

# A.I.D. EVALUATION SUMMARY PART I

PD-AAV-609  
50106

(BEFORE FILLING OUT THIS FORM, READ THE ATTACHED INSTRUCTIONS)

**A. REPORTING A I.D. UNIT**  
(Mission or AID/W Office)  
USAID Mission to  
Bangladesh  
(ES 7)

**B. WAS EVALUATION SCHEDULED IN CURRENT FY ANNUAL EVALUATION PLAN?**  
yes  slipped  ad hoc

**C. EVALUATION TIMING**  
interim  final  ex post  other

**D. ACTIVITY OR ACTIVITIES EVALUATED** (List the following information for project(s) or program (s) evaluated; if not applicable, list title and date of the evaluation report.)

Project #	Project/Program Title (or title & date of evaluation report)	First PROG or equivalent (FY)	Most recent P&C (mo/yr)	Planned LOP Cost ('000)	Amount Obligated to Date ('000)
Bangladesh 388-0050	Evaluation of the Non-Governmental Organizations Component of the Family Planning Services Project USAID, Bangladesh	1981	Sept. 1989		

**E. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR**

Action(s) Required	Name of officer responsible for Action	Date Action to be Completed
1. Institutionalize the programming and budgeting of subprojects in cycles to reduce management burdens of USAID, the CAs and their subprojects.	S. Anderson S. Epstein	completed
2. Design and implement internal evaluation systems for CAs to assist both USAID and the CAs in program management.	S. Anderson	completed
3. USAID and AVSC assist BAVS to (1) diversify clinical family planning services and (2) study the duplication of BAVS/FPAB services at 15 sites and plan a strategy for eliminating the duplication.	S. Anderson	September 1987
4. USAID explore sources of funding support for reactivating the Family Planning Council of Voluntary Organizations (FPCVO) as a strong body to work with the NGOs on issues constraining their work or otherwise affecting their full contribution to the national program.	S. Epstein/ S. Anderson	completed
5. CAs, on an experimental basis, will channel subproject grants through local officials in rural areas to promote NGO/government coordination.	S. Epstein/ S. Anderson	June 1988

(Attachments, if necessary)

**F. DATE OF MISSION OR AID/W OFFICE REVIEW OF EVALUATION** no 3 day 5 year 1986

**G. APPROVALS OF EVALUATION SUMMARY AND ACTION DECISIONS:**

Signature Typed Name Date	Project/Program Officer <i>Sigrud Anderson</i> Sigrud Anderson P&H/Office, Dhaka	Representative of Borrower/Grantee John McWilliam Director, POPTech. ISTI	Evaluation Officer <i>Turra Bethune</i> Turra Bethune USAID/Dhaka	Mission or AID/W Office Director <i>J.R. Westley</i> J.R. Westley Director
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CONTINUATION OF PART 1, SEC.E

E. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR Action(s) Required see attachment	Name of Officer responsible for Action	Date Action to be completed
6. Replicable subproject innovative activities will be encouraged, identified, documented and shared with other NGOs and the government.	S. Anderson	completed
7. The CAs will continue to (1) limit proliferation of small sub projects and (2) concentrate on strengthening their central support systems, e.g., logistics, training, supervision, MIS and so forth.	S. Anderson	completed
8. Urban area service gaps will be identified and service coverage instituted.	S. Anderson	completed
9. Guidelines for the expansion of NGO activities into the rural areas will be developed with the BDG.	S. Anderson	completed
10. MIS of all CAs will be simplified and standardized amongst them to allow comparability between programs and to facilitate monitoring and evaluation.	S. Epstein/ M. vanlandnigham	Jan. 1988
11. Analyze cost effectiveness of the CAs and review CA interest in income-generating activities to promote self-financing of services. Documentation and reporting on self-financing activities will be clarified.	S. Epstein/ A. Kantner/ M. vanlandnigham	May 1988
12. Undertake educating religious leaders and elected local government officials at the sub-district and union level. Explore the possibility of training Parliamentarians.	S. Anderson	completed

EVALUATION ABSTRACT

USAID has supported NGO activities in Bangladesh for more than a decade through various centrally funded grants and contracts. Since 1981, bilateral funding for these NGO family planning efforts were incorporated into a separate component under the large 5-year Family Planning Services Project. As the project was designed, USAID signed cooperative agreement grants with four international NGOs and provided bilateral funding for two national NGOs. They were: The Asia Foundation, (TAF); the Association for Voluntary Surgical Contraception (AVSC), Family Planning International Assistance, (FPIA), the Pathfinder Fund, (PF); and Family Planning Association of Bangladesh (FPAB); and the Family Planning Services Training Center, (FPSTC), respectively.

USAID contracted for a team to perform an end-of-project evaluation to be included in the overall FPS Project evaluation, and preparatory to drafting a new follow-on project, Family Planning Health Services Project for FY'87-91. A three member team evaluated the project from January 16 - February 14, 1986, against general and particular criteria in the scope of work. To prepare their final report, they scrutinized appropriate files and records, studied the current hand judgements of sub-project management of contraceptive service delivery.

Overall, they found that the NGO component of the Family Planning Services Project was functioning very well. The NGO strategy was sufficiently comprehensive to cover NGO activities through FY 1988. Also, since the Government of Bangladesh, (BDG), has acknowledged the contribution of NGO efforts in reducing fertility in the urban and semi-urban areas, the former ban on NGO expansion into the rural areas has been lifted. The majority of the findings and conclusions focused on strengthening and standardizing the administrative oversight of USAID and the six Cooperating Agencies (CAs). Recommendations focus on alleviating the management burdens of the project so it can function more efficiently in preparation for the additional and more difficult responsibility of expansion of service delivery into the rural areas. The team provided conscientiously detailed critiques of each NGO program and discussed the interactions and issues shared in common by the NGOs, USAID, and NGO subprojects, and recommended continuation of the NGO component with certain management improvements. To date, the NGO component has 81 projects at 297 sites. (August 1986).

I. EVALUATION COSTS

1. Evaluation Team

Name	Affiliation	Contract Number OR TDY Person Days	Contract Cost OR TDY Cost (US\$)	Source of Funds
1. Miriam Labbok	ISTI			
2. Sallie Craig Huber	ISTI	114.15 days	\$ 82,109.64	USAID/Dhaka, Bangladesh PIO/T:50029 App:72-1151021-4 Budget plan code:HDAA-85-27388- G-BG-13 ISTI
3. Ellen Blair	"			Assignment No. 85-65
2. Mission/Office Professional Staff Person Days (estimate)	50 days (Approx)	3. Borrower/Grantee Professional Staff Person-Days (estimate)		

# Summary of Evaluation Findings, Conclusions and Recommendations

## NAME OF OFFICE

Office of Population and Health, USAID/Bangladesh.

## PURPOSE OF ACTIVITY(IES) EVALUATED

The purpose of the NGO component to the Family Planning Services Project was to assist the Bangladesh Government (BDG) in its own program of increasing the contraceptive prevalence rate, through private sector service delivery of modern contraceptive methods, which would reduce fertility, lower the crude birth rate, and attempt to address more readily the BDG's primary demographic priority. Six national and international NGOs - the Asia Foundation, BAVS, FPAB, FPIA, FPSTC, and Pathfinder - administer 81 projects at 297 sites (as of August 1986), in the urban, semi urban, and several rural areas of Bangladesh.

## PURPOSE OF THE EVALUATION AND METHODOLOGY USED:

The purpose of the evaluation was:

- 1) to measure project achievements to date against project strategy and goals, and incorporate the results of this NGO component into an end-of-project evaluation of a larger umbrella Family Planning Services Project;
- 2) to investigate appropriate records of 6 Cooperating Agencies, at home offices and field sites, to document achievements;
- 3) to examine perceived implementation constraints to effective and timely community based distribution (CBD) service delivery in NGO project areas;
- 4) to critique the quality of services and the coverage provided by NGO outreach in the assigned urban and semi-urban areas;
- 5) to probe the working administrative relationships and appropriate accountabilities among USAID, the CAs, the field project managers, to support program and BDG goals;
- 6) to calculate the cost-effectiveness of NGO field workers to provide quality contraceptive delivery and referral services;
- 7) to analyze the contribution of the NGO component of the FPS Project to influence family planning policy of the MOHPC and contribute to increasing contraceptive prevalence of modern methods;
- 8) to evaluate training needs as a way to improve and upgrade CA and NGO professional performance;
- 9) to assess NGO operations that could lead to improved consolidation, continued innovation, encouraged expansion, enhanced evaluation, and possibly alternative strategies in the immediate future as the CAs anticipate rural responsibilities.

Date Summary Prepared: May 1987

The evaluation team prepared their final report by applying the following methodology. They reviewed all relevant files, documents, NGO reports, and earlier evaluation reports; interviewed appropriate USAID officers, MOHFP national and upazila officers, site project managers, CA and project field workers; and conducted site visits to 54 NGO project areas. After performing the above, the team prepared a draft report which was critiqued by the Mission which, in turn, required the evaluation team to redraft their original findings, conclusions and recommendations, and resubmit a final report in mid-December 1986.

## FINDINGS

-The NGO program covers 75 to 80% of the 81 municipal areas of the country. FP services have increased by 11% since 1981 and, by 1985, the program was providing services to 25% of the active contraceptive users in the country. Although the ban on NGO project expansion to the rural areas is withdrawn, there are still some gaps and overlapping of NGO services in the urban areas.

-Within the program, a centralized NGO logistics and supply system was established through one of the six cooperating CAs. As a result, supplies are provided on a more regular basis.

-A critical problem exists in inaccurate reporting of project CPR service statistics, inappropriate standard denominators for measurement, and complicated and cumbersome reporting requirements.

-Consolidation of the numerous sub-projects and a lengthened planning and budgeting cycle has reduced the management burden of the program; however, at the subproject level (a) there is often disagreement between paid administrative staff and volunteer board members and staff, (2) paid staff often lack clear mandates from headquarters for program development, (3) some managers and CBD fieldworkers are reticent to act independently and confidently in implementing their own program ideas, and (4) there is need for daily supervision of clinic and field staff to provide encouragement and feedback

-There is no standardized criteria for CA subproject staff selection.

## CONCLUSIONS

NGOs should continue their FP services with limited expansion into the rural areas. Service gaps and overlapping should be avoided with better planning and coordination.

As the program expands into the rural areas, the logistic and supply system will require additional efforts to enable it to continue to effectively support NGO services.

NGO project record keeping and reporting systems need simplification and standardization.

The use of volunteers helps increase coverage and reduce costs but they need to be involved in program responsibilities including decision making.

CAs should be encouraged to adopt innovative strategies for delivering FP services as well as adoption of income generating projects to support service delivery.

The CAs are encouraged to help fieldworkers share experiences and stimulate interest through a regular newsletter and opinion leader training.

Staff selection criteria may be less important to competent job performance than appropriate training, good management and supervisory practices, and adequate reporting and record keeping systems

## FINDINGS

-In "integrated" FP/MCH projects, family planning needs to be seen as an important part of MCH care and not as a secondary activity. Some of these subprojects duplicate MCH services available in the same area.

-Training needs have outstripped capacity for training major cadres of workers, parttime agents and community leaders at all levels. NIPORT, a government training facility, is mandated to be responsive to NGO training needs, but NIPORT has neither the trainers nor the curriculum or production capability to help meet NGO training needs. As a result, all NGO training has been done either in-house or by contracting with another NGO. The CAs, with USAID assistance, have formed the CA Coordinating Committee for Training (CCT) for identifying CA training needs and CA training agencies.

-Within the NGO program, the Bangladesh Association for Voluntary Sterilization (BAVS) program is the most cost-effective (Simmons, et al) per couple year of protection (CYP). In the older, more mature CA programs, costs per CYP have declined.

-BAVS clinics are not providing alternative methods to clients ineligible for voluntary surgical contraception because of medical or other contraindications.

## CONCLUSIONS

CAs should encourage subprojects which already have MCH services linked to FP services to find out what MCH services exist in their areas so as not to duplicate services.

CAs are encouraged to determine (1) better ways to link services and record keeping systems, and (2) whether preferential treatment should be provided for FP clients who use MCH services as a way to link services in the minds of clients and staff.

The CAs are commended for forming the CCT with Pathfinder serving as Secretariat. The CCT is urged to assure that any guidelines concerning medical protocols be reviewed, updated, and distributed regularly. USAID should provide TA to the CCT and help maintain a library to house relevant resource materials and updates.

Any subproject's paid medical practitioner, whether physician or paramedic, must be fully trained and motivated to promote and provide FP services.

CAs should compare costs among themselves and plan for anticipated budgetary needs for expansion into the rural areas.

Since the CAs are willing to explore and develop self-reliant schemes, they need to work out details according to USAID regulations.

BAVS needs to provide alternative contraceptive methods to those clients unable to undergo voluntary sterilization.

## FINDINGS

-There is insufficient coordination between the NGO community and the government to maximize FP service coverage.

-CBD follow-up services need further attention and effort, especially regarding clients with overaged Copper T IUDs.

-Additional data collection and analysis is needed to seek out and test innovative service delivery ideas, effectiveness of interventions, and for development of protocols.

## CONCLUSIONS

The national program of FP will benefit if the NGO community works with the government to maximize coverage with contraceptive services.

The CAs must make all possible efforts--at headquarters and field levels--to maintain, strengthen, and establish coordination with subdistrict and district level government officials.

CBD follow-up practices need to be studied to find the optimal follow-up schedule for client and field-worker staff.

The CAs are urged to locate IUD clients to offer proper follow-up services.

Innovative projects need to be studied and evaluated for replication. Step-by-step implementation plans should be developed and shared with other CAs.

Child Survival funds should be used to collect existing information on MCH, and MCH/FP activities to determine which MCH interventions have the greatest impact on fertility in the short run.

If studies prove the feasibility of MCH interventions with FP service models, then specific protocols should be developed jointly by USAID and the CAs to determine which interventions can be added to what type of subproject.

Selected CA innovations need assessment through OR studies to explore such questions as:

- (1) is non-geographic coverage of a target audience allowable;
- (2) what should constitute the daily schedules/workload of fieldworkers;
- (3) which projects focus on special groups;
- (4) how can one work with illiterate distributors; and
- (5) how successful are depot holders for resupplying clients?

## RECOMMENDATIONS

### Major recommendations are:

1. USAID should continue to support the FP activities of the CAs.
2. The CAs should continue the ongoing shift in emphasis from proliferation of small subprojects to strengthening their central support systems.
3. USAID should explore funding to reactivate the Family Planning Council of Voluntary Organizations (FPCVO) as a strong body to work with the NGOs on issues constraining their work or otherwise affecting their full contribution to the national program.

