMATI (24 m/m)	
UNFPA		NIPORT: 1) Management Training Specialist (48 m/m) 2) Field Training Specialist (39 m/m)	Dick Reynolds Jack Nelson
		NIPCOM/MATS: Health Manpower Training Advisor (39 m/m)	Vacant
		MCH/FP: 1) MCH/FP Advisor (36 m/m) 2) Senior Logistics Advisor (18 m/m)	Vacant Dharam R. Gupta
WHO		Sterilization Programme: 1) Long-term 96 m/m for 4 medical officers 2) Short-term (9 m/m)	Kierski I. Ozef Other posts vacant
UNDP		M.Ts: 1) Medical Officer (60 m/m) 2) Consultants in Lab. Techniques, Sanitation, Public Health Nursing (24.1 m/m)	Al Alawy
USAID		Through AID-CARE Grant for FMTI (NIPORT) 1) Nurse Advisors (54 m/m)	Cynthia Tice and Ashraf Mirza (½ time)
		2) Educational Specialist (36 m/m) 3) Public Health Physician (half-time) (36 m/m)	Frederick Henning Lawrence Marum
		Out of AID/Washington Central Funds: Short-term advisors (periodically)	

APPENDIX F

BANGLADESH CONTRACEPTIVE PREVALENCE SURVEY, 1981 (TABLES)

MANAGEMENT INFORMATION SYSTEM (MIS) UNIT
POPULATION CONTROL AND FAMILY PLANNING DIVISION
MINISTRY OF HEALTH AND POPULATION CONTROL

DACCA, BANGLADESH
DECEMBER 1981

Foreword

The 1981 Contraceptive Prevalence Survey was sponsored by the Ministry of Health & Population Control, financially supported by USAID and conducted by the Management Information System(MIS) Unit of the Population Control & Family Planning Division. The main objective of this survey was to provide feed-back to the planners and program administrators on levels and trends of current contraceptive use. Through this survey we know that the current contraceptive prevalence rate among currently married women (including both urban and rural) is 18.6 percent. It indicates dynamism of the PCFP program; because CPS'79 showed much lower prevalence rate of only 12.1 percent which has been substantially increased during the inter-survey period. A regular survey of this kind would therefore, clearly give indices of achievement which is essential for monitoring of this program.

This survey which began in May'81 has come out with preliminary findings within November'81. This is thus one of the fastest survey for which the credit can be acclaimed by the MIS Unit as well CPS officials. I congratulate them for the wonderful zeal, spirit, enthusiasm and effeciency that they have displayed in the completion of the survey. The final report is understood to be published within the first quarter of 1982, and I am confident that they will again be able to complete this task within the stipulated date.

It is nevertheless, a cherished hope that the population control program of Bangladesh could achieve its objectives with the concerted effort of the Government, Non-Government and International agencies. We look forward for a better accomplishment of task in the year 1982, the result of which can again be measured through the CPS to be conducted in future.

Prof. M.A. Matin
Minister
Ministry of Health & Population Control
Government of the People's Republic of Bangladesh
Dacca.

November 16,1981.

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P r e f a c e

Bangladesh Population Control program has set up an ambitious demographic target of reducing the population growth rate from 2.36 percent to 1.78 percent by the end of the Second Five Year Plan period. In order to achieve this demographic target, we shall have to recruit a total of 38 percent of the eligible couples as continuous contraceptive users. The Contraceptive Prevalence Survey conducted in 1979 revealed that only 12.1 percent of currently married women or their husbands were practicing family planning at that time. Subsequently program efforts had been intensified so that more and more couples are inspired to become family planning acceptors. It is indeed encouraging to note here that our special endeavours have produced the result. The prevalence rate as revealed through the Contraceptive Prevalence Survey 1981 has reflected a rise of contraceptive prevalence rate from 12.1 percent to 18.6 percent.

It is gratifying to note that the MIS officials and CPS field officials have made it possible to complete the field work of the Second survey by August'81 and could demonstrate the initial findings of the survey by the month of November'81. To my knowledge, this is possibly an unique national survey that could provide feed-back to the policy makers within the shortest possible time. I, therefore, would like to congratulate the MIS officials for their achievement.

The main responsibility of planning and executing the work was shouldered by the Director MIS, Mrs. G. Afruz Mahbub and Deputy Director Mr.S.N.Mitra and their colleagues. I would like to take the opportunity to congratulate all of them for their valuable contribution and continuous hard work without which it would have been impossible to bring out this preliminary report of the Contraceptive Prevalence Survey. I wish them all good luck and a happy new year for their contribution to the population control and family planning programme.

A.M. Hyder Hussain
Secretary
Ministry of Health & Population Control
Government of the People's Republic of Bangladesh
Dacca.

TABLE - 2.5

PERCENTAGE DISTRIBUTION OF EVER MARRIED WOMEN UNDER 50 YEARS OF AGE BY CURRENT MARITAL STATUS

Current marital status	National	Rural	Urban
Currently married	90.9	91.1	88.8
Not currently married	9.1	8.9	11.2
Total	100.0	100.0	100.0
N	6937[a]	6269	2241

[a] Weighted total of ever married women in the sample.

TABLE - 2.6

PERCENTAGE DISTRIBUTION OF EVER MARRIED WOMEN UNDER 50 YEARS OF AGE BY CURRENT MARITAL STATUS, BANGLADESH 1975,1979 AND 1981

Current marital status	BFS	CPS Year	
	1975[1]	1979[1]	1981
Currently married	88.5	92.6	90.9
Not currently married	11.5	7.4	9.1
Total	100.0	100.0	100.0

[1] Source: BFS - Bangladesh Fertility Survey,1975.
CPS - Contraceptive Prevalence Survey,1979.

TABLE - 2.8

PERCENTAGE DISTRIBUTION OF EVER MARRIED WOMEN UNDER 50 YEARS OF AGE BY AGE GROUP, BANGLADESH 1975,1979 AND 1981

Age group	BFS 1975[1]	CPS Year 1979[1]	CPS Year 1981
∠ 15	4.1	2.0	2.3
15 - 19	18.5	17.2	18.0
20 - 24	20.7	20.1	18.8
25 - 29	17.0	18.2	18.2
30 - 34	12.1	12.6	13.5
35 - 39	10.3	12.0	10.6
40 - 44	9.6	8.2	8.8
45 - 49	7.6	9.7	9.8
Total	99.9[a]	100.0	100.0

[1] Source: BFS - Bangladesh Fertility Survey,1975.
CPS - Contraceptive Prevalence Survey,1979.

[a] Total is less than 100 percent due to rounding error.

TABLE - 2.24

MEAN NUMBER OF CHILDREN EVER BORN TO EVER MARRIED WOMEN UNDER 50 YEARS OF AGE BY AGE GROUP[1]

Age group	National	Rural	Urban
/ 15	0.1	0.1	-
15 - 19	0.7	0.8	0.6
20 - 24	2.1	2.2	2.0
25 - 29	3.7	3.8	3.5
30 - 34	5.4	5.4	4.8
35 - 39	6.4	6.4	6.2
40 - 44	7.3	7.3	6.9
45 - 49	7.6	7.6	7.4
All	4.0	4.0	3.8

[1] Not stated cases for children ever born were 8 for Rural and 6 for Urban. These are excluded from the table.

TABLE - 2.25

MEAN NUMBER OF CHILDREN EVER BORN TO CURRENTLY MARRIED WOMEN UNDER 50 YEARS OF AGE BY AGE GROUP[1]

Age group	National	Rural	Urban
/ 15	0.1	0.1	-
15 - 19	0.8	0.8	0.6
20 - 24	2.2	2.2	2.0
25 - 29	3.8	3.8	3.7
30 - 34	5.5	5.5	4.9
35 - 39	6.6	6.6	6.4
40 - 44	7.5	7.5	7.1
45 - 49	8.0	8.0	7.7
All	4.0	4.0	3.9

[1] Not stated cases for children ever born were 5 for Rural and 2 for Urban. These are excluded from the table.

TABLE - 2.26

MEAN NUMBER OF CHILDREN EVER BORN TO EVER MARRIED WOMEN UNDER 50 YEARS OF AGE BY AGE GROUP, BANGLADESH 1975, 1979 AND 1981

Age group	BFS 1975[1]	CPS Year 1979[1]	CPS Year 1981
/ 15	0.1	0.1	0.1
15 - 19	0.8	0.7	0.7
20 - 24	2.4	2.1	2.1
25 - 29	4.2	3.6	3.7
30 - 34	5.7	5.0	5.4
35 - 39	6.7	6.0	6.4
40 - 44	7.1	6.5	7.3
45 - 49	6.7	6.6	7.6
All	4.0	3.7	4.0

[1] Source: BFS - Bangladesh Fertility Survey,1975.
CPS - Contraceptive Prevalence Survey,1979.

TABLE - 2.27

MEAN NUMBER OF CHILDREN EVER BORN TO CURRENTLY MARRIED WOMEN UNDER 50 YEARS OF AGE BY AGE GROUP, BANGLADESH 1975, 1979 AND 1981

Age group	BFS 1975[1]	CPS Year 1979[1]	CPS Year 1981
/ 15	0.1	0.1	0.1
15 - 19	0.9	0.8	0.8
20 - 24	2.5	2.1	2.2
25 - 29	4.3	3.6	3.8
30 - 34	5.9	5.1	5.5
35 - 39	6.9	6.2	6.6
40 - 44	7.6	6.7	7.5
45 - 49	7.3	6.8	8.0
All	4.0	3.7	4.0

[1] Source: BFS - Bangladesh Fertility'Survey,1975.
CPS - Contraceptive Prevalence Survey,1979.