### Other recommendations include:

1. Identify and fill FP service gaps in urban areas and develop guidelines, with the government, for the expansion of NGO activities in rural areas.
2. CAs consider, on an experimental basis, channeling a few subproject grants through the newly elected local officials in rural areas to promote coordination between NGOs and the government in the provision of FP services.
3. Continue the use of programming subprojects in cycles to reduce the management burdens at USAID, the CAs, and their subprojects.
4. Standardize and simplify MIS for greater comparability between CA programs and to reduce staff time spent on paper work.
5. To assist both USAID and the CAs in program management, establish internal evaluation systems within the CAs.
6. Document the results of innovative project activities undertaken by CAs and emphasize their replication.
7. Continue to analyze the cost-effectiveness of the CAs and explore the possibility of developing financing schemes for self-reliant which adhere to USAID regulations.
8. Continue to support coordination of CA training efforts and activities.
9. Undertake an analysis of the BAVS/fpab duplication of services at 15 sites, where both BAVS and FPAB have VS clinics.
10. Assist BAVS to undertake strategic planning for future activities like gradual introduction of the contraceptive implant (Norplant).
11. BAVS clinical facilities should be also used for IUD and injectable contraceptive services.
12. FPAB should continue to manage the CA commodity distribution program.
13. Place more emphasis on educating religious leaders and newly-elected upazila and union officials. Parliamentarians may also be a target group for training.

## LESSONS LEARNED

- 1) NGOs supported by USAID in Bangladesh have demonstrated administrative and managerial competence to cover urban and semi urban areas with quality contraceptive delivery services and in many cases MCH services as well;
- 2) Conscientious monitoring of subprojects by CA project officers with USAID support provides and appropriate balance of administrative oversight and technical assistance;
- 3) Bangladeshi NGO subprojects can competently provide CBD services and contribute to the government's goal of fertility reduction;
- 4) Perceptive planning, with comprehensive development strategies and periodic evaluations, offer a targeted and cost-effective way to anticipate the growing diversity of NGO needs and for working towards providing an adequate response;
- 5) Innovative pilot subprojects in the private sector can thrive in resource poor countries, like Bangladesh, when all supporters involved, - the CAs, USAID, and BDG - work toward a common goal;
- 6) Volunteers and semi-professional staff, when adequately trained and motivated, can implement field projects, provide appropriate evaluative feedback, and make contributions to NGO policy;

**ATTACHMENTS** (List attachments submitted with this Evaluation Summary) always attach copy of full evaluation report, even if one was submitted earlier)

The executive summary of the report of Evaluation of the Non-Governmental Organizations Component of the Family Planning Services Project is attached. (The complete report is on file in P&H USAID/Dhaka and ANE/TECH/HPN, AID/W.)

**MISSION COMMENTS ON FULL REPORT**  
**COMMENTS BY MISSION, AID/W OFFICE AND BORROWER/GRANTEE**

The referenced evaluation was conducted by a three-member team from January 16 to February 14, 1986. This was an end of project evaluation of the NGO component of the overall Family Planning Services Project (FPSP). There was some confusion over the findings and recommendations of the evaluation team as the statements appeared to be contradictory to the evaluation findings. This necessitated some additional work by one of the NGO Evaluation Team Members during the evaluation of the overall FPSP. However, the Mission is satisfied with the end results of the evaluation and a couple of specific recommendations have already been implemented and some are in on-going/continuing status as mentioned under part I, item E of PES.

Prepared for:

Office of Population  
Bureau for Science and Technology  
Agency for International Development  
Washington, DC  
Under Contract No. DPE-3024-C-00-4063-00  
Project No. 936-3024

EVALUATION OF THE NON-GOVERNMENTAL  
ORGANIZATIONS COMPONENT OF THE  
FAMILY PLANNING SERVICES PROJECT:  
USAID/BANGLADESH

by

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January 16 - February 14, 1986

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- B Major Issues for the NGO Evaluation
- C Interview Forms for Evaluation Field Visits
- D Persons Met/Site Visits
- E Summary of Site Visit Interviews
- F USAID/Bangladesh Population Sector NGO Strategy (1985-1988)
- G CAs Objectives, Strengths and Strategies/Plans
- H Central Support Systems and Processes for Each Cooperating Agency
- I USAID/NGO Cooperative Agreement Budgets
- J GOB Circular on NGOs
- K USAID/NGO Service Statistics Reporting Forms
- L Suggestions for Measuring Project Impact Based on Contraceptive Prevalence Calculations
- M BAVS Reporting System for 1986
- N FP Field Worker Concerns (by Pathfinder's Rangpur CBD Worker--Fancy Das)

GLOSSARY

AID/W	Agency for International Development/Washington (as distinct from USAID--see below)
AVSC	Association for Voluntary Surgical Contraception
BACE	Bangladesh Association for Community Education
BAVS	Bangladesh Association for Voluntary Sterilization
BFPA	Bangladesh Family Planning Association (Since this report was written, this organization has changed its name to the Family Planning Associa- tion of Bangladesh--FPAB. The acronym BFPA, however, will be used throughout this report.)
BFRP	Bangladesh Fertility Research Program
CA	Cooperating Agency (used herein to refer to the six NGOs funded under the FPSP. All others are referred to as NGO's)
CBD	Community-based distribution
CCT	Coordination Committee for Training
CEA	Cost effectiveness analysis
CPR	Contraceptive prevalence rate
CPS	Contraceptive Prevalence Survey
CWFP	Concerned Women for Family Planning
CYP	Couple years of protection
DDFP	District Director of Family Planning
FP	Family planning
FPCVO	Family Planning Council of Voluntary Organizations
FPIA	Family Planning International Assistance
FPSP	Family Planning Services Project
FPSTC	Family Planning Services and Training Center

FWA	Family Welfare Assistant
GOB	Government of Bangladesh
ICDDR,B	International Center for Diarrheal Disease Research, Bangladesh
IPPF	International Planned Parenthood Federation
IUCW	International Union for Child Welfare
IUD	Intrauterine device
MCH	Maternal and child health
MIS	Management information system
MO	Medical Officer
MOHPC	Ministry of Health and Population Control (Since this report was written, the MOHPC has changed its name to the Ministry of Health and Family Planning--MOHFP. The acronym MOHPC, however, will be used in this report.)
NGO	Non-governmental organization
NIPORT	National Institute for Population Research and Training
OR	Operations research
ORT	Oral Rehydration Therapy
PF	Pathfinder Fund
PFA	Patient flow analysis
PIACT	Program for the Introduction and Adaptation of Contraceptive Technology
SMP	Social Marketing Project
TA	Technical assistance
TAF	The Asia Foundation
TBA	Traditional birth attendant
USAID	United States Agency for International Development (used herein to refer to the Dhaka Mission)

UVAPA                    Use of Voluntary Agencies in Population Activities  
VS                         Voluntary sterilization

LIST OF REFERENCE MATERIALS FOR NGO EVALUATION

JANUARY 1986

(Provided by USAID)

- A. Family Planning Services Project Paper No. 388-0050, as amended, July 1984.
- B. Review of AID-funded Non-Governmental Family Planning Activities in Bangladesh, prepared for the Mid-term Evaluation, Family Planning Services Project, KeeKee Minor, June 1 - July 6, 1982.
- C. Mid-term Evaluation of USAID Family Planning Services Project in Bangladesh (388-0050), Minkler, Henderson, Simmons, Ahmed Ali, Voran, APHA, January 24, 1983.
- D. U.S. Assistance to the Family Planning and Population Program in Bangladesh 1972-1980, Pillsbury, Kangas, Margolis, APHA, April 1981.
- E. Evaluation of Family Planning Services and Training Center (FPSTC) Bangladesh, Epstein, Akhter, Harbison, April 10-29, 1984.
- F. USAID/Bangladesh Population Sector NGO Strategy, 1985-1988.
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- I. Summary Views on the Economic Analysis of Family Planning in Bangladesh, Simmons, Rob, Bernstein, June 1985.
- J. Suggested programme components for Population Control under Third Five Year Plan, 1985-90, Population Control Wing, Ministry of Health and Population Control, June 1984.
- K. Evaluation of Pathfinder's Central Cooperative Agreement, August 1985.
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- M. Evaluation of FPPIA's Central Cooperative Agreement (in process).
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- O. Mini-CPS/Pathfinder, Department of Statistics, Jahangirnagar University, 1984.
- P. TAF and BFPA evaluations, Dec 1985.
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- R. VS Reimbursement Review Findings (Pillsbury, Knowles). (Pillsbury's report is not yet received.)
- S. An Assessment of the Management of the Bangladesh Population Program by Donald Chands, Brooks Ryder and Wesim Zaman, January 1984.
- T. Study Report on Role of Volunteers in Family Planning Services of the Family Planning Association of Bangladesh, June 1985.
- U. Summary of Mini CPS Findings in Saidpur CBS Project of Pathfinder Fund.
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- W. Ministry of Health and Population Control Circular No. PC/S-2 (Coord)/104/83/441, dated April 12, 1983.
- X. Scope of Work for the Overall Evaluation of the Family Planning Services Project (388-0050) funded by USAID.
- Y. Annual Report 1984 - USAID/Bangladesh Cooperative Agreement with AVS - #388-0050-A-00-1014-06.
- Z. FPPIA Letter to Sigrid Anderson on the Assessment Report on the Role of Part-time Medical Officers and Paramedics of the FPSTC subgrants, dated December 27, 1985.
- A.A. Key Results - Bangladesh Contraceptive Prevalence Survey - 1983, by Mitra and Associates.
- A.B. Final Report - Bangladesh Contraceptive Prevalence Survey - 1983, by Mitra and Associates.

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In addition to the references collected and provided by USAID (see attached list), the Team also consulted the following references during the evaluation:

- AVSC Subagreements--BGD 03-CO-10-B  
BGD 32-TR-1-A  
BGD 31-TR-2-B  
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A Report on a Consultation to BAVS, Fishburne, 1980  
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- BAVS A proposal for the Addition of MCH Components to Existing BAVS Clinics  
Counselor Training Curriculum  
Orientation Workshop on the 1986 Program
- BFPA Study Report on Role of Volunteers in FP Services  
Project Evaluations: Utilization of Traditional Healers in FP and UVAPA, FOCUS, 1986  
Work Programme/Budget, 1986
- FPSTC FY85 Annual Report and Training Calendar
- PF Preliminary Needs Assessment of NGO Field Staff Training
- IUCW Report on Rural and Child Welfare Project, November 1985  
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## EXECUTIVE SUMMARY

Since the 1950s, non-governmental organizations (NGO) have played a key role in family planning (FP) service delivery in the area which is now Bangladesh. The United States Agency for International Development (USAID) has supported NGO efforts in Bangladesh for more than a decade through centrally funded grants and contracts. Since 1981 the USAID mission has provided bilateral funding for the FP efforts of several NGO cooperating agencies (CA) which are implementing major FP service programs.

An Evaluation Team composed of Miriam Labbok (Team Leader), Ellen Blair, and Sallie Craig Huber was contracted by the International Science and Technology Institute to examine the NGO component of the current bilateral Family Planning Services Project (FPSP) (No. 388-0050).

The Team visited Bangladesh from January 16 to February 14, 1986 to

- o Undertake a review and analysis of the NGO FP objectives, inputs, strategies and programs and their contribution to achieving the overall purpose of the project, and
- o Make recommendations for the future of these NGO activities.

During the evaluation, the Team held extensive discussions with the directors and staff of the six CAs currently receiving FPSP funding (Association for Voluntary Surgical Contraception/ Bangladesh Association for Voluntary Sterilization, Bangladesh Family Planning Association, Family Planning International Assistance, Family Planning Services and Training Center, The Pathfinder Fund, and The Asia Foundation). Field visits were made to 54 subproject sites. In addition, Team members met with USAID staff, officials of the Government of Bangladesh (GOB), and representatives of other donors and NGOs. Huber returned to Bangladesh during March 1986 as part of the Team contracted to evaluate the overall FPSP. Additional insights on the NGO component gained during the second visit are included herein.

From 1981-1984, the focus of CA program effort was to replicate and expand existing project models--primarily community based distribution (CBD) and clinical services for voluntary sterilization (VS). During the current phase (1985-88), the strategy has shifted to consolidation and improvement of existing

projects; expansion to rural areas; and improvement of management, evaluation and training.

While subprojects have successfully proliferated since 1981, the actual outputs attributable to these efforts were found difficult to measure with precision due to differences in definitions of terms and in record-keeping and reporting systems used by the CAs. Moreover, national surveys call into question the precise contribution being made by the NGOs in terms of overall contraceptive prevalence rates (CPR). Further analyses and studies are recommended to obtain a more accurate picture of the NGO contribution to the national effort.

To date, CAs have concentrated in urban areas, but recent studies have revealed both lack of coverage and overlap in some places. Various approaches to identifying and filling service gaps are recommended. In addition, it is recommended that guidelines be developed for the expansion of NGO activities in rural areas. The CAs are also urged to consider utilizing a portion of USAID funds to channel subproject grants through newly elected officials in rural areas.

With almost 90 subprojects being carried out in nearly 300 sites, management issues have reached a new level of importance. Extended programming cycles and consolidation of subproject activities are recommended to reduce management burdens for USAID, the CAs and their subprojects. CAs are also urged to take steps to use management information systems (MIS) to help identify excess capacity and ensure efficient use of funds. CA MISs also need standardization and simplification to allow greater comparability between CA programs and to reduce staff time spent on paperwork. An argument was also made for undertaking cost analyses of program elements. In particular, these should be included in any cost effectiveness analysis that might be made of CAs in future. It is also recommended that CAs improve their internal evaluation systems to assist both USAID and the CAs in program management.

Several notable innovative project activities have been undertaken. Limited attention, however, is being given to documenting the results of these activities and little emphasis placed on their replication and/or transfer to other NGOs and the GOB.

Recently, the GOB has moved to integrate maternal and child health (MCH) activities with family planning and USAID has made available "child survival" funds. The time is therefore ripe for CAs to move selectively into combining MCH activities with FP and to document the impact of the integration.

USAID policies regarding CA efforts to become self-reliant are not fully consistent; on the one hand, USAID is increasing its level of funding, while, on the other, it is urging self-sufficiency. To help CAs improve their ability to generate and account for income, USAID should clarify its position on the use, documentation and reporting of project-generated income.

The CAs are taking steps to coordinate training activities but considerable additional efforts will be needed both to expand and to improve training opportunities. USAID should assist in these efforts, with technical assistance if necessary. Use of volunteers, while essential in many subprojects, raises issues in regard to responsibilities and accountability. These should be addressed by the CAs.

In addition to the recommendations made to address specific problem areas, four major recommendations are offered that should take precedence over the rest. These are:

- o USAID should continue to support FP activities of the CAs.
- o The CAs should continue the ongoing shift in emphasis from proliferation of small subprojects to strengthening their central support systems.
- o USAID should explore funding to reactivate the Family Planning Council of Voluntary Organizations (FPCVO) as a strong body to work with the NGOs on issues constraining their work or otherwise affecting their full contribution to the national program.
- o USAID and the CAs should work together to create a new forum for the entire FP NGO community to encourage regular discussion, debate, and exchange of project information. Issues raised in such a forum would bear the weight of a united voice in approaching the GOB (through the FPCVO) for mutually agreeable solutions.

Fourteen problems are identified that could be addressed through better CA/NGO coordination.

I. INTRODUCTION: REPORT METHODOLOGY AND SCOPE OF WORK

## I. INTRODUCTION: REPORT METHODOLOGY AND SCOPE OF WORK

This report contains the observations and recommendations of a three-person Evaluation Team (Miriam Labbok--Team Leader--Ellen Blair, and Sallie Craig Huber) who visited Bangladesh January 16 - February 14, 1986, under sponsorship of the U.S. Agency for International Development (USAID/Bangladesh) through an Agency for International Development/Washington (AID/W) contract with the International Science and Technology Institute. The principal objectives of this evaluation included the following:

- o To undertake a review and analysis of the existing USAID-funded non-governmental organizations' (NGO) family planning (FP) objectives, inputs, strategies, and programs and their contribution to the achievement of the overall purpose of the Family Planning Services Project (FPSP) (No. 388-0050), and

- o To make recommendations as to future orientation and scope of NGO objectives, strategies, and programs, assuming continued USAID assistance to Bangladesh for FP services.

The evaluation scope of work (Appendix A) indicated that the recommendations could be related to strengthening and/or reorienting either existing and/or new objectives, inputs and programs. The evaluation was undertaken with an orientation of quality assurance in programs and in services rendered.

The evaluation involved a process of review, analysis and the formulation of recommendations for the NGO component of the FPSP. To carry out this process, a review of the scope of work, interviews with USAID staff, and a review of documents were carried out prior to the final identification of a list of major issues. The major issues (Appendix B) were utilized in the development of work sheets for semi-structured interviews (Appendix C) and were the focus of in-depth discussion with the Dhaka offices of the six cooperating agencies (CA) currently receiving bilateral USAID funds (see list of CAs, Section II.1). The team also interviewed two additional major CA subgrantee agencies based in Dhaka--Concerned Women for Family Planning (CWFP) and the International Union for Child Welfare (IUCW)--and made visits to five subproject sites in the Dhaka area during the first week in Bangladesh. Field trips were carried out to a total of 34 subproject sites during the second week of the consultancy.

Findings from these interviews and site visits resulted in the development of a refined outline which served as a guide for further analysis through field trips to an additional 15 sub-project sites during the third week of the consultancy.

In all, the team visited a total of 54 (18.5 percent) of the 292 existing subproject sites. In addition, the team met with Bangladesh Government (GOB) and elected officials, including one District Commissioner, two Upazilla Chairmen, two Municipal Chairmen, six Deputy Directors of FP (DDFP), one Upazilla Health and FP Officer, and two Upazilla FP Officers, and visited two Upazilla Health and FP complexes and one Family Welfare Center. In Dhaka, interviews were held with Ministry of Health and Population Control (MOHPC) officials, population NGOs not supported by USAID, other donors, and various USAID personnel (Appendix D). Appendix E summarizes the general findings from the field visits. Comments made in the text of this report regarding the CAs and their subprojects are based on observations during the field visits and discussions with the individuals noted in Appendix D.

During the final week, specific suggestions were shared at a debriefing with the six CAs. This resulted in refinement of orientation of the final report. Thus, by the end of the assignment, the NGO viewpoint had been explored from nearly all perspectives including those of the CAs in Dhaka, their sub-grantees and subproject staff and clients, of donors and of other NGO project leaders.

One team member, Sallie Craig Huber, returned to Bangladesh during March 1986 to participate in the Overall Evaluation of the USAID FPSP. As a result of the second visit, this NGO evaluation was further reviewed and revised by Huber with input and concurrence from the other two NGO team members.

II. OVERALL NGO PROJECT:  
BACKGROUND, GOALS, USAID SUPPORT, AND ACHIEVEMENTS

## II. OVERALL NGO PROJECT: BACKGROUND, GOALS, USAID SUPPORT, AND ACHIEVEMENTS

### II.1 Background

NGO activity in FP in the area now known as Bangladesh began as early as 1953. During the decades of the 1960s and 1970s, activity increased slowly in both the public and private sectors, with the NGOs playing an important role in information and education efforts as well as in limited services provision. Many of these NGO efforts were supported by AID through centrally funded grants and contracts. With the initiation of the FPSP in 1981, USAID began providing bilateral funding to a number of NGOs that were implementing major programs for FP services and training. These activities are designed to complement the GOB national program.

The last overall evaluation of the FPSP, which included an assessment of the CA activities, was conducted by the American Public Health Association (APHA) in August 1982. It was preceded by a more detailed evaluation of the CAs' programs carried out by another consultant (K. Minor) in June-July 1982. Minor recommended continuation of bilateral funding for CAs and urged USAID and the GOB to facilitate the contribution and maximize the performance of the CAs in relation to the national FP effort. Minor also called for a standardized record-keeping system using standard definitions for all CAs and recommended that USAID avoid small CA subprojects in order to reduce management burdens. She further suggested that clarification be sought of GOB expectations for NGOs working in FP.

Other evaluations of the separate CA activities have been undertaken at various times since 1981. An evaluation of the Family Planning Services and Training Center (FPSTC) was conducted from April 10-29, 1984. Evaluations of the Association for Voluntary Surgical Contraception (AVSC) and The Pathfinder Fund's centrally funded Cooperative Agreements were conducted in March and April 1985. FPIA's AID/W Cooperative Agreement and the local Asia Foundation (TAF) and Bangladesh Family Planning Association (BFPA) Cooperative Agreement activities were all evaluated in November and December 1985. These evaluation reports were consulted during the course of the current evaluation and are available from USAID/Dhaka or from the concerned CA.

The main NGO activities funded under this component of the FPSP fall into two general categories--programs for community-based distribution (CBD) of contraceptives and clinical activi-

ties focused on the provision of high quality voluntary sterilization (VS) services. In addition, funds have been devoted to other NGO activities including the development of a curriculum for GOB program staff training (CARE), operations research (OR) on the transfer of findings from the International Center for Diarrheal Disease Research, Bangladesh (ICDDR,B) to the GOB program, a pilot project designed to encourage late marriage and reduced fertility through female secondary education (funded through TAF), and research to determine the appropriate contraceptives for use in Bangladesh (Bangladesh Fertility Research Program [BFRP]). In addition, the Social Marketing Project (SMP), also funded by USAID, is sometimes included under the NGO component.

At present, the FPSP (as amended in 1984) supports the six FP services Cooperative Agencies (CA) that are considered to fall within the terms of reference of the present evaluation. (Hereafter, the acronym CA will be used to refer to the six organizations; all other non-governmental organizations will be called NGOs.) The six CAs are:

- o Association for Voluntary Surgical Contraception (AVSC)/ Bangladesh Association for Voluntary Sterilization (BAVS) (also AVSC/BAVS)
- o Bangladesh Family Planning Association (BFPA)
- o Family Planning International Association (FPIA)
- o Family Planning Services and Training Center (FPSTC)
- o The Pathfinder Fund (PF)
- o The Asia Foundation (TAF)

The major emphasis of the support to all these organizations is to reduce fertility by increasing the prevalence of modern contraceptive use through improving and expanding FP service delivery.

## II.2 USAID's Strategy for CA Activities

Since the start of the FPSP, the CAs have been guided in the development and implementation of subprojects by two "USAID/Bangladesh Population Section NGO Strategy" papers, the first covering the period 1981-84 and the second 1985-88. These papers were developed collaboratively by USAID and the CAs.

Chart I

Comparison of USAID/Bangladesh NGO Strategies  
First and Second Phases

<u>Component</u>	<u>1981-1984</u>	<u>1985-1988</u>
1. Overall Focus	Replication and expansion of existing NGO service models	Consolidation & improvement of existing models with selective expansion
2. Coverage	Primarily urban; rural subprojects considered only if within GOB guidelines	Rural expansion encouraged as innovation (see Item 5)
3. USAID/NGO Management	(Not directly addressed but encouraged larger scale projects to reduce costs)	Proposes multi-year, larger subprojects covering multiple sites
4. Collaboration	NGO/GOB collaboration urged at local & national levels to improve motivation and productivity in GOB program	Urges NGO collaboration among themselves and with GOB to transfer successful project elements
5. Innovation	Limited activity based on cost effectiveness	Exploration of other donor support, rural expansion (see Item 2) and self-reliance (see Item 9)
6. Integration	Secondary activities, closely linked with FP	Non-FP components of all subprojects to be assessed for cost effectiveness and impact on FP.
7. Evaluation	Focus on quality and low cost with defunding of subprojects performing poorly	Checklist of "adequate standards" to be developed
8. Logistics	Recognizes and resolves to alleviate problems in commodity system	(Not addressed)
9. Self-Reliance	Encouraged but proposals must be based on proven successful models	Self-reliance encouraged as area of innovation (see Item 5)

The first strategy (1981-1984) gave priority to replication and expansion of the three existing NGO approaches of CBD, quality clinical programs for VS, and social marketing. The present NGO strategy (1985-88), based on cost and quality concerns prevailing at the time it was drafted, calls for consolidation, review and improvement of existing projects; selective and innovative expansion; and for development of better systems for evaluation of ongoing projects (Appendix F).

The various components of the two strategies are summarized and compared in Chart I.

### II.3 Levels of USAID Support to CAs

Support to the six CAs receiving funds under this component of the FPSP has totaled more than \$16 million since 1981 (see Table 1).

Table 1 \*

USAID-Funded Family Planning Cooperating Agency  
Actual Obligations by Fiscal Year and CA

CA	Obligation (\$ 000s)					Total
	FY 81	82	83	84	85	
AVSC/BAVS	500	1,578	1,690	2,700	--	6,468
TAF	117	525	550	1,000	1,500	3,692
BFPA	75	300	300	300	--	975
FPFA	--	--	--	600	600	1,200
FPSTC	100	350	200	200	300	1,150
Pathfinder	200	798	400	300	702	2,400
BACE **	--	55	100	--	--	155
Total	992	3,606	3,240	5,100	3,102	16,040

\* Obligations to the SMP, ICDDR,E, BFRP and CARE are not included in this table. Activities of the former two are the subject of separate evaluations and the latter two are no longer being funded.

\*\* The Bangladesh Association for Community Education (BACE) was incorporated in the Asia Foundation grant in FY 84.

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The AVSC has received about 40 percent of the total, followed by TAF with about 23 percent, PF with about 15 percent and FPIA, FPSTC and BFPA sharing the remaining 22 percent. FPIA's low share of the total reflects only two years of funding (FY 84 and 85) compared with four or five years for the other CAs.

Except for the first year and FY 1984, total funding has been in the range of \$2.1 million to \$3.6 million. In FY 81, an obligation of \$992,000 provided start-up funds for planning and organizing activities. These activities consumed most of 1981 and early 1982. By June 1983, 50 new CBD projects had been started in 95 sites while BAVS was operating 28 clinics and providing 17 percent of the VS services in the country.

Funding peaked in FY 1984 at \$5.1 million then dropped in FY 1985 to around \$3 million, reflecting primarily a temporary suspension of funding to AVSC.

## II.4 Assessing Project Achievements

### II.4.1 Background

In keeping with the 1981-84 Strategy, the early years of the project were devoted to expansion and replication of ongoing efforts in CBD and provision of quality VS services--primarily in urban areas. At the start, CBD project expansion slightly outpaced growth of VS projects. Both grew rapidly, however, and by the end of 1985, this focus had resulted in the development of a total of 86 subprojects (of varying size) operating in 292 sites (see Table 2).

Table 2  
USAID-Funded Family Planning  
CAs by Number of Projects and Sites  
January 1986

<u>CA</u>	<u>No. of Projects</u>	<u>No. of Sites</u>
AVSC/BAVS	1	34
The Asia Foundation*	27	60
BFPA	2	40
FPIA**	6	101
FPSTC	23	23
Pathfinder	27	34
TOTAL	86	292

\* Includes Concerned Women for Family Planning (12 sites)

\*\* Includes FPSTC (20 sites) and 3 new projects at 9 sites; excludes CWFP (1 site)

#### II.4.2 Outputs

Overall, the CAs have made exceptional progress in achieving their projected outputs (see Table 3). Figures are particularly impressive for voluntary surgical contraception (VSC) where CY 84 actual outputs for VSC referrals were 59 percent over projected levels and 22 percent above projections for VSCs performed. Regarding projections for temporary methods, numbers of active users exceeded the projection by 15 percent and couple years of protection (CYP) were 12 percent above projection.

#### II.4.3 Contribution to National Effort

According to USAID calculations, the NGO sector as a whole can claim credit for 25 percent of total active users of contraception as of December 1985, an increase from 11 percent in 1981. Converted to contraceptive prevalence rate (CPR), the figures indicate that NGOs were providing services to almost six percent of all eligible couples by the end of 1985, up from 1.4

Table 3  
 USAID-Funded Family Planning Cooperating Agencies\*\*  
 Projected and Actual Outputs  
 1984  
 ('000s)

<u>Outputs</u>	<u>AVSC/BAVS</u>		<u>FPSTC</u>		<u>BFPA</u>		<u>Pathfinder</u>		<u>TAF</u>		<u>Total</u>		<u>Excess of A over P (%)</u>
	<u>P*</u>	<u>A*</u>	<u>P</u>	<u>A</u>	<u>P</u>	<u>A</u>	<u>P</u>	<u>A</u>	<u>P</u>	<u>A</u>	<u>P</u>	<u>A</u>	
<u>Temporary Methods</u> (Year End)													
Active Users	-	-	35	41	60	85	93	91	120	141	308	358	15
Couple Years Protection	-	-	28	30	45	51	69	68	90	110	232	259	12
<u>Voluntary Surgical Contraception</u>													
Referred	-	-	4	4	3	15	9	4	6	9	27	43	59
Performed	82	103	-	-	-	-	10	10	-	-	92	112	22

\* P = Projected  
 A = Actual

\*\* FPPIA is not included since no subprojects were bilaterally funded in 1984.

percent in 1985 (Table 4). <sup>1/</sup> Although Table 4 uses aggregated figures for all NGOs, it is recognized that CA subprojects account for a large proportion of NGO services in Bangladesh and therefore it is fair to conclude that CAs have made an appreciable contribution to the national FP effort.

Table 4  
Active Users as Percent of Eligible Couples  
and Percent Attributable to Provider  
1981-1985

YEAR	Active Users as Percent of Eligible Couples				Active Users (%) Attributable to Provider			
	GOB	SMP	NGO	Total	GOB	SMP	NGO	Total
1981	8.6	2.2	1.4	12.2	71	18	11	100
1982	9.8	2.4	1.9	14.2	70	17	13	100
1983	10.9	2.7	3.1	16.7	65	16	19	100
1984	13.9	2.9	4.7	21.5	65	14	22	100
1985	14.7	2.9	5.8	23.4	65	13	25	100

Source: USAID Mission, Dhaka, Bangladesh

Notes: The number of active users is estimated using couple year of protection assumptions for non-clinical methods and decrement tables for clinical methods.

Another way to judge the effectiveness of the NGO effort might be to compare CPR trends in urban areas, where NGO efforts have been concentrated, with those in rural areas. Special Contraceptive Prevalance Survey (CSP) calculations undertaken for the 1986 Overall Evaluation of the FPSP (Oot, et. al.) showed that between 1983 and 1985 the urban CPR rose more rapidly (by 9.5 percentage points) than did the rate in rural areas (by 4.4 percentage points).

<sup>1/</sup> USAID calculations are based on the GOB's management information system (MIS), which collects only commodity distribution figures. USAID's calculations involve converting these estimates using couple year of protection assumptions for non-clinical methods and decrement tables for clinical methods.