TABLE - 2.28

MEAN NUMBER OF LIVING CHILDREN AMONG EVER MARRIED WOMEN UNDER 50 YEARS OF AGE BY AGE GROUP

Age group	National	Rural	Urban
/ 15	0.1	0.1	-
15 - 19	0.6	0.6	0.5
20 - 24	1.7	1.7	1.6
25 - 29	2.9	2.9	2.9
30 - 34	4.2	4.2	3.9
35 - 39	4.9	4.9	4.9
40 - 44	5.3	5.3	5.4
45 - 49	5.3	5.3	5.4
All	3.0	3.0	3.0

TABLE - 2.29

MEAN NUMBER OF LIVING CHILDREN AMONG CURRENTLY MARRIED WOMEN UNDER 50 YEARS OF AGE BY AGE GROUP

Age group	National	Rural	Urban
/ 15	0.1	0.1	-
15 - 19	0.6	0.6	0.6
20 - 24	1.8	1.8	1.7
25 - 29	3.0	3.0	3.1
30 - 34	4.2	4.3	4.0
35 - 39	5.1	5.1	5.2
40 - 44	5.6	5.5	5.6
45 - 49	5.7	5.7	5.6
All	3.1	3.1	3.2

TABLE - 2.30

MEAN NUMBER OF LIVING CHILDREN AMONG EVER MARRIED WOMEN UNDER 50 YEARS OF AGE BY AGE GROUP, BANGLADESH 1975, 1979 AND 1981

Age group	BFS 1975[1]	CPS Year 1979[1]	CPS Year 1981
/ 15	0.1	0.1	0.1
15 - 19	0.6	0.6	0.6
20 - 24	1.9	1.7	1.7
25 - 29	3.3	2.9	2.9
30 - 34	4.3	4.1	4.2
35 - 39	5.0	4.9	4.9
40 - 44	5.1	5.3	5.3
45 - 49	4.7	5.1	5.3
All	3.0	3.0	3.0

[1] Source: BFS - Bangladesh Fertility Survey,1975.
CPS - Contraceptive Prevalence Survey,1979.

TABLE - 2.31

MEAN NUMBER OF LIVING CHILDREN AMONG CURRENTLY MARRIED WOMEN UNDER 50 YEARS OF AGE BY AGE GROUP, BANGLADESH 1975, 1979 AND 1981

Age group	BFS 1975[1]	CPS Year 1979[1]	CPS Year 1981
/ 15	0.1	0.1	0.1
15 - 19	0.7	0.6	0.6
20 - 24	2.0	1.8	1.8
25 - 29	3.3	2.9	3.0
30 - 34	4.5	4.2	4.2
35 - 39	5.3	5.0	5.1
40 - 44	5.5	5.5	5.6
45 - 49	5.1	5.3	5.7
All	3.0	3.0	3.1

[1] Source: BFS - Bangladesh Fertility Survey,1975
CPS - Contraceptive Prevalence Survey,1979.

TABLE - 2.32

PERCENTAGE DISTRIBUTION OF CURRENTLY MARRIED WOMEN UNDER 50 YEARS OF AGE BY CURRENT PREGNANCY STATUS

Current pregnancy status	National	Rural	Urban
Pregnant	14.1	14.2	13.5
Not currently pregnant	85.9	85.8	86.5
Total	100.0	100.0	100.0
N	6306[a]	5713	1990

[a] Weighted total of currently married women in the sample.

TABLE - 2.33

PERCENTAGE DISTRIBUTION OF CURRENTLY MARRIED WOMEN UNDER 50 YEARS OF AGE BY CURRENT PREGNANCY STATUS, BANGLADESH 1975, 1979 AND 1981

Current pregnancy status	BFS	CPS Year	
	1975[1]	1979[1]	1981
Pregnant	12.5	13.2	14.1
Not currently pregnant	87.5	86.8	85.9[a]
Total	100.0	100.0	100.0

[1] Source: BFS - Bangladesh Fertility Survey, 1975.
CPS - Contraceptive Prevalence Survey, 1979.

[a] Includes also 'does not know' cases.

TABLE - 3.15

PERCENTAGE OF EVER MARRIED WOMEN UNDER 50 YEARS OF AGE HAVING KNOWLEDGE[1] OF AT LEAST ONE METHOD, BANGLADESH 1975, 1979 AND 1981

Year	Source[2]	Percentage
1975	BFS	81.9
1979	CPS	94.8
1981	CPS	98.2

[1] Unprompted plus prompted knowledge.

[2] Source: BFS - Bangladesh Fertility Survey, 1975.
CPS - Contraceptive Prevalence Survey, 1979 and 1981.

TABLE - 3.16

PERCENTAGE DISTRIBUTION OF EVER MARRIED WOMEN UNDER 50 YEARS OF AGE BY NUMBER OF METHODS KNOWN, BANGLADESH[1] 1979 AND 1981

No. of methods known	CPS Year 1979[2]	1981
0	5.2	1.7
1 - 4	50.1	30.4
5 +	44.7	67.9
Total	100.0	100.0

[1] Comparable data are not provided in 1975 BFS (Bangladesh Fertility Survey) Report.

[2] Source: CPS - Contraceptive Prevalence Survey, 1979.