The 1983 CPS data, however, do not appear to support the conclusion that NGOs can be fully credited for this rapid rise. The data indicated that 60 percent of pill purchasers (urban and rural) bought either SMP brands (19 percent), or purchased their pills from other commercial sources (41 percent), leaving only 40 percent of the total users of pills at that time having received pills from GOB or NGO providers. Furthermore, in the same 1983 survey, only two percent of urban users of modern, non-clinical contraception reported obtaining supplies from NGO fieldworkers. An additional 15 percent said they had received supplies from GOB fieldworkers. Even if the latter providers were actually NGO workers mistaken for GOB workers, this would account for a total of only 17 percent of all urban users receiving supplies from NGO programs. It is also possible that between 1983 and 1985 the NGOs increased the level of their pill distribution and that data in the 1985 CPS will reflect a stronger CA performance.

While statistical evidence of the contribution of the NGO component of the FPSP to the national program may not be overwhelming, this is only part of the picture. The component was designed with broader goals. It was expected to be in the forefront of family planning efforts, providing flexibility, community involvement and a certain amount of risk-taking in pilot or demonstration projects. In these regards, it has succeeded (see Chapter III). On the other hand, the aim was also that successful elements of NGO projects should be transferred to other NGOs and/or the government programs. Here the record has not been as strong as anticipated. There are only a few examples of such large-scale transfers: the ICDDR,B Extension project, training of GOB clinicians by BAVS, and some inter-NGO training efforts. While it has not yet taken the opportunity to replicate any of the NGO program initiatives, the GOB is nonetheless aware of the contribution being made by the NGOs in general and the CAs in particular. It has signaled its recognition by providing contraceptives and other commodities and inputs, and has given every indication of providing for continuation of CA efforts in the future.

#### Suggestion

Greater emphasis needs to be given to the transfer of NGO programming innovations to other NGOs and to the GOB program. The sooner this is done, the better, in order to avoid duplication of research on new program elements and the repetition of failures, as well as their accompanying costs.

#### II.4.4 Contribution to Local Service Areas

While there is an overall impression that many CA sub-projects are making an impressive contribution to contraceptive use in their assigned and often limited geographic areas, it is difficult to document them. CAs are reporting CPRs averaging from 40-50 percent, certainly an impressive level. CPRs are calculated by dividing the numbers of active users by the numbers of eligible couples in the service area. The CA service statistics that provide numbers of active users are considered extremely reliable. Because CAs calculate numbers of eligible couples differently, however, there is uncertainty as to the accuracy of some of the reported results.

Over the past year, USAID has been working with CAs to standardize reporting procedures through the USAID-funded MIS (see Appendix K). Thus although CAs and their subprojects may still use different forms for their service statistics, they now all have a common understanding of the definition of active user<sup>2/</sup> and therefore the numerators in CPR calculations are generally comparable. On the other hand, the denominators (number of eligible couples) vary considerably among the NGOs. Some are based on the 1981 census data, others depend on couple or household registration systems, and very few are updated regularly. Since there is no telling which of these bases is more reliable, it is impossible to assess which CPRs are the most accurate. Furthermore, in a number of subprojects, the reported CPR has fluctuated substantially over the years. In some cases, the cause may be expansion or redefinition of the project area. This is unlikely to explain all the erratic results, however.

Mini-CPSs carried out by PF and TAF for nine subprojects give weight to the conclusion that current calculations of subproject CPRs should be viewed with caution. PF undertook these surveys because of suspicions about the very high CPRs being reported in some subprojects; TAF's were done as part of its 1985 evaluation, and the subprojects were randomly selected. Unfortunately, none of the mini-CPS reports gave service statistics-based prevalence data reported by these projects just prior to the surveys. Therefore, mini-CPS data have been compared with USAID service statistics (see Table 5).

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<sup>2/</sup> With the exception of FPIA, whose differences are discussed in Section III.4.

Table 5

Comparison of Contraceptive Prevalence Rates  
Based on Mini-CPS and Service Statistics Data

<u>CA and Subprojects</u>	<u>Mini-CPS</u>		<u>Service Statistics</u>	
Pathfinder	Date	CPR	Date	CPR
Saidpur	May 85	42	Jun 84	70
Rajshahi	Nov 84	39	Mar 85	49
Pabna	Nov 84	42	Oct 84	67
Bhola	Nov 84	17	Sep 84	54
Moulvi Bazar	Nov 84	16	Jul 84	59
Asia Foundation				
DWFP (Comilla)	Nov 85	65	Mar 85	58
SKP (Kushtia)	Nov 85	48	Apr 85	28
PSKS (Kushtia)	Nov 85	33	Nov 85	28
FREHC (Mirserai)	Nov 85	18	Nov 85	55

For all PF projects, mini-CPS rates are below the reported service statistics, by a large margin in some cases. The reason may be that some of these subprojects were selected specifically because their service statistics were suspected of being incorrect. The TAF subprojects, on the other hand, reveal only one mini-CPS rate that is lower than the service statistics rate although in this case (FREHC), the difference is extremely large (18 versus 55 percent). In the other three TAF subprojects, the CPS rates are higher than the service statistics rates. This may be because active user data provided by subprojects include only those users receiving supplies and/or services from the subproject. Those who obtain their methods from another source are presumably not reported as active users.

Conclusions

The NGO component of the FPSP is assumed to be making an important contribution to the national FP program in terms of the provision of services in limited assigned geographic areas; however, service statistics and surveys suggest the impact of CA programs may not be as great as it appears. Additional research may be required to determine the true impact, in terms of contraceptive services provided, by this component of the FPSP.

USAID's efforts to develop a standardized reporting system among the CAs removes one hurdle in the path of efforts to compare subproject effectiveness. Making comparisons among CAs,

however, may be too limited an objective in a project whose ultimate goal is to contribute to the national FP effort. At least it should be possible to compare the efforts of all NGOs. Ideally, it would be better yet if comparisons could be drawn between the NGOs and the GOB program. The GOB reporting system, however, now provides figures only on commodity distribution while the CAs also have data on active users and sterilization acceptors and referrals (see Appendix K). Without rationalizing these two reporting systems, any attempt to compare the CAs with the GOB program would be invalid.

### Suggestions

USAID's efforts to develop a standardized reporting system should be seen as only the beginning of a more comprehensive effort that could include both other NGOs and the GOB. It is recognized that rationalizing these systems may be difficult, but to the extent that CAs and other NGOs are seen, and see themselves, as contributing to the national FP effort, standardized service statistics systems should be a goal. USAID is encouraged to play whatever role is required to attain its achievement.

### Recommendations

1. When 1985 CPS data are available, USAID and the CAs should study the results to determine what impact the growth in NGO (and particularly CA) urban projects between 1983 and 1985 may have had. Two specific results should be examined--the type of pills used (to determine whether CA subprojects may have decreased the high use of commercial brands reported in the 1983 survey) and the source of supply.

2. USAID should commission a systematic study to determine the accuracy of service statistics-based prevalence rates for CA subprojects. The study should attempt to identify the source of the discrepancies and suggest ways to improve the accuracy of active user and eligible couple data (see Appendix L for further details).

III. DESCRIPTION OF COOPERATING AGENCIES

### III. DESCRIPTION OF COOPERATING AGENCIES

#### III.1 General Comparison

The six Cooperating Agencies now being funded through USAID represent a wide range of experience and skills and have made contributions to most aspects of the national effort to provide FP services. While three are indigenous Bangladeshi NGOs (BAVS, BFPA, and FPSTC) and three are affiliates of U.S.-based organizations (FPIA, PF and TAF), all channel their funds directly to local subprojects. Each has a distinctive mission (see Appendix G). In very general terms, BAVS concentrates on providing voluntary sterilization; BFPA has focused on increasing participation of volunteers, youth and women; FPIA specializes in a variety of management issues and innovative strategies; FPSTC has a special interest in coordination among NGOs; PF has focused on support to innovative CBD projects; and TAF is interested in several areas, including strengthening local FP-providing organizations and integrating population with development.

Each also has its own set of operating procedures (i.e., project review and approval processes, the support or technical assistance (TA) it provides, and reporting requirements, and evaluation mechanisms--see Appendix H for details).

While it is possible to describe how CAs differ in terms of their goals and operating procedures, it is not possible to compare them on the basis of how they budget their funds. Wide ranges exist in the percentage of budgets allocated to certain line items such as subproject support (58-93 percent), administrative costs (5-25 percent), and indirect costs (5-21 percent) (see Appendix I). These variations within line items may be related to differences in program emphasis. It is equally likely, however, that they relate to a confusion over the definition of terms, which budget elements are to be included in each line item, and how to allocate costs in cases where there is both bilateral and central funding (e.g., for AVSC/BAVS, FPIA, and PF). For example, BAVS shows the highest percentage of budget going for subprojects (93 percent) with no program support and indirect costs listed and only five percent of its budget devoted to administrative costs. This may be because its program support and indirect costs come from central funds. PF on the other hand shows only 58 percent of its budget devoted to subprojects and over 31 percent going to program support and indirect costs.

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The following sections provide descriptions of each of the six CAs, focusing primarily on activities that are funded bilaterally through the FPSP. It should be noted, however, that these activities represent only part of the portfolio of most of the agencies. While all BAVS activities are bilaterally funded, BFPA carries out a considerable number of other programs funded by its parent body, the International Planned Parenthood Federation (IPPF). FPSTC's bilaterally funded activities also represent only a percentage of its agenda, with the Ford Foundation and FPIA subsidizing other projects. While all TAF's population work is bilaterally funded, TAF is involved in a considerable number of non-population areas as well.

### III.2 Association for Voluntary Surgical Contraception/Bangladesh Association for Voluntary Sterilization (AVSC/BAVS)

#### Background

BAVS is funded entirely by bilateral funds and is an independent organization. It receives technical and administrative support, however, from both AVSC headquarters in New York, which has a central AID grant, and from the AVSC regional office in Dhaka. For the past 10 years, BAVS has been in the vanguard of delivery of VS services in Bangladesh. It has pioneered quality VS services and provided both primary and refresher technical training for GOB and NGO personnel.

#### Findings

From 1983 to 1986, BAVS expanded the number of its clinics from 28 to 33 (two for vasectomy only). Over the past 18 months, however, BAVS has experienced a 63 percent decline in the number of VS procedures performed in its clinics. This compares with a 52 percent fall in demand in the GOB program. It is believed that this demand has now stabilized at approximately 250,000-300,000 procedures per year. <sup>1/</sup> As a result, BAVS has taken moves to reduce staff slightly and has also begun to consider new avenues for use of remaining excess capacity (staff and facilities).

Another issue affecting BAVS is that BFPA, with IPPF funding, is providing VS services in 15 cities where BAVS clinics are also located. USAID undertook a survey in July 1985 of BFPA and BAVS activities in these 15 cities. Although the survey has not yet been analyzed, a preliminary review of the responses indicated that in general BAVS has been operating longer in each

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<sup>1/</sup> Conclusion reached in the demographic analysis undertaken for the 1986 Overall Evaluation of the FPSP (Oot, et. al.).

indicated that in general BAVS has been operating longer in each city and has a larger staff, but provides less comprehensive services, has a much higher budget (4-6 times), and has performed approximately the same number of VS procedures in a comparable time period.

BAVS has been conducting refresher training of GOB clinical personnel, an activity that is expected to continue at the current rate. BAVS recently received short-term TA aimed at improving training, which is expected to be implemented soon. There is also talk of adding some MCH services and of providing "comprehensive" FP services in the BAVS system, but little evidence of either. Temporary contraceptives are available at clinics, but statistics do not indicate many acceptors of these methods. In particular, the BAVS record-keeping system does not routinely show contraceptive methods provided for clients who are rejected or otherwise decide against VS. This leaves doubt as to whether these services are truly comprehensive.

#### Suggestions

BAVS has the reputation for initiative and innovation and has developed excellent VS facilities. One current issue therefore is how best to utilize the excess capacity that has developed with the stabilization of demand for sterilization. There are several possibilities. Consideration might be given to the following suggestions.

1. BAVS could begin gradual introduction of the contraceptive implant NORPLANT, which requires a surgical approach for insertion and removal. Anticipated introduction of NORPLANT services throughout the country could tap BAVS's training expertise.

2. BAVS clinical facilities could also be used for expanded intrauterine device (IUD) and injectable contraceptive services.

3. At the same time, greater attention must be given to improving the existing "comprehensive" services provided by BAVS clinics.

4. Part of the BAVS excess capacity might be put to good use in providing teams to give periodic hands-on training in newly constructed and staffed Upazilla Health and Family Welfare Complexes. For example, eight of the 12 upazillas in Comilla District have facilities and medical officers (MO) assigned, but none of the MOs have had refresher training in VS.

### Recommendations

1. USAID should analyze the survey of duplication of BAVS/BFPA services as soon as possible. When results are available, USAID should meet with both organizations together, as well as with representatives of the GOB and IPPF, to discuss the findings and seek early solutions to the duplication issue. Although USAID is not funding the clinical aspects of BFPA's work, the advisability of continued USAID funding of BAVS projects in these 15 sites is of concern and should be examined carefully by USAID with AVSC and BAVS.

2. BAVS must continue to be assisted by AVSC, and by USAID if requested, to undertake strategic planning for future activities in Bangladesh.

### III.3 Bangladesh Family Planning Association (BFPA)

#### Background

The BFPA, founded in the early 1950s, is the Bangladesh affiliate of the International Planned Parenthood Federation (IPPF). Its overall objectives include the provision of education and services to supplement the national FP program and its strategy is primarily to increase the involvement of volunteers, youth and women as service providers. Developing demonstration FP activities with the ultimate goal of self-reliance is another organizational objective. Primary sources of funding for BFPA are USAID and IPPF.

#### Findings

With FPSP funding, the BFPA has developed and carried out two innovative CBD subprojects: the Traditional Healers project, which uses local healers to promote FP and Use of Voluntary Agencies in Population Activities (UVAPA), which involves members of local clubs and voluntary agencies. These two activities were evaluated in early 1986; findings from those assessments are available from USAID or BFPA. Each subproject works in 20 generally rural sites scattered throughout Bangladesh. Together, they use 2,000 volunteer contraceptive distributors who receive Taka 100 (\$3 US) per month to cover travel and incidental expenses. As of September 1985, the traditional healers reported CPRs of 51 of their selected target populations and the voluntary agencies 63 percent.

A second type of BFPA activity funded by USAID is a contraceptive commodity distribution scheme, through which BFPA obtains commodities from the GOB warehouse and distributes them to most

of the other CAs. This system appears to be a welcome solution to problems that were experienced when each CA had to obtain supplies individually through the GOB logistics system. Third, BFPA has developed a strong reputation for its demand creation activities. These include seminars for opinion leaders (among them religious leaders) and the development of two USAID-funded color films that incorporate FP themes. These are shown through BFPA'S mobile file unit, which is not USAID-funded, and are also available to other NGOs. Fourth, BFPA has attempted to establish depot holders for resupply to clients in mature programs.

One of BFPA's strengths is its status as the first FP organization in Bangladesh and the experience it has gained over the years. It also has played an important role in information, education and motivation (IEM) and the implementation of innovative projects. Resource development activities are also gathering momentum.