TABLE - 3.2

PERCENTAGE OF EVER MARRIED WOMEN UNDER 50 YEARS OF AGE HAVING KNOWLEDGE[1] OF SELECTED FAMILY PLANNING METHODS, BANGLADESH 1975, 1979 AND 1981

Method	BFS	CPS Year	
	1975[2]	1979[2]	1981
Oral pill	63.9	93.1	94.5
Condom	21.1	57.3	59.2
IUD	40.1	31.8	41.7
Tubectomy	53.1	84.5	92.4
Vasectomy	51.4	71.1	71.5
Induced Abortion/ M.R.	-[a]	21.7	53.2
Injection	-	40.9	59.9
Vaginal method	-[a]	7.4	16.7
Abstinence	11.4	6.6	29.5
Safe period	20.0	11.8	36.4
Withdrawal	15.1	2.3	22.4
Other	4.9	-[b]	12.5

[1] Unprompted plus prompted knowledge.

[2] Source: BFS - Bangladesh Fertility Survey,1975.
CPS - Contraceptive Prevalence Survey,1979.

[a] These methods may be included in other.

[b] Knowledge of 'other' was not provided by 1979 CPS data.

TABLE - 4.1

PERCENTAGE OF EVER MARRIED WOMEN UNDER 50 YEARS OF AGE HAVING EVER USED FAMILY PLANNING, BANGLADESH 1975, 1979 AND 1981

Year	Source[1]	Ever used any method	Ever used[2] effective method
1975	BFS	13.6	10.0
1979	CPS	19.6	15.8
1981	CPS	35.7	20.2

[1] Source: BFS - Bangladesh Fertility Survey,1975.
CPS - Contraceptive Prevalence Survey,1979 and 1981.

[2] Effective method: Oral pill, Condom, IUD, Tubectomy, Vasectomy,induced Abortion/M.R., Injection.

TABLE - 4.7

PERCENTAGE OF EVER MARRIED WOMEN UNDER 50 YEARS OF AGE HAVING EVER USED SELECTED FAMILY PLANNING METHODS, BANGLADESH[1] 1979 AND 1981

Method	CPS Year	
	1979[2]	1981
Oral pill	11.0	13.4
Condom	3.4	6.0
IUD	0.8	1.5
Tubectomy	2.3	3.7
Vasectomy	0.9	0.8
Induced abortion/M.R.	0.1	0.6
Injection	0.5	0.9
Vaginal method	0.4	1.5
Abstinence	1.5	6.9
Safe period	4.1	16.8
Withdrawal	0.6	7.1
Other	-[a]	1.6

[1] Comparable data from 1975 BFS (Bangladesh Fertility Survey) were not available.

[2] Source: CPS - Contraceptive Prevalence Survey, 1979.

[a] The ever use rate for 'other' is not provided by 1979 CPS data.

TABLE - 5.4

PERCENTAGE OF CURRENTLY MARRIED WOMEN UNDER 50 YEARS OF AGE USING CONTRACEPTION BY BROAD CATEGORIES[1] OF METHODS AND BY AGE GROUP

Age group	No.of currently married women (Weighted)	Users by categories of methods[1]			Total users	Non-users
		Modern methods		Traditional methods		
		Permanent	Temporary			
/ 15	149	-	1.3	1.4	2.7	97.3
15 - 19	1158	0.5	4.2	4.8	9.5	90.5
20 - 24	1226	2.5	6.8	8.3	17.6	82.4
25 - 29	1195	6.0	8.6	9.2	23.8	76.2
30 - 34	881	8.5	7.8	9.0	25.3	74.7
35 - 39	643	8.9	5.9	8.4	23.2	76.8
40 - 44	518	7.5	6.2	9.7	23.4	76.6
45 - 49	535	4.1	2.2	6.2	12.5	87.5
All	6306[a]	4.8	6.1	7.7	18.6	81.4

[1] Tubectomy and vasectomy are included in Modern permanent category; all other modern methods in Modern temporary category; and all traditional methods in Traditional method category.

[a] Weighted total adds to 6305 instead of 6306 due to rounding after weighting.

TABLE - 5.5

PERCENTAGE OF CURRENTLY MARRIED WOMEN UNDER 50 YEARS OF AGE USING CONTRACEPTION BY BROAD CATEGORIES[1] OF METHODS AND BY NUMBER OF CHILDREN EVER BORN

Children ever born	No.of currently married women (Weighted)	Users by categories of methods[1]			Total users	Non-users
		Modern methods		Traditional methods		
		Permanent	Temporary			
0	790	0.1	2.3	2.3	4.7	95.3
1	833	0.3	5.5	6.7	12.5	87.5
2	806	3.2	7.7	9.1	20.0	80.0
3	704	5.8	8.5	7.7	22.0	78.0
4	642	6.7	6.2	10.0	22.9	77.1
5	595	8.8	7.1	7.8	23.7	76.3
6	541	8.3	7.1	8.5	23.9	76.1
7	423	9.5	5.7	10.0	25.2	74.8
8	360	6.3	5.9	9.0	21.2	78.8
9	234	4.2	4.7	7.5	16.4	83.6
10	168	3.6	6.0	11.5	21.1	78.9
11	101	4.9	4.9	5.9	15.7	84.3
12 +	103	6.4	8.6	10.0	25.0	75.0
Not stated	6	16.7	16.7	16.7	50.1	49.9
All	6306	4.8	6.1	7.7	18.6	81.4

[1] Tubectomy and vasectomy are included in Modern permanent category; all other modern methods in Modern temporary category; and all traditional methods in Traditional method category.

TABLE - 5.6

PERCENTAGE OF CURRENTLY MARRIED WOMEN UNDER 50 YEARS OF AGE USING CONTRACEPTION BY BROAD CATEGORIES[1] OF METHODS AND BY NUMBER OF LIVING CHILDREN

Living children	No.of currently married women (Weighted)	Users by categories of methods[1]			Total users	Non-users
		Modern methods		Traditional methods		
		Permanent	Temporary			
0	916	0.1	2.4	2.3	4.8	95.2
1	1064	0.8	5.1	6.3	12.2	87.8
2	952	4.0	7.4	8.9	20.3	79.7
3	913	6.2	8.4	9.9	24.5	75.5
4	764	8.8	5.9	8.8	23.5	76.5
5	613	9.1	8.4	7.4	24.9	75.1
6	464	8.9	5.6	10.9	25.4	74.6
7	318	6.8	5.3	8.5	20.6	79.4
8	164	3.3	7.5	11.3	22.1	77.9
9 +	138	3.8	8.1	11.3	23.2	76.8
All	6306	4.8	6.1	7.7	18.6	81.4

[1] Tubectomy and vasectomy are included in Modern permanent category; all other modern methods in Modern temporary category; and all traditional methods in Traditional method category.

TABLE - 5.7

PERCENTAGE OF CURRENTLY MARRIED WOMEN UNDER 50 YEARS OF AGE USING CONTRACEPTION BY BROAD CATEGORIES[1] OF METHODS AND BY EDUCATION

Educational level	No.of currently married women (Weighted)	Users by categories of methods[1]			Total users	Non-users
		Modern methods		Traditional methods		
		Permanent	Temporary			
Never attended school	4284	4.9	3.7	6.3	14.9	85.1
Less than primary level	1122	4.3	8.1	8.5	20.9	79.1
Completed primary level	452	5.3	9.1	10.6	25.0	75.0
Class VI-VII	186	5.9	13.7	16.4	36.0	64.0
Class VIII-IX	143	3.6	21.3	15.0	39.9	60.1
SSC and HSC	95	2.1	35.8	16.8	54.7	45.3
Degree and above	12	2.4	39.3	21.6	63.3	36.7
Not stated	11	-	5.2	26.1	31.3	68.7
All	6306[a]	4.8	6.1	7.7	18.6	81.4

[1] Tubectomy and vasectomy are included in Modern permanent category; all other modern methods in Modern temporary category; and all traditional methods in Traditional method category.

[a] Weighted total adds to 6305 instead of 6306 due to rounding after weighting.

TABLE-5.8

PERCENTAGE OF CURRENTLY MARRIED WOMEN UNDER 50 YEARS OF AGE USING CONTRACEPTION BY BROAD CATEGORIES[1] OF METHODS AND BY EMPLOYMENT STATUS AND BY RELIGION

Sub-group	No.of currently married women (Weighted)	Users by categories of methods[1]			Total users	Non-users
		Modern methods		Traditional methods		
		Permanent	Temporary			
Employment Status:						
Paid employment	449	7.6	9.1	10.0	26.7	73.3
Unpaid employment	138	9.4	1.6	11.5	22.5	77.5
Not employed	5717	4.5	6.0	7.4	17.9	82.1
Not stated	2	-	-	-	-	100.0
Religion:						
Muslim	5436	4.0	6.0	7.3	17.3	82.7
Non-muslim	870	9.9	6.7	10.2	26.8	73.1
All	6306	4.8	6.1	7.7	18.6	81.4

[1] Tubectomy and vasectomy are included in Modern permanent category; all other modern methods in Modern temporary category; and all traditional methods in Traditional method category.

TABLE - 5.9

PERCENTAGE OF CURRENTLY MARRIED WOMEN UNDER 50 YEARS OF AGE USING CONTRACEPTION BY BROAD CATEGORIES[1] OF METHODS AND BY NUMBER OF METHODS KNOWN

Number of methods known	No.of currently married women (Weighted)	Users by categories of methods[1]			Total users	Non-users
		Modern methods		Traditional methods		
		Permanent	Temporary			
0	99	-	-	-	-	100.0
1	207	0.6	0.6	1.0	2.2	97.8
2	370	0.8	0.6	0.6	2.0	98.0
3	562	2.5	1.3	2.5	6.3	93.7
4	725	2.5	1.5	3.1	7.1	92.9
5	832	3.3	3.2	4.6	11.1	88.9
6	830	4.7	5.1	6.0	15.8	84.2
7	776	6.7	6.1	7.6	20.4	79.6
8	725	7.5	9.8	9.9	27.2	72.8
9	515	8.7	10.5	16.3	35.5	64.5
10	336	6.8	17.7	20.5	45.0	55.0
11	249	7.3	18.7	21.0	47.0	53.0
12	79	6.6	23.5	26.4	56.5	43.5
All	6306[a]	4.8	6.1	7.7	18.6	81.4

[1] Tubectomy and vasectomy are included in Modern permanent category; all other modern methods in Modern temporary category; and all traditional methods in Traditional method category.