One weakness of the BFPA program is its programming arrangement, which involves widely scattered small innovative projects attached to its branch structure. This dispersion does not allow for adequate consolidation and documentation of innovative activities or for ready expansion and/or transfer of innovations to other organizations. BFPA's dependence on volunteer leadership, which can be a strength in some circumstances, can also detract from management efficiency if lines of authority are not made perfectly clear to all volunteers and staff. Finally, its duplication of clinical services with BAVS needs careful consideration and an early solution (see also Section III.2).

### Suggestions

1. In keeping with USAID's current NGO strategy, BFPA should seek ways to consolidate its two CBD efforts, attempt further documentation of the impact and cost effectiveness of these activities, and look for an appropriate forum in which to share this experience. The excellent and very appropriate record-keeping system developed for use by the volunteer distributors in these subprojects should be considered for replication in other projects that use part-time and/or volunteer fieldworkers.

2. BFPA management of the CA commodity system should be continued.

3. BFPA's skills in demand creation activities should be further tapped. More funding for opinion leader seminars should be considered. Additional emphasis should be placed on educating religious leaders and newly-elected upazilla and union officials. Parliamentarians may also be a target group for training, following the upcoming elections.

### III.4 Family Planning International Assistance (FPIA)

#### Background

FPIA, which is the international division of the Planned Parenthood Federation of America, has funded projects in Bangladesh through its AID/W cooperative agreement since 1972. Bilateral funding from the FPSP, however, only began in the current amendment period (FY 1984). Since then, with combined central and bilateral funds, ongoing projects have been continued and other new ones have started. To ensure close and regular monitoring of projects in Bangladesh, FPIA reestablished a country office in Dhaka in 1985, using a portion of the bilateral funds. (FPIA had maintained a South Asia Regional Office in Dhaka until 1982 when it merged with the Asia/Pacific Regional Office in Bangkok.)

#### Findings

Both their innovative nature and their size make FPIA subprojects unique among CA efforts in Bangladesh. In keeping with USAID's current NGO strategy, FPIA has funded primarily large, consolidated subprojects operating in multiple sites (see Table 2). Several of these subprojects are rural based, implemented by GOB workers from the Department of Social Services in one case and by local NGOs in others. A recently approved project will work through Village Defense Party volunteers, whose primary missions are village extension and community development.

One innovative plan of the FPIA is to design subprojects directed at specific target groups rather than at geographic catchment areas. Because the GOB assigns geographic working areas for all NGOs, it is reluctant to approve this initiative.

Other FPIA project innovations include the use of part-time field workers with reduced caseloads and a forced savings scheme for project workers, which withholds a portion of each paycheck to be used for skill training and to back loans to the workers for income-generating projects. FPIA's Rural Development and Family Planning project in Barisal (with 40-50 sites), in which FPIA and GOB fieldworkers are assigned to different areas of the same union, is an example of excellent collaboration between a CA and the GOB for the benefit of the national program.

Likewise, the Rural Family and Child Welfare Project (through IUCW) is unique in using government fieldworkers who are from the Ministry of Social Welfare, not the MOHPC--the usual source of family planning workers. This project is experimenting

with establishment of depot holders to resupply clients in mature programs.

### Issues

FPIA's international headquarters has established its own unique definition of continuing user, which is used in place of USAID's standard definitions of active user. The FPIA's definition counts a woman as a continuing user, even though she may return only once during a funding period (usually 18 months) for a pill resupply. The USAID system on the other hand requires that she be carried only as long as she is being supplied by pills. Clearly the effect is to inflate FPIA's service statistics in comparison to statistics of other CA subprojects, which all conform to the USAID guidelines

While short funding cycles are a general problem among CA subprojects (see Section III.3.1), the solution is peculiarly difficult in relation to FPIA. This is because FPIA's bilateral funds are channeled through its AID/W cooperative agreement and therefore its Bangladesh subprojects are subject to regulations beyond the control of local USAID and FPIA's country office staff. In this case, AID/W and FPIA headquarters require an 18-month renewal cycle. A second constraint for FPIA is that one of its subprojects, which includes one-fifth of its sites, is with FPSTC (see Table 2), which requires a one-year funding cycle (see Section III.5).

### Suggestions

1. Efforts by FPIA to gain GOB approval for projects that do not follow the traditional geographic area coverage design need a review and solution.
2. FPIA's innovative, rural-based activities should be documented and shared.

### Recommendation

1. USAID should work with FPIA (at headquarters level if necessary) to obtain an FPIA waiver allowing its subprojects in Bangladesh to utilize the standardized terms developed for all bilaterally funded CAs. This would be administratively possible; their subprojects generally collect data adequate to report active users, as defined by the USAID reporting system. If FPIA does not agree to adjust its definition for the purpose of reporting to USAID, then its service statistics should be listed separately from those for other CAs so FPIA performance is not unjustly compared with that of the other CAs.

### III.5 Family Planning Services and Training Center (FPSTC)

#### Background

The FPSTC is a local organization formed in 1973 to serve as secretariat for the Family Planning Council of Voluntary Organizations (FPCVO). (This entity is further described in Section IV.4.) Originally funded by the Ford Foundation and FPIA, the FPSTC began receiving direct USAID support with the initiation of the FPSP in 1981. These three donors still provide the bulk of support to FPSTC. The original purpose of the FPSTC was to provide "...promotional, technical and other services to the voluntary organizations engaged in MCH, nutrition and family planning, specially in the urban areas."

FPSTC also develops, funds and monitors FP service projects, some combined with MCH and income generation activities, that are carried out by local NGOs.

#### Findings

Although it contained 52 recommendations, an extensive evaluation of the FPSTC carried out in April 1984 concluded that the FPSTC had made a significant contribution to the overall FP program in Bangladesh.

Particular strengths of the organization include its use and involvement of local opinion leaders in project development and management, its training program for project managers and supervisors (both for its own subprojects and those of other NGOs), and its efforts to improve the flow of NGO program information both to the GOB and to field staff.

Problem areas identified in both the 1984 and the present evaluation need sustained attention. FPSTC funds multiple small subprojects in almost 50 widely scattered sites. The monitoring and evaluation of these projects, which are renewed annually, places an enormous management burden on both FPSTC, the subgrantees and the donors (USAID and FPIA). That the Governing Body of FPSTC is comprised primarily of busy GOB officials with numerous other responsibilities presents other problems. The Board takes a more active role than might be expected or desired in the review and approval of new and renewal FPSTC project proposals. This complicates smooth project management and detracts from FPSTC's original role as a forum to assist the donors, NGOs, and the GOB in the coordination of NGO efforts. Presently, FPSTC has neither the autonomy of an NGO nor the authority of the GOB or a donor (other than as donor to its own subprojects) to coordinate NGO efforts as originally envisioned. Some would also question the advisability of an organization

implementing subprojects while also trying to coordinate and report to the GOB on the activities of entities like itself.

### Conclusions

Despite the above constraints, the FPSTC's contributions are useful and worthy of continued of USAID funding, specifically its work in service delivery, in manager- and supervisor-level staff training, and its innovations in the addition of MCH and income generation to FP subprojects. FPSTC's plans to limit the addition of new subprojects, to expand selectively, and to add new project innovations are in keeping with USAID's NGO strategy and deserve support.

### Recommendations

1. To reduce the management burdens of its planned future activities, FPSTC is urged to seek approval once again from its Governing Body and FPIA to extend the length of project cycles. USAID should provide assistance in this matter if necessary.

2. FPSTC's mandate and efforts to provide a forum for the other FP NGOs should be further assessed and, if found to be useful and acceptable to the NGO community, promoted.

## III.6 The Pathfinder Fund (PF)

### Background

PF has a long history in Bangladesh dating back to the early 1950s when it took part in the establishment of the BFPA. Its recent involvement began with the opening of the Country Office in 1978. Between 1978 and 1981, a variety of clinical and CBD activities were funded using AID/W and private resources. At the initiation of bilateral funding in 1981, PF had three 'multi-site clinical subprojects with Bangladesh Railroads and the Ministry of Labor (at industrial sites) as well as a number of satellite clinics in and around Dhaka. Four CBD subprojects were also in operation. These activities have now grown to 24 CBD subprojects and three clinic-based activities at 10 sites.

### Findings

PF has recovered from a rash of program staff changes which occurred in 1984 and early 1985. The new Country Representative, who joined in late 1984, has made exceptional progress in hiring and training an almost completely new program staff. Thanks to excellent work by interim staff and support from headquarters, subproject activities continued undisturbed during the tran-

sition, and although there were few new subprojects between late 1983 and the present, much happened over the past year to consolidate the program.

An excellent training program for all new program staff who joined PF in May 1985 was developed by an external consultant. New project management systems have been developed for record keeping and reporting and for CBD fieldworkers' daily work plans. Revisions have been made in the CBD project operations and new efforts are being undertaken to improve interactions between subprojects through quarterly meetings of subproject managers in Dhaka. The Country Representative has encouraged evaluations of PF's work, including mini-CPS for several of the ongoing CED subprojects (see Section II.4.4 for a discussion of these efforts). As of year-end 1985, FPSP funds to PF were supporting 20 urban CBD subprojects reporting CPRs ranging from 19-64 percent, with most in the 30-40 percent range.

Other than these CBD efforts, PF has recently taken the lead in several other activities affecting the larger NGO community. In January 1986, PF coordinated a much needed and very successful workshop in Chittagong which was attended by GOB, donors and all NGOs participating the FP program in that city. The outcome was a rationalization and reassignment of working areas so that there are now no gaps in FP coverage of Chittagong city. Another recent and ongoing activity being coordinated by PF is an effort to identify training resources and to match them with training needs. A committee of all the CAs has been established, chaired by PF, to solve current shortages in training resources (see Section IV.9.1 for more on this subject).

#### Conclusions

Now that the period of staff shortages is over and the newly trained program officers have had almost one year of experience, the time may be ripe for PF and USAID to look to the future. To date, PF has done an excellent job of developing an urban CBD model which has been replicated in many sites throughout Bangladesh. PF and USAID may wish to consider whether PF should further develop this model and adapt it for rural areas. An alternative might be to monitor the present CBD component and focus more time and energy on innovations such as the Chittagong workshop, coordination of training and other activities currently planned by PF such as FP orientation workshops for upazilla chairmen. PF seems to do the latter activities well and is recognized as being successful in this role by USAID and the other CAs. Furthermore, PF seems to be in a better position than other CAs to take on the innovative activities described above--both from the perspective of their U.S. headquarters' interest in this type of activity and from

their Country Representative's willingness and capability to do so.

### III.7 The Asia Foundation (TAF)

#### Background

FP subprojects supported by TAF began in Bangladesh with a PVO co-financing grant of \$500,000 in 1979. Between that date and 1981, when TAF received FPSP bilateral funds, nine subprojects had been developed with indigenous NGOs. By 1983 the number of subprojects, in both urban and rural areas, had grown to 18 and by the end of 1985 TAF was supporting 25 FP subprojects in 60 sites. Since 1985, TAF has also funded two pilot efforts to lower fertility while improving the educational status of females in Bangladesh. These subprojects provide scholarships for female students in secondary, higher intermediate and bachelor's degree courses. One of the two projects, carried out by the Bangladesh Association for Community Education (BACE), was directly funded by USAID for two years (1982-84) prior to TAF's involvement.

TAF's objectives for its FP subprojects are to provide services and education to the residents of project catchment areas. In some projects, TAF also provides loans for income generation activities. Since a number of these subprojects are rural based, TAF has the advantage of experience as the CAs move increasingly into rural areas. The female education subprojects are providing valuable experience on which USAID proposes to build follow-on activities.

#### Findings

TAF's FP activities were evaluated in 1985 using a unique and very successful evaluation format. Three local firms, selected through competitive bids, were contracted to prepare evaluations of the financial, management and subproject elements of TAF's program. An individual consultant was employed to coordinate, analyze and summarize all aspects of the evaluation. The female secondary education subprojects were evaluated by Martin, et. al. in 1985. Findings of both evaluations are available through USAID and TAF. These evaluations compliment TAF for its program design and implementation to date. Both present a number of useful recommendations, many of which are being acted upon already.

The other CAs, USAID and its evaluators recognize TAF as having several special strengths in regard to programming. It has fostered the growth of existing local NGOs through awarding them subproject grants and providing the TA required to enhance

their project development and management capabilities. Most of these NGOs are community based and many are located in rural Bangladesh. Project activities are guided by an operations manual developed by TAF, which is currently being revised as a result of evaluation suggestions. TAF appears to have a good system for subproject monitoring through regular program staff visits. TAF has encouraged innovative service delivery activities including use of depot holders or resupply agents in high prevalence project areas and the use of traditional birth attendants (TBA) to motivate clients and distribute contraceptives in rural areas.

#### Suggestions

TAF has done a commendable job in developing and supporting a number of innovative FP subprojects. Experience in the design and implementation of rural subprojects should be documented and shared with other CAs anticipating a shift of focus to rural areas. Special attention should be given to a description of the interaction between TAF's rural subprojects and local GOB FP officials and staff. The other innovations introduced in TAF projects--particularly the use of depots or resupply agents--also deserve a close assessment for possible replication by other CAs, NGOs and/or the GOB.

IV. PROGRESS IN ACHIEVING STRATEGIC GOALS

#### IV. PROGRESS IN ACHIEVING STRATEGIC GOALS

##### IV.1 Overall Focus/General Comments

The achievement of the NGOs in meeting their first phase (1981-84) strategic goals of replicating and expanding existing NGO service models is described in Section II.4.1. With the second phase (1985-88), the overall strategy has changed, with the stress now on consolidation and improvement of existing models. Other elements of the strategy call for expansion into rural areas, a goal now supported by the GOB, and reaching out to new target audiences. In addition, the present strategy calls for continued progress in improving systems for management, evaluation and training (see Chart I).

This chapter will review progress to date in meeting the goals in the 1981-84 Strategy Paper and describe and comment on plans for implementing the 1985-88 Strategy.

##### IV.2 Coverage

###### Findings

Until very recent months, activities of the CAs have been concentrated in urban areas, at the request of the GOB, which assigns geographic working areas for all NGOs. Subprojects funded by USAID (or AID/W) CAs are active in approximately 75-80 percent of the 81 municipal areas of Bangladesh. Although urban geographic assignments are thought to provide complete coverage for most cities and municipalities, the recent Chittagong workshop coordinated by PF revealed that some assigned areas were not being covered due to the assigned NGOs' lack of funds. Other areas in Chittagong were found to be assigned to more than one NGO. Urban assignments may be further complicated by recent GOB decisions to assign Family Welfare Assistants (FWA) to the major cities. Apparently, however, FWAs have always been assigned to work in the smaller cities and municipalities, and this was not mentioned as a problem or constraint by any of the CAs during the evaluation.

The previous GOB proscription against development of NGO projects in rural areas has now been lifted, paving the way for new activities there. The GOB, USAID's NGO strategy, and the CAs themselves all favor expansion to the rural areas. USAID-funded CAs, however, have relatively little experience working in rural Bangladesh, and those that do are working primarily in very

limited geographic areas. (One exception is FPIA's Rural Development and Family Planning Project covering most of Barisal District.) The CAs and other NGOs that have worked in rural areas have not shared their techniques and experiences adequately. Furthermore, no specific guidelines have been developed to deal with coordination between the existing GOB FP and health workers and new NGO efforts in rural areas. As the expansion to rural areas gets under way, potential problem areas between GOB and NGO fieldworkers may include the distribution of geographic working areas, reporting systems and channels, credit and payment systems for agents who refer new acceptors of clinical methods.