[a] Weighted total adds to 6305 instead of 6306 due to rounding after weighting.

TABLE - 5.10

PERCENTAGE OF CURRENTLY MARRIED WOMEN UNDER 50 YEARS OF AGE USING CONTRACEPTION BY BROAD CATEGORIES[1] OF METHODS AND BY LAND OWNERSHIP

Land ownership	No.of currently married women		Users by categories of methods[1]			Total users	Non-users
	Unweighted	Weighted	Modern methods		Traditional methods		
			Permanent	Temporary			
National:							
Own land	4877	4239	3.5	6.7	8.5	18.7	81.3
Does not own land	2826	2067	7.4	4.9	6.1	18.4	81.6
All	7703	6306	4.8	6.1	7.7	18.6	81.4
Rural:							
Own land	3968	-	3.4	5.9	8.5	17.8	82.2
Does not own land	1745	-	7.5	3.5	6.0	17.0	83.0
All	5713	-	4.6	5.2	7.7	17.5	82.5
Urban:							
Own land	909	-	5.5	18.5	8.9	32.9	67.1
Does not own land	1081	-	7.2	12.3	6.6	26.1	73.9
All	1990	-	6.4	15.1	7.7	29.2	70.8

[1] Tubectomy and vasectomy are included in Modern permanent category; all other modern methods in Modern temporary category; and all traditional methods in Traditional method category.

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TABLE - 5.11

PERCENTAGE OF CURRENTLY MARRIED WOMEN UNDER 50 YEARS OF AGE CURRENTLY USING CONTRACEPTION BY BROAD CATEGORIES[1] OF METHODS AND BY DIVISION AND BY URBAN-RURAL AREA

Sub-group	No.of currently married women (Weighted)	Users by categories of methods[1]			Total users	Non-users
		Modern methods		Traditional methods		
		Permanent	Temporary			
Division:						
Rajshahi	1453	3.7	9.6	6.6	19.9	80.1
Khulna	1409	5.7	6.1	8.7	20.5	79.5
Dacca	1924	6.8	5.7	7.2	19.7	80.3
Chittagong	1520	2.4	3.4	8.5	14.3	85.6
Area:						
Urban	1990[a]	6.4	15.1	7.7	29.2	70.8
Rural	5713[a]	4.6	5.2	7.7	17.5	82.5
All	6306	4.8	6.1	7.7	18.6	81.4

[1] Tubectomy and vasectomy are included in Modern permanent category; all other modern methods in Modern temporary category; and all traditional methods in Traditional method category.

[a] Unweighted total.

TABLE - 6.1

PERCENTAGE DISTRIBUTION OF CURRENT USERS OF MODERN[1] FAMILY PLANNING METHODS BY REPORTED SOURCE OF SUPPLY/SERVICE

Source of supply/service	National	Rural	Urban
Government Family Planning Worker	24.9	28.0	11.0
Government Health Worker	0.9	1.1	
Other Voluntary Agency Worker	1.7	1.8	1.2
Government Family Planning/Health Clinic	49.1	51.4	38.9
Non-Government Clinic	4.1	3.9	4.9
Commercial Source	17.1	11.6	41.0
Not stated	0.6	0.7	0.2
Don't know	1.7	1.4	2.8
Total	100.1[a]	99.9[a]	100.0
N	688[b]	560	429

[1] Modern method: Oral pill, Condom, IUD, Tubectomy, Vasectomy, Induced abortion/M.R., Injection, Vaginal method.

[a] Total does not add to 100 percent due to rounding error.

[b] Weighted total of current users in the sample.

TABLE - 6.2

PERCENTAGE DISTRIBUTION OF CURRENT USERS OF NON-CLINICAL[1] FAMILY PLANNING METHODS BY REPORTED SOURCE OF SUPPLY

Source of supply	National	Rural	Urban
Government Family Planning Worker	49.6	59.2	17.0
Government Health Worker	0.9	1.2	
Other Voluntary Agency Worker	2.8	3.5	0.4
Government Family Planning/Health Clinic	9.7	9.6	10.0
Non-Government Clinic	0.4	0.4	0.4
Commercial source	33.8	23.8	67.6
Not stated	0.6	0.8	-
Don't know	2.2	1.5	4.6
Total	100.0	100.0	100.0
N	337[a]	260	259

[1] Non-clinical method: Oral pill, Condom, Vaginal method.