#### Conclusions and Suggestions

CA subprojects have made progress in providing maximum service coverage in their assigned geographic areas. As the NGO community fills gaps in services to urban residents and expands into rural areas, ultimately the entire national program will benefit. In the process, however, mechanisms will be needed to increase collaboration and reduce competition with GOB FP workers. The following approaches might be considered:

- o Cover separate geographic areas,
- o Deliver different services,
- o Limit activities in rural areas, or
- o Devise a system whereby the local GOB worker receives credit for the NGO's new acceptors, thus fostering positive mutual cooperation.

Some of the CAs already have experience with one or more of these mechanisms. They should be encouraged to convey that experience to other CAs and NGOs as well as to the GOB.

It will be important to ensure the involvement and commitment of the local community leaders while at the same time fostering cooperation and collaboration between the GOB and NGO efforts in the rural areas. Here, too, some of the CAs have valuable experience which should be shared with others.

#### Recommendations

1. The CAs should undertake a review, in collaboration with the responsible Deputy Directors of FP (DDFP), in each of the cities where they are working to determine existing gaps in FP coverage. In the larger cities, exercises similar to the Chittagong workshop may need to be held; in other areas where only a few CAs are working, the review may involve only a meeting with the DDFP. The objective of these reviews should be to

ensure adequate coverage of all municipal and periurban areas within the next two to three years.

2. Guidelines for the expansion of NGO activities into rural areas should be developed collaboratively by the NGO community and the GOB. USAID is encouraged to foster this exercise where necessary. A review of CA and other NGO experience to date in rural projects may be useful as background.

3. On the basis of the above guidelines, CAs should be encouraged to utilize a portion of their USAID funding to channel subgrants to local rural NGOs through local elected officials, e.g. upazilla and/or union chairmen and the local population control committees. They should do so on a pilot basis initially, in areas selected in collaboration with the GOB, to ensure the best chance for success and to document the process for replication.

#### IV.3 Project Management Issues

##### IV.3.1 General Observations

During the earlier years of the FPSP, the NGO component had a limited number of subprojects, and coordination of the CAs did not represent an overwhelming management burden either to USAID or to the CAs. During the second phase, however, with 292 subprojects in place, management efficiency has become an important issue

The present strategy proposes larger, multi-year subprojects covering multiple sites as one way to reduce management burdens. Consolidation and extension of subproject funding cycles may have important implications for reducing some CA management burdens. They will not, however, solve all management problems for CAs and their subprojects. Both CAs and subprojects need to focus specifically on their own internal operations, the CAs primarily on issues of efficiency and the subprojects primarily on issues of leadership. While these additional issues are not addressed in the Strategy Paper, they are discussed below in Sections IV.3.3 and IV.3.4.

##### IV.3.2 USAID

###### Findings

USAID has taken action on several fronts to reduce the management burden of the CA component of the Project. Its first move occurred several years ago, when it shifted all bilaterally funded CA activities from grants to cooperative agreements.

Subsequently, in accordance with its 1985-88 strategy, USAID has been gradually moving these agreements towards consolidation (funding multiple subprojects and/or multi-site subprojects all at once), is approving activities for longer periods of time, and has worked with the CAs to establish a standardized system for reporting their service statistics to USAID (see Section II.4.3).

Some of the CAs have difficulty with the consolidation of subproject activities due to constraints imposed by their international or national headquarters or by their governing bodies, e.g. Pathfinder and FPSTC. Others, however, are moving readily in this direction or were originally designed that way, e.g., FPIA, EAVS, and BFPA.

The process that is most time consuming for both CAs and USAID, however, is the practice of short subproject funding cycles (one year to 18 months has been the general practice). USAID has begun to simplify the renewal process for low-budget subprojects and to extend the funding for subprojects until the time for renewal of the FPSP (September 1987) and intends to continue the process as subprojects come up for renewal in the coming months. During this evaluation, for instance, TAF was in the process of synchronizing the start-up and completion dates of all subprojects as part of the renewal of its cooperative agreement.

Considerations of control, however, in some cases outweigh those of efficiency and militate against efforts aimed at lengthening funding periods. FPSTC staff, for example, recognize the excess time and cost of continuing one-year cycles; the Governing Board, however, prefers to keep a tight rein on subprojects through short funding cycles (see Section III.5). Likewise, while local FPIA country office staff are aware of the burden of the short funding cycles, both they and FPIA headquarters staff appreciate the added opportunities for monitoring and TA that accompany the short cycles (see Section III.4). TAF, too, noted some reluctance to give up the opportunity for close monitoring that is a corollary of short funding cycles.

Arguments in favor of longer funding cycles, however, are perhaps more compelling than those against. Program staff of both USAID and the CAs now spend significant amounts of time preparing and approving proposals for short funding cycles. This time could be better spent in monitoring subproject activities and in developing and sharing innovations in CA programming. Furthermore, longer cycles encourage and offer the opportunity to develop an overview of CA activities. As long as such projects continue to be viewed as short-term efforts, however, both USAID and the CAs may be disinclined to do strategic planning.

Although USAID is providing leadership for consolidation of subprojects, extension of funding cycles, and standardization of reporting service statistics, it has not played as strong a role as it might have in helping the CAs identify technical assistance (TA) resources that could help in improving management efficiency (see Section IV.3.3 below). It is true that the cooperative agreement form of funding theoretically shifts the burden of identifying sources of TA from USAID to the CA; however, the use of this funding mechanism in a bilateral project is somewhat unique and all parties are learning.

In Bangladesh, plentiful TA resources are available from USAID--either centrally or within the USAID mission itself. On occasion, CAs have identified and used some of these resources on their own; however, communication is irregular and often CAs do not avail themselves of existing opportunities for support.

#### Suggestion

Efforts to assist CAs in the identification and utilization of USAID, AID/W and centrally funded TA resources should be regularized. A concerted effort should be made by the USAID staff to collect and disseminate this information at least two or three times each year. If USAID is able to collect and distribute TA information as suggested, the CAs should be encouraged to send copies to all subprojects and also to their international headquarters. These actions may educate all parties so that USAID will be able to count on the CAs and their subgrantees to locate TA resources directly in the future.

#### Recommendations

1. USAID should continue to explore alternative ways to reduce management burdens with the CAs that have not yet agreed to the consolidation of subproject activities. This is especially important and should be feasible in the case of CAs implementing standard model (CBD and clinical VS) subprojects that have been operating successfully for several years.
2. USAID should require all CAs to extend subproject programming cycles. A three-year program approval with annual program review and budget submission should be the optimal goal. CAs that have a problem with this proposal should be given special attention by USAID and efforts should be made to work out an agreeable arrangement.
3. See Section II.4.3 for a suggestion on how to continue to improve standardization of reporting systems.

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### IV.3.3 Cooperating Agencies

#### Findings

Many of the CAs and their subproject models have been in operation for up to a decade, during which significant changes have occurred in both the programs and in the environment in which they function. The issue now is whether existing models of service delivery, i.e., CBD and clinical VS, and their management are still appropriate, or whether changes are in order to ensure better utilization of resources.

CA management efficiency is currently plagued by two interrelated problems: too much time is being spent on paperwork and this paperwork is not necessarily yielding the kind of information that is needed to help improve management.

o Time Requirements. The CAs and their subprojects maintain a variety of forms and formats for client registration, service statistics, logistics, and other project activities. Most CAs determine what information will be maintained by subprojects, although some allow the subprojects to design the systems used to collect and maintain this information (see Section II.4.4). Due to the requirements for information from the GOB, USAID, the CA's own headquarters, and BFPA (in the case of CAs' receiving commodities through the BFPA system), many subprojects submit up to six different monthly reports. This requires many subproject field personnel to spend as much as 50 percent of their time on paperwork rather than on service delivery. This problem is compounded by redundancy in some systems, e.g., CWFP workers record the same demographic data about each client on at least three different forms. In other cases, the addition of specific information to a form may be needed to reinforce project aims, e.g., BAVS forms presently have no place to indicate alternative contraception given in cases of VS rejection.

Several CAs are actively addressing the problem of excessive paperwork for reporting. PF has recently reevaluated its forms and formats, and a new system has been designed and is being tested. BAVS has changed its MIS to reduce the number of forms and reports required from its branch clinics. This new system, presented in a recent BAVS workshop, met with approval from branch clinic staff in attendance (see Appendix M).

o Content. Not only are CA staff spending too much time on paperwork; in addition, the forms currently in use are designed to facilitate reporting and auditing, rather than improving project activities. For CBD projects, for instance, there is no indication on how staff time is allocated among the various kinds of service activities, for travel, or for record

keeping and reporting. For clinic-based programs, there is no information on time spent or staff costs for various interventions. It is reasonable to assume that these management factors have changed over time. Alone among the CAs, however, PF has begun an examination of a few of these issues in its trial program for the use of set work plans for field visits. BAVS, on the other hand, has made no effort to analyze its management costs, although, with excess capacity becoming a major problem, the need has become urgent (see Section III.2).

A recent cost effectiveness analysis (CEA) of the FPSP (Simmons, et al.), using couple years of protection (CYP) as the output measure, drew some conclusions about the relative cost effectiveness of the six CAs. It found, not surprisingly, that VS programs (BAVS) appeared most cost effective, that costs per CYP have decreased over time with program maturity, and that some programs appear to be more cost-effective than others.

The differences in cost per CYP, however, are difficult to interpret, without a better understanding of program and central organizational differences among the CAs. It would have been more useful, from a management viewpoint, if this cost effectiveness analysis had been based in part on a cost analysis of each organization. This could have provided insights on the differences among CAs, by showing how each spent the funds allocated to it. <sup>1/</sup>

#### Suggestion

If further CEAs are planned, they should be expanded to include a cost analysis of each CA that would be discussed in detail with that CA for management purposes. The analysis could also include an evaluation of the cost implications of possible program changes (e.g., additional MCH programming, shift from urban to rural) to assist in prediction of budgetary needs for replication or expansion.

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<sup>1/</sup> Cost effectiveness analyses are a useful way to compare similar programs or effects of program changes over time from the cost perspective, and therefore it might be useful to follow CEA over time with changes from urban to rural programming or from a single purpose to a multi-purpose program. These analyses during periods of program changes may also allow for improved prediction of expansion costs. Cost analyses, on the other hand, are more useful to an individual organization, since they indicate the cost of each component of program management and provide a basis on which to judge which components may be more costly than necessary.

Apart from any external CEA exercise, data should be collected on a regular basis as part of efforts to improve the MIS of each CA. Data for CBD subprojects might include

- o The time required for different types of home visits, e.g., first contact, pill resupply, VS counseling;
- o The ratio of travel to actual service time in CBD projects, given different population densities and different lengths of time projects have operated in an area;
- o The ratio of service time to record keeping and reporting time; and
- o The implications of method mix in all of the above.

For clinic-based VS projects, the variables to be studied would be different. They should cover

- o Average time spent by each type of staff for each type of client visit, e.g., tubectomy, vasectomy, follow up;
- o Personnel costs associated with each type of visit;
- o Average service/waiting time ratio for each type of visit; and
- o Any significant differences in any of the above under different client load conditions, method mixes, or patient flow plans.

Collecting the service data outlined above for both CBD and clinical projects should be undertaken as part of regular information management. It should be collected often, simply (not as a major research effort), and in different locations. It should be specific and current in order to be of the greatest use to the CA program staff responsible for designing and monitoring subprojects and to the subproject staff responsible for managing them. One tool developed specifically for out-patient clinics, which yields the types of data mentioned above, is Patient Flow Analysis (PFA). It is possible that PFA could be modified to capture the data recommended for the CBD program as well.

The form developed by USAID and the CAs (Appendix K) to assess activities of the CAs could serve as an excellent focus for improvement of the MIS of each CA. The rationale for an MIS should be to improve subproject management and supervision in addition to its present function of central reporting. The entire system should exist to ensure attention to the major

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outcome objective: FP services for the population being served. Using the USAID/CA format for definitions and minimum necessary data, it is possible to envision a system in which the primary focus is community-based impact with the addition only of a statement of the population to be served. Appendix L provides a detailed description of impact or prevalence-based programming. This and other possible approaches should be studied carefully by USAID and the CAs for possible adoption as an alternative to the present new acceptor target system.

#### Recommendations

1. The CAs, with USAID input and external TA if required, should undertake a PEA exercise for existing CBD and VS (clinical) models to identify excess capacity, to update systems of operation and management in keeping with changes in program needs and maturity, and to identify possible areas for innovation.

2. External TA should be sought to work with all USAID-funded CAs to standardize their MIS systems. This consultancy should include a close examination of the excessive clerical activities undertaken by field staff as well as assistance in designing an impact or prevalence-based reporting and management system for the CA subprojects.

#### IV.3.4 Subprojects

Several of the CAs rely on volunteer board members for direction and management of subprojects. Volunteers often appear to play a dominant role, and there is apparently not always a strong mutually cooperative relationship between volunteers and paid management staff. Where this lack of cooperation exists, overall subproject management may suffer.

In subprojects that are not run by volunteers, project managers appear to have a well-developed sense of daily responsibility and in some cases a fairly good sense of the larger picture and ideas about future directions. These individuals, however, appear to lack a clear mandate from the CA headquarters to apply these ideas to overall program development. Furthermore, they may not have the confidence to act independently to pursue these ideas in their project or community.

Daily management of subproject activities is generally smooth. Close supervision of clinic and field staff by a person or persons who have skills in individual monitoring and providing feedback, however, is crucial to keeping up morale and performance levels. Better and more regular communication--either formal or informal--is needed between subproject management and

staff to elicit feedback about program issues and changes that might be affecting the program.

### Suggestions

Every subproject should designate one person, whether paid or volunteer, to take overall responsibility for the project. He or she should feel responsible to the community and to the sponsoring CA for finding ways to use or eliminate excess capacity; to maximize worker productivity and effectiveness; and to accommodate the program's activities, to the extent possible, to the needs and characteristics of the community.

In subprojects with a heavy volunteer involvement, a more productive working relationship with paid managers should be forged. The roles of paid staff and volunteers must be clearly delineated and mutually understood and agreed upon. (These relationships presumably would be strongly influenced by the CA and its country policy.) It seems likely that management staff who work in the subprojects on a daily basis are in the best position to determine the current and future directions of subproject activities, while volunteers could be most useful in providing a broad contextual picture and in rallying community resources and support for program objectives.

Each subproject must be encouraged to foster an atmosphere that consciously encourages feedback from all levels of staff. It is likely that some subprojects will need more change than others to elicit this response. It may be particularly difficult for subprojects run largely by voluntary board members to find a mechanism for this. Facilitating openness and honesty and fostering disciplined, creative thinking is not always easy. Such skills should not be taken for granted; rather they should be nurtured actively at the subproject level. The people who function at the service delivery level often know about crucial details and facts that can have an important impact on program performance. They also have the most realistic ideas about the feasibility of new methods of service delivery from both staff and client perspectives; however, they may need to be prompted to share this knowledge. It is incumbent upon CA staff to assist and supervise the subproject management improvements suggested above.

### Recommendation

1. The CAs must take the responsibility to assess the broad management strengths and needs in their subprojects and the effects that their organizational structure may be having on subproject management. Those CAs that have not already done so should form a conscious policy regarding subproject management. This should be clearly and strongly communicated to the sub-

projects, and TA should be offered to enable the subprojects to respond to the management policy.

#### IV.4 Collaboration and Coordination

##### Background

Over the years that NGOs have been involved in FP efforts in Bangladesh, these organizations have worked relatively independently, focusing on their specific project activities and geographic areas of operation. This was appropriate when only a few NGOs were involved in limited projects. Then, issues such as coverage, duplication of services, training needs and commodity distribution could be handled on an ad hoc basis, albeit sometimes inefficiently. Now, however, with the infusion of FPSP funds and the resultant growth of NGO activities, some means for regular coordination is becoming increasingly important.

The GOB, while appreciating the contribution of the CAs to its own efforts, also has made efforts to provide some coordination and control. The coordinating role of the FPSTC is described in Section III.5. In addition, a GOB circular dated December 4, 1983 (Appendix J) sets out very clear and specific guidelines regulating the activities of NGOs working in FP.

##### Findings

The GOB's initial efforts to encourage FP NGO coordination may have been premature: several years ago, neither the NGOs nor the national program had reached their present stage of strength or maturity. Even now, however, primarily because its Governing Body is composed of GOB officials, the FPSTC is viewed with some suspicion by the NGO community, which does not relish being closely watched or "coordinated" by this body (see Section III.5).

The FPCVO has been virtually dormant in recent months (it held its first meeting in more than a year during March 1986). Purportedly, this recent lack of activity was due to a lack of funds, but it is equally likely that it was due to a lack of enthusiasm on the part of NGOs which remain skeptical about this group and its real purpose or intent.

Interaction at field level between CAs and the GOB is generally smooth. There have, however, been some problems. For example, in one upazilla, due to a dispute among government officials, the usual compensation for VS was withheld. In other cases, reimbursement for IUDs insertions has been delayed due to problems with certification and approval of the service

points. These kind of problems often result in disruption of services. GOB/NGO coordination meetings are mandated, but in fact the degree to which they are held at district level and below seems to vary from satisfactory to non-existent. These meetings could be a valuable forum for communication and coordination which could conceivably prevent or ameliorate situations like those cited above.

Coordination among the USAID-funded CAs, on the whole, has been good. Several have taken an important lead in the coordination of activities that have been mutually beneficial to all the CAs. Examples include PF's coordination of training and the Chittagong workshop on area reallocation (see Section III.6), BFPA's commodity distribution program (see Section III.3) and an upcoming NGO conference to be sponsored by BAVS. On the other hand, much more could be done, in particular in relation to coordinating the development of new subprojects and transferring elements of successful programs both to other NGOs and to the GOB (see Section II.4.3).

USAID has played an important role in promoting CA interaction and solving some joint problems, such as a condom shortage in 1985 and other commodity distribution problems, and in the standardization of service statistics definitions and reporting forms (see Section IV.3.1). USAID may be overstepping the traditional bounds of the cooperating agreement form of funding through these actions. Furthermore, although the present USAID staff responsible for monitoring NGO activities take an unusual degree of special interest and have done an exceptional job of bringing the NGO component to its present position, this may not be feasible in future due to staff, funding or other unforeseen changes in the USAID mission. An additional concern is that USAID coordination efforts to date have dealt only with the USAID-funded CAs, not the FP NGO community at large.

#### Suggestions

As CA efforts expand to rural areas, it will become increasingly appropriate for all CAs at both subproject and headquarters levels to maintain, strengthen, or if necessary, establish coordination with upazilla- and district-level GOB officials. This coordination may have different emphases and take various forms in different areas and also may have different levels of usefulness. Subproject personnel should probably take the lead in forging the new cooperative relationships at the local level, with CA headquarters providing support and advice as needed.

### Recommendations

1. USAID should explore providing whatever funds may be required to reactivate the FPCVO as a strong body that works with the NGO community on issues constraining their work or otherwise affecting their full contribution to the national program. Such support might be conditioned on assurances that the NGO community is truly and well represented in this body.

2. A new mechanism should be created, perhaps through a USAID grant to Voluntary Health Services Society or a similar NGO which is not implementing FP service projects. This new mechanism would allow the entire FP NGO community to participate in an active forum that meets regularly to discuss and debate problems and issues of mutual concern and to transfer information about project innovations. Position papers, minutes and other documentation from these sessions could be put forward to the FPCVO for action. The considerable numbers of NGOs involved in such an effort should have a positive impact on ensuring implementation of proposed actions.

3. Coordination among CAs in establishing new subprojects might be facilitated through the development of a needs assessment and local cooperation statement as part of project proposals. These should list other facilities and services in the area, plans for cross referrals, and should give an indication of the complementary nature of the proposed service.

## IV.5 Innovative Strategies and Integration of Non-FP Activities

### IV.5.1 Innovation

#### Findings

One of the stated purposes of the CAs in regard to the total USAID FP effort in Bangladesh is to develop innovative strategies for delivery of FP services. Projects such as BFFPA's UVAPA and Traditional Healers (see Section III.3), FPIA's Rural Development and Family Planning project and Rural Family and Child Welfare Project, and income generation projects sponsored by several different CAs are examples of programs that are employing approaches other than the urban CBD and VS-oriented clinical services that have been the usual service models delivered by the CAs. A number of other innovative strategies are in the planning or approval stages. While these subprojects are meeting needs, more could be done both by the CA originating the effort and by other NGOs or the GOB to replicate these initiatives.

An area of particular concern to the NGO community at large is the GOB's practice of assigning geographic areas to NGOs. While FPIA efforts to implement several innovative subprojects have been thwarted on the basis of this policy (see Section III.4), other CAs are also fearful that it will discourage the development of innovative subprojects that are directed to specific, non-geographic target groups, e.g., factory workers or technical school students.

#### Recommendations

1. To facilitate CA subproject replication, the successes and failures of CA innovations must be better documented and communicated. This will involve identification and evaluation of innovative projects, both those currently operating and those that will be implemented in future. Evaluation should be based on standardized criteria including measures of success, replicability and the degree to which the total program effort contributes to stated GOB/USAID FPSP goals (see Section IV.6).

2. Greater efforts should be made to transfer the successful innovative subprojects to the programs of other CAs and NGOs and to the GOB. Preliminary to any transfer, the sponsoring CA should be responsible for preparing a detailed, step-by-step implementation plan. Each plan must be complete and sufficiently detailed so that it can be used in the future even if those persons who developed the original program are no longer available for consultation. If possible, the "originator CA" should allow its headquarters staff as well as relevant subproject staff to be available for TA to other CAs or NGOs wishing to replicate innovative projects.

3. In order for the CAs to explore a broad range of innovative strategies, they should make every attempt to maintain communication with the GOB regarding its expectations and regulations for NGO activities and any guidelines, official or unofficial, that it uses in determining its approval of CA and other NGO proposals.

4. Efforts should be made by the FP NGO community, with assistance from USAID and other donors if necessary, to encourage the GOB to lift its limitation of NGO activities to assigned geographic target areas.

#### IV.5.2 Integration

##### Background

Although a limited number of CA subprojects include such non-FP activities as income generation for acceptors, most of

the so-called integrated projects have added other (non-FP) maternal and child health (MCH) interventions to their FP programs. Any discussion of MCH within these projects must take into account that family planning in and of itself is a crucial and primary MCH intervention. Family planning services are not ancillary services to be integrated with or grafted on to MCH; they are very much part of MCH just as are pre- and post-natal care, immunization, nutrition and all the host of other services included in the MCH package. Ideally, this whole complex of services should be made available to all women and children throughout the world. Unfortunately, human and financial resources do not allow the achievement of this ideal--even in the world's wealthiest and most developed countries. In reality, lines must be drawn and priorities must be set to allow for at least some MCH interventions to be provided widely and well in the absence of an ability to provide comprehensive services to all women and children.

Recently, both the GOB and USAID have come to view favorably integration of these MCH interventions with FP programs. Integration of FP and MCH is now established GOB policy. USAID earlier had disapproved CA requests to use other donor funds (Ford Foundation and the British High Commission in Bangladesh) to add MCH services to ongoing USAID-funded FP subprojects. Indeed, the NGO strategy papers suggest that integration efforts should proceed cautiously. They imply that MCH activities are secondary to FP and stress the need for close monitoring of cost effectiveness and evaluation of the impact on the primary FP objectives of the project. More recently, however, "child survival" funds appear to have become available, and USAID is soliciting proposals. This switch has caused some confusion among CAs in regard to USAID's views.

### Findings

Some CA subprojects have successfully added a limited number of MCH interventions, such as oral rehydration therapy (ORT) and nutrition education or referrals for immunization, to ongoing CBD programs of FP. However, where MCH services have been added to the FP services delivered in a clinic setting or at mini-clinics (those established in the headquarters of CBD projects to insert IUDs and/or give contraceptive injections) these non-FP services often are operated as separate or parallel services, which are not linked to family planning in the minds of the MCH providers. Furthermore, the record-keeping systems for MCH, where they exist, are not linked with the FP systems of these programs in most of the sites visited.

The doctors and paramedics staffing these so-called integrated MCH services seem to provide reactive rather than proactive services. Women coming for non-FP services for themselves

or their children are not routinely motivated for FP. Although most subprojects promote the addition of MCH to ongoing FP services as a way to see that acceptors' other health needs and those of their children are not routinely motivated for FP. Although most subprojects promote the addition of MCH to ongoing FP services as a way to see that acceptors' other health needs and those of their children are served, little effort is made to link records or even identify which MCH clients are also FP acceptors. Furthermore, in several sites visited, the record-keeping system for CEP is a completely separate system so that clinic staff are not allowed to enter any notations on CBD client cards, even if they resupply contraceptives or treat a side effect during a clinic visit (see Section IV.9.2 for more on this subject).

BAVS has submitted a proposal for use of the newly available "child survival" funds. The workplan, however, appears to have been developed under some pressure with little reference to Bangladesh realities or to the experience of other NGOs working in MCH there. Although the proposal states that MCH services will be established to serve FP, especially VS, acceptors, no indication is given of how, or even if, FP status will be determined. Furthermore, the specific services to be offered are not enumerated in detail.

To increase FP acceptance past the point of meeting present unmet needs, additional interventions other than MCH are sometimes added to FP programs. The selection of interventions to increase FP impact usually involves a consideration of both proximate (biologically based) and intermediate or distal (socioeconomically based) determinants of fertility. Proximate determinants include contraceptive use, delayed age of marriage or delayed coital activity, prolonged lactational amenorrhea, availability of abortion, and abstinence. (The latter three are socially accepted in Bangladesh.) More distal determinants include women's education and employment as well as generally improved socioeconomic status. In Bangladesh, the selection of which of these less direct interventions are to be added should depend on their measurable impact on fertility in the Bangladesh setting. The impact of a minimal increase in education without concomitant social changes is of questionable impact and major changes in socioeconomic status are not within the potential of a FP program.

One distal determinant that has measurable fertility impact in Bangladesh is employment for women. The FP program is addressing this issue directly by employing women in larger numbers than ever before. This is especially true in the CA subprojects, which thus have a double effect on the determinants of fertility--proximal, in their provision of contraceptive services, and distal in the employment of women.

### Recommendations

1. Since the integration of FP and MCH is established GOB policy and since "child survival" funds are now readily available, USAID should continue and clarify its new policy of encouraging integrated programming by the CAs. USAID funding for efforts in this area might be best used to encourage innovations and to document the impact of integration on FP. Documentation of efforts undertaken in this regard should give attention to such concerns as worker overload and should evaluate also the child survival impact of these activities. In its efforts to encourage the CAs to integrate services, USAID should be prepared also to assist with identification of TA as needed.

2. To the extent possible, any intermediate determinant interventions funded by USAID population monies, e.g. women's education or employment activities, should be designed with double effect, i.e. having an active proximate component, e.g. the provision of contraceptives to participants or specific activities to encourage delayed marriage, in addition to the intermediate component.

### Suggestions

Prior to any widescale introduction of these interventions in ongoing or new CA subprojects, it is suggested that the groundwork be laid through the following actions:

- o "Child survival" funds should be used to collect existing information on MCH (including combined MCH/FP activities) in Bangladesh and to undertake new studies, if necessary, to determine which MCH interventions have the greatest potential for impact on fertility over the shortest time at the lowest cost and with the least disruption in existing models of FP services.
- o If the above investigation determines that other MCH interventions are feasible additions to ongoing FP services models, very specific protocols should be developed by the CAs, in collaboration with USAID, to determine which interventions can be added to the various types of subprojects. The protocols should be based on the capability and capacity of the subprojects to undertake the intervention and appropriateness of the particular intervention(s) to the type of subproject being undertaken, e.g., CBD or clinical.
- o CAs should encourage existing and proposed subgrantees to explore the MCH services provided by other sources in their catchment areas. If these are adequate, no

effort should be made to duplicate them in FP operations. The subprojects should, however, be encouraged to refer patients for MCH services elsewhere.

- o Subprojects that have already incorporated MCH elements with their FP services are urged to review these activities to determine a) how to improve the links between FP and MCH and b) whether special priority or some other preferential treatment should be provided for FP clients utilizing MCH services as a way to link these services in the minds of clients and staff alike. One suggestion, which may also contribute to self-reliance or allow the purchase of MCH medications (currently restricted with USAID funds), would be to charge a sliding scale fee for non-FP MCH services, giving preference to FP clients.

#### IV.6 Internal Evaluation/Operations Research

##### Findings

A major aspect of the work of each CA central office is the monitoring and evaluation of its ongoing subprojects and the planning, clearance, and approval of new activities (Appendix G). USAID has also participated in the review and evaluation of all CA subprojects. Because these now total 86 in 292 project sites (see Table 2), USAID has had to develop some strategies, including multipage checklists to standardize and simplify site visit monitoring, to lighten this phenomenal responsibility. Consolidation of small projects and simplification of the renewal process for low budget projects may also help ease USAID's burden (see Section IV.3.2). Nonetheless, a thorough execution of this job is clearly beyond the resources of the current USAID staff, and the sheer size of the program now will make it more difficult for USAID to continue the major "hands-on" coordination role it adopted during the growth of these programs.

The internal evaluation systems of the CAs are not equally useful in their ability to identify the subprojects that merit special attention, that can handle innovations, and that should be discontinued. Several of the CAs expressed an interest in improving their internal evaluation and operations research (OR) capabilities. Some have already begun undertaking steps in this direction. PF is carrying out OR on fieldworker scheduling patterns, and FPSTC plans to study the impact of intensive MCH activities on FP in several of its subprojects. The mini-CPS exercises described in Section II.4.3 have also been undertaken as internal assessments of programs and systems.