[a] Weighted total of current users of non-clinical family planning methods in the sample.

TABLE - 6.3

PERCENTAGE DISTRIBUTION OF CURRENT USERS
OF CLINICAL FAMILY PLANNING METHODS
BY REPORTED SOURCE OF SERVICE

Source of service	National	Rural	Urban
Government Family Planning Worker	1.1	1.0	1.8
Government Health Worker	0.9	1.0	-
Other Voluntary Agency Worker	0.6	0.3	2.4
Government Family Planning/Health Clinic	87.0	87.7	83.0
Non-Government Clinic	7.7	7.0	11.7
Commercial source	0.9	1.0	0.6
Not stated	0.7	0.7	0.6
Don't know	1.1	1.3	-
Total	100.0	100.0	100.1[a]
N	351[b]	300	170

[a] Total is more than 100 percent due to rounding error,

[b] Weighted total of current users of clinical family planning methods in the sample.

TABLE - 6.4

PERCENTAGE DISTRIBUTION OF CURRENT USERS OF A NON-CLINICAL[1] FAMILY PLANNING METHOD BY REPORTED SOURCE OF SUPPLY

Source of supply	Oral pill	Con-dom	Vaginal method
Government Family Planning Worker	54.8	42.4	25.3
Government Health Worker	-	2.0	5.5
Other Voluntary Agency Worker	3.6	1.0	-
Government Family Planning/Health Clinic	9.1	9.2	19.8
Non-Government Clinic	0.6	-	-
Commercial source	29.9	41.4	40.6
Not stated	-	2.0	-
Don't know	1.8	2.0	8.9
Total	100.0	100.0	100.1[a]
N[b]	221	98	18

[1] Non-clinical method: Oral pill, Condom, Vaginal method.

[a] Total is more than 100 percent due to rounding error.

[b] Weighted total of current users of a non-clinical family planning method in the sample.

APPENDIX G

OPERATIONS RESEARCH PROJECTS COMPLETED

SINCE THE 1980 PROGRAM EVALUATION*

1. An Economic Evaluation of the Operation (working) of the Union Family Welfare Centers of Ghatail Thana under Tangail Thana District and Those in Some Other Thanas of Bangladesh.

   Dr. Muhommad Kaysar Hussain, Professor, Depart. of Economics
   Jahangirnagar University
   Savar, Dacca
   May 1978 - November 1980.

2. Determinants of the Utilization of Maternal and Child Health.

   Dr. Shafiqur Rahman, Director
   Biomedical Research and Training
   NIPORT. October 80 - 81.

3. Supervisory Roles of Thana Family Planning Officers, Family Planning Assistants and Local Formal Leaders.

   Dr. Ghyasuddin Ahmed and Mr. Prodip Kumar Muhiri
   July 1980 - February 1982.

4. The Effect of Traditional Birth Attendants (TBA) and Tetanus Toxoid in Reduction of Neonatal Mortality.

   Dr. Shafiqur Rahman, Director
   Biomedical Research and Technical Training
   NIPORT, August 1978 - August 1981.

5. Development of a More Cost-Effective Family Planning Delivery System.

   Association for Survey and Programming Systems (ASAPS)
   April 1978 - March 1980
   (Final report submitted March 1981)

6. Development of Safe Anaesthesia Practice in Voluntary Surgical Contraception.

   Dr. Azizur Rahman, Director
   BAVS
   April 1982 - June 1982

*Source: A Review of Study Objectives and Reported Findings of Completed Operations Research Projects 1978 - 1982. Prepared by Sk. Ali Noor, Program Analyst, USAID/Dacca. Revised May 1982.

APPENDIX H

REORGANIZATION OF THANA ADMINISTRATION

(November 7, 1982)

The Government of Bangladesh has reorganized the Thana Administration as a whole, and the same has been implemented in forty-five Thanas on November, 1982; and by August, 1983 all the Thanas will stand upgraded and reorganized. In the new set-up there is a Thana Council with an elected Chairman who is the Chief of the set-up. The Thana Health Administrator (THA) has been redesignated as the Thana Health and Family Planning Officer (TH & FPO) and will be responsible for Health and Family Planning activities. The Thana Family Planning Officer (TFPO) will work under the supervision of the TH & FPO. A post of an Assistant TFPO has been created. In other words, the administration has been decentralized and it will be headed by the people's representative at the Thana level. A photo copy of the relevant pages are enclosed, as you may like to be up-to-date with this information.

[*Published in the Bangladesh Gazette, Extraordinary, dated the 23rd October, 1982.*]

GOVERNMENT OF THE PEOPLE'S REPUBLIC OF BANGLADESH
CHIEF MARTIAL LAW ADMINISTRATOR'S SECRETARIAT

Cabinet Division

No. DA-12(26)/82-449, dated Dhaka, the 23rd October, 1982.

RESOLUTION

SUBJECT: Reorganisation of the Administration at the Thana level.

Government has decided to reorganise the Administration at the Thana level. Under this reorganised set up each thana will be the focal point of all administrative activities. Responsibility for all development activities at the local level shall be transferred to the Thana Parishad. For the present Government will retain the direct responsibility for regulatory functions and major development activities of national and regional coverage as illustrated at Annexure-I.

2. The services of officers dealing with subjects transferred to the Thana Parishad will be deemed to have been placed at the disposal of the Thana Parishad and they will be accountable to the respective Thana Parishad. Government and respective Departments however will continue to be responsible for the appointment, transfer, promotion, discipline and remuneration of these officers.

3. The officers dealing with the subjects retained by the Government will be answerable to the Thana Parishad. The Thana Parishad will be competent to call for report from these officers on their activities and also summon them for hearing. Thana Parishad will also be entitled to cause inspection of their offices and report to Government on any lapse in the discharge of their duties which may come to the notice of the Parishad. Thana Parishad will also provide the necessary assistance to enable these officers to function effectively in the Thanas.

4. The organisational chart of the reorganised Thana Administration and the charter of duties of the officers named in the chart may be seen at Annexure-II.

5. The reorganised administrative set up will be introduced in phases. In the first phase 45 thanas will be brought under the reorganised administrative set up with effect from 7th of November, 1982. The list of these thanas is at Annexure-III. These thanas will cease to be part of subdivisional administration and will function directly under district administration.

6. Till such time, Chairmen of Thana Parishads are elected, the Thana Commissioners will act as the Chairmen of the Thana Parishads. Necessary amendment in the legislation is being made.

By order of the
Chief Martial Law Administrator

(M. M. ZAMAN)
Cabinet Secretary.

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CHARTER OF DUTIES
THANA ~~COMMISSIONER~~ EXECUTIVE OFFICER

1. He will be staff officer to the elected Chairman of Thana Parishad who will be the Chief Executive of Thana. He will also be the chief executive officer of the Thana Parishad, shall be responsible to the Chairman of Thana Parishad and assist him in implementation of policies and decisions of the Thana Parishad.

2. Assist the Chairman in supervising all Thana level development and administrative work.

3. Assist the Parishad in preparing a co-ordinated development plan of the Thana and ensure its execution.

4. Exercise preventive jurisdiction of a First Class Magistrate under sections 133, 144 and 145 of Cr.P.C. in order to maintain law and order in the Thana area.

5. Initiate Annual Confidential Report of all Thana level officers except Magistrate—Munsiff. The Chairman Thana Parishad will be the countersigning officer. District officers of respective departments will be the technical reporting officers of Thana officers.

6. Attend emergency duties, such as relief duties following natural calamities. receive stores including food and distribute relief materials as directed by Thana Parishad.

7. Protocol duties.

8. Supervise and control revenue and budget administration of the Thana.

9. Ensure that the Government directives on Thana administration are followed.

10. Co-ordinate all Thana level training activities.

11. Act as Treasury Officer.

12. Perform such other functions as may be entrusted to him by the Government or the Thana Parishad Chairman or as may be conferred on him by the Government under any law.

CHARTER OF DUTIES
THANA HEALTH AND FAMILY PLANNING OFFICER

1. He will work under the guidance of Thana Parishad as co-ordinated by Thana ~~Commissioner~~. Executive Officer.

2. He is responsible for all clinical and technical supervision and guidance to all professional and technical personnel to ensure optimum service to both out-patient and inpatient departments

3. He is directly responsible for implementation of all operation cases and operation activities in the field of Family Planning (Ligation and Vasectomy).

4. He has the managerial and administrative responsibility to ensure proper maintenance of the Thana Health Complex including its outpatient department, wards and OT, laboratory and kitchen, etc.

5. He will assign specific duties and responsibilities to his subordinate officers.

6. The Medical Officers should be allocated defined geographical area of responsibility covering specified number of unions and villages which they should visit as a routine and hold Family Planning camps on fixed schedules with occasional unscheduled supervisory visit.

7. He will ensure that Thana level supervisors, officers working under him, contact the Union Parishad schools and specific representative groups to ascertain their health needs and demands and follow up previously noted needs by regularly inspecting the areas.

8. He will ensure that Family Planning programme fully implemented in his area.

9. He will monitor the two way referral and information pathways and logistic systems between the Thana Health Complex and villages and ensure the implementation of Health programme.

10. He will visit the Unions and villages regularly to acquaint himself with the problems and achievements of Health and Family Planning activities.

11. He is responsible to discharge Health and Family Planning programme through Primary Health care service which include:-

a. Communicable disease control.
b. Expanded immunization programme.
c. Family planning.
d. Maternity and child health care.
e. Prevention and control of locally endemic diseases.
f. Health education and training.
g. Improvement of water.
h. Provision of first aid.

CHARTER OF DUTIES
THANA EDUCATION OFFICER

1. He will work as the chief functionary of the Ministry of Education at Thana level and will work under the guidance of Thana Parishad as co-ordinated by Thana ~~Commissioner~~. Executive Officer.

2. He will be responsible for the execution of all directives related to primary education and work under the direction of Primary Education Officer/Area Project Officer.