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### Suggestions

While these efforts represent a good start, they need to be reviewed to ensure that they serve USAID's needs as well as those of the CAs. They should also be shared with other CAs that have not yet developed systems. TA should be provided as needed to help prepare operations manuals for internal evaluation. These systems should include a mechanism for relative categorization of project success based on elements such as objectives and measures, outputs, cost effectiveness, and checklist attainment. If properly developed and used, these systems should yield an internal management plan with guidelines for corrective action.

External evaluations of CA activities being carried out by the GOB or other outside organizations, such as the Voluntary Sterilization Surveillance Team, should be used to reinforce internal evaluation mechanisms created by the CAs and ongoing USAID monitoring. USAID should ensure that it has input in all external evaluation plans and should receive any outputs produced by other's evaluations of activities it funds.

Several of the CA innovations, in addition to those already under study, should be assessed through OR or internal evaluations. These include the projects proposed by FPIA for non-geographic coverage, the daily schedules for fieldworkers being introduced by PF, BFPA's projects that focus on special groups and those by TAF with illiterate distributors (see Sections III.3, III.6, and III.7). Perhaps the most important are those subprojects that have attempted to establish depot holders for resupply to clients in mature programs (see Sections IV.3, III.4, and III.7). It is vital for program expansion and cost savings to determine whether this type of approach is effective.

Some of these activities may require the use of outside technical expertise. Although funds for TA are available in each CA's present funding allotment, CAs may not be aware of all available resources. USAID itself can provide the following TA resources: guidelines concerning project implementation; USAID/Bangladesh staff with expertise in financial, legal and population matters; and AID/W-funded CAs that have been selected to provide technical expertise on request in several areas including policy, IEC, training, OR, demography, computer science, MCH and management. Furthermore, the University Research Corporation was opening a regional office in Dhaka during this evaluation. This AID/W CA may be able to respond to some of the CAs' needs for assistance with OR and the development of internal evaluations systems.

### Recommendation

1. To assist USAID in monitoring CA programs and making decisions regarding the continuation of funding, each CA should review and revise existing systems or develop new self-administered, action-oriented internal evaluation plans. These should be acceptable to USAID and also serve the management assessment needs of the CAs and their subprojects. USAID should assist with the identification of TA for this process if required.

## IV.7 Commodity Logistics

### Findings

Family planning commodities are an essential ingredient of FP services. The cafeteria approach is an accepted concept in Bangladesh, and the CAs as a group offer a high quality selection of modern contraceptive methods. Present CA efforts to develop comprehensive services within each subproject or to develop referral systems between CA units should continue to achieve the goal of complete user access to all available methods.

BFPA's assumption of the task of the commodity supplier for most of the other CAs has proved very beneficial (see Section III.3). While the GOB still supplies the contraceptives with USAID support (funds and TA), BFPA warehouses and distributes them. The other CAs are required to submit monthly supply reports to BFPA in order to obtain new supplies. This arrangement has had a significant impact on alleviating the stockouts that were experienced regularly prior to its establishment.

In the period to be covered by the next USAID project, this dual system will remain necessary. In the long run, however, as the CAs begin to work in outlying areas, it will become inefficient to maintain two completely separate logistics systems. In recognition of this eventuality, USAID currently is also funding the GOB supply system through the government component of the FPSP. It would be prudent, therefore, at present for BFPA to take every possible step to stay abreast of GOB supply activities and actions.

### Recommendations

1. USAID should continue to provide BFPA with the resources (funds and TA) required to ensure optimal commodity warehousing, supply lines and personnel. This effort should include a complete survey of every warehouse and a review of the supply competences of all of the logistics personnel.

2. At the same time, USAID should continue its efforts to upgrade the GOB supply system, encouraging interaction and mutual training for GOB and NGO supply officers whenever possible to ensure ultimate meshing of the two logistics systems.

#### IV.8 Financial Considerations

##### IV.8.1 Self-Reliance and Resource Development

###### Findings

The FP program in Bangladesh is heavily dependent on foreign donor support. Although these funds have been sufficient to support a sizeable program in recent years, it is now desirable that services be extended to a larger segment of the population while reliance on foreign funds is reduced.

CAs perceive themselves on the horns of a dilemma when it comes to generation of resources for program funding. One CA representative noted that USAID "keeps pushing" bilateral funds on the CAs while at the same time urging them to increase efforts at self-reliance.

Although all indications point to an increasing flow of funds from an even greater number of donors to NGOs working in FP in Bangladesh, CAs are apprehensive about relying in the long term on external financing. Some CAs and their subprojects have already developed self-reliance efforts. For several years, IPPF has been encouraging its member associations (including BFFA) to undertake planned programs for resource development and has provided TA for these efforts. In Bangladesh, this program appears to have had an impact as indicated in Table 6.

Table 6

BFFA  
Resource Development Efforts  
(1985)

<u>Income Source</u>	<u>Amount Realized</u>
National Raffle	Tk. 172,070 (\$ 5,736)
Fees for Service	273,435 (\$ 9,115)
Donations from Individuals (Local and Foreign)	152,504 (\$ 5,083)
	<hr/>
TOTAL	Tk. 598,009 (\$19,934)

This income represents over six percent of BFFPA's total budget for 1985. In addition, the Association owns the land and buildings of its Dhaka headquarters as well as land for three of its branches with a total value of more than \$1,000,000 (US).

Other self-reliance efforts include an elaborate plan developed by BAVS, which has created Self-Reliance Committees in each of its branches, to undertake local fund-raising and land acquisition efforts. Centrally, BAVS is revising its staffing patterns in an effort to reduce the fixed costs of its entire program. In addition, BAVS now charges a fee for some of its training courses and also raises funds through the sale of SMP products in some of its clinics. Certain subprojects of TAF are also selling SMP products. CWFP has used income from tuition fees from its training courses to pay for land on which an organizational headquarters building will be constructed.

USAID regulations on how to account for these funds, however, are not clear. There are questions regarding to whom it belongs, how it may be used, whether it can be used to generate interest, and if and how it should be accounted for and reported.

#### Suggestions

TA may be required to assist with the development of innovative resource development schemes and/or to examine existing schemes for performance and enhancement. This TA could also include the development of simple reporting and accounting systems as needed. These systems should include information about income from all sources (e.g., grants, loans, donations and in-kind contributions), and the percentage of total income represented by project-generated income over time. The percentage of internal (in-country and/or project-generated) income should increase with a corresponding decrease in external (grants and donations from outside Bangladesh) income. This simple measure would indicate the degree of project self-reliance attained. In making these calculations, attention must be given to controlling for the impact of program growth and related increases in external funding.

#### Recommendations

1. USAID should clarify the regulations related to sub-project income generation for the CAs as soon as possible.
2. To encourage and monitor resource development efforts further, USAID and the CAs should collaborate in the development of a simple, annual reporting format to indicate project income generated during the year and the uses of this income.

#### IV.9 Other Issues

##### IV.9.1 Training

###### Background

When new or creative programs of FP service delivery are initiated, appropriate training is needed for all cadres of personnel (management, supervisory, fieldworker, and supply). To date, however, in spite of the National Institute for Population Research and Training's (NIPORT) mandate and efforts to be as responsive as possible to NGOs, all CA training has been done by the individual CA itself or by individual arrangement with another NGO. During the early years of the FPSP, these special arrangements were able to meet most training needs. As a result of the rapid growth of CA activities, however, need now outstrips capacity.

Training efforts to date have focused on major cadres of workers. In addition, workshops and other training sessions have been planned and/or implemented by some of the CAs to encourage active interest among elected officials, local GOB officials, and other community influentials, and some refresher courses, such as PF's quarterly meetings for project managers, have been offered. Little attention, however, has been given to revising training to correspond to changes in worker roles--e.g., as the demand for sterilization declines, the sterilization worker must be trained in alternative methods of family planning, and to training other cadres of workers such as part-time agents.

In the field, updates of standard operating procedures, both managerial and technical, and other back-up materials, are often not available. Where they exist, their usefulness may be limited by the inability of staff to understand and implement their content.

The CAs have launched a coordinated effort to address their mutual training needs. PF is serving as the secretariat for this endeavor--the CA Coordinating Committee for Training (CCT). The CCT has appropriately begun by identifying the gap between numbers to be trained and facility capacities. The next step will be to assess training needs for each major cadre of worker. (The Program for Introduction and Adaptation of Contraceptive Technology [PIACT] recently carried out a similar study in Bangladesh as a first step in developing a curriculum for training traditional healers.)

The CCT review indicates that CAs will not be able to meet their training goals for 1986. Even with the help of NIPORT, which has a mandate to assist in this area, the job cannot be

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done; NIPORT has neither the trainers, the curriculum, nor the production capability to help at this time. It does, however, have reasonable access to underutilized GOB training buildings, such as the Family Welfare Visitor Training Institutes and Medical Assistant Training Schools. These may be a help in the near future.

### Suggestions

The proposed training needs assessment should include an evaluation of the knowledge base of present workers to identify gaps or weaknesses in the various curricula. It should also review all materials available, and the methods and content of NIPORT, ICDDR,B, and other NGO training programs. Whoever carries out these investigations should report findings to the CCT and work on content with trainers. Particular attention should be given to advances in contraceptive service technology, task orientation, problem-solving approaches, and other interactive training techniques in proposed curricula.

The CCT is also urged to ensure that any guidelines concerning medical protocols be reviewed and updated on a regular basis. These updates should be copied and distributed to all relevant personnel. A method should be established for rapid feedback from the field to minimize cases of misunderstanding that might lead to non-implementation or prolonged continuation of activities no longer warranted.

To facilitate communication about new technologies and other innovations, it would be helpful to maintain a cooperative clearinghouse/library of all operational guidelines, protocols, background materials and updates that would be available to all FP NGOs. One NGO, selected by the NGO community, should be supported by USAID to maintain all materials listed above, as well as FP reference materials. Some of the CAs have made a start in collecting some of these materials (FPSTC has a newly functioning unit funded by Ford Foundation, BFPA maintains a library of reference materials, and others also have small libraries). USAID is encouraged to provide any additional TA or short-term training necessary to assist in these efforts.

The ICDDR,B Matlab Extension Project has demonstrated that in Bangladesh training of fieldworkers alone is not enough to ensure significant improvements in service delivery. Community approval is needed to reinforce workers' self-image and motivation. Therefore, two additional activities are suggested to provide ongoing stimulation of worker interest--a regular newsletter and opinion leader training.

An informational flyer or newsletter could be developed for distribution at regular intervals to all CAs, other NGOs and

interested GOB personnel. It could draw from existing efforts of this sort: FPSTC presently produces a newsletter for distribution to its subproject staff, BFPA distributes a book on contraceptive technology and other technical information, and BAVS also distributes a newsletter. Coordination and consolidation of these efforts would save costs, increase dissemination of information, and contribute to the cross-fertilization of ideas.

The proposed newsletter should be oriented to the reading habits of the worker who actually provides services--the fieldworker. Therefore, articles should be brief and written in simple language with frequent input from the workers themselves. (One CBD fieldworker produced very insightful written responses to some questions posed during our visit--see Appendix N.) The newsletter should have illustrations and a question and response section to facilitate feedback from readers. It could also include MIS data feedback as well as updates on technology. Newsletter items could become a focus for discussion at subproject staff and supervisory meetings. Such a publication would not be expensively produced; emphasis should be on brevity, succinct communication of updates, and articles of interest for and by subproject workers.

Scheduled training sessions for community leaders and influentials should be held and additional workshops should be planned. Sessions should be as action-oriented as possible and designed so that participants are provided with guidelines that are appropriate to their community roles.

All efforts in the area of training should take advantage of the experience of other similar organizations including NIPORT, ICDDR,B, Community Health Care Program and other active NGOs. Findings at each stage of the CCT's work should be shared with all interested parties, and representatives of other organizations should be included in meetings and workshops as frequently as possible.

#### Recommendations

1. USAID should continue to support CA efforts to coordinate all aspects of training--upgrading of content, development of training curricula and backup material based on needs assessments, and the development and implementation of special training programs. Some TA may be required, given the magnitude of the training requirements. USAID should assist the CAs in the identification of appropriate TA resources.

2. A mutual effort to share training capacities among the CAs, other NGOs and the GOB is strongly recommended to avoid duplication.

#### IV.9.2 Staff Selection, Utilization and Capacity

##### Findings

Staff for CA subprojects are selected according to a variety of criteria. Most subprojects have minimum educational criteria for staff at the level of fieldworker and above. Several of the CAs recruit senior and professional staff nationally while others require recruitment of staff from the locality to which they will be assigned. The latter arrangement is usually the case with regard to fieldworkers and, to a lesser extent, supervisors of field staff. Some subprojects also have requirements regarding personal contraceptive use and an interest or experience in what is described as "social work."

It is likely that the criteria used in staff selection may be less important to job performance than appropriate training for the job to be done, good management and supervisory practices, and adjustment of reporting and record-keeping systems and expectations based on the capacity of the workers and their training. Moreover, when rural projects are designed, educational qualifications may need to be downgraded. Rural projects may also need to be reviewed in terms of record-keeping and reporting expectations if workers with less education are to be employed.

Almost all subprojects visited require excessive record keeping and other clerical duties of staff at the level of fieldworker, supervisor, and counselor. According to their job descriptions, these categories of staff have the primary responsibility to recruit, resupply and counsel clients; however, the excessive amount of time they are spending to carry out clerical activities appears to be reducing the time available to accomplish their primary duties.

The use of volunteers as a means to expand project capacity has been tried in some subproject. Several CAs, e.g., BAVS and BFPA, were found to rely heavily on volunteers for program management--both in headquarters and in their subprojects. Volunteers are also useful in field positions in a number of subprojects, e.g. TBAs and resupply agents in some TAF projects, BAVS field agents, and BFPA Traditional Healers and UVAPA project field workers.

Usually, the use of volunteers serves to increase coverage and reduce costs. On the other hand, use of volunteers can also result in poor performance and/or lack of accountability.

Several of the CAs have added clinicians--part-time medical doctors and/or paramedics--to their CBD subproject (see Section

IV.5.2). Paramedics are usually employed to provide IUD insertions and contraceptive injections and to handle side effects from all methods. Part-time doctors are sometimes hired also to handle the FP services.

Findings of a recent study undertaken by FPIA in Bangladesh concluded, however, that few of these doctors service clients coming for FP complications, none do routine staff training, female doctors are more acceptable to clients than males, and well-trained paramedics are at least as successful as doctors in dealing with FP issues and can deal with most clients coming for medical attention as well. This consultancy confirmed these findings.

#### Recommendations

1. The CAs should examine the responsibilities of each category of worker that has primary duties related to recruitment and other interaction with clients. The goal should be to streamline secondary clerical responsibilities, particularly record keeping. Paperwork burdens of supervisory level staff should also be reduced, if possible, to allow for an increased fieldworker to supervisor ratio. Both actions should ultimately reduce overall program costs, measured on the basis of cost per client served. Some CAs may wish to investigate the feasibility of employing office-based clerical staff to take care of the record-keeping and reporting tasks now done by field staff.

2. Volunteer participation in CA-funded subproject management and implementation needs to be better managed. Proposals for volunteer utilization might address the following issues:

- o How volunteers will be informed of and held responsible for the expectations for their participation in the project.
- o How volunteer participation will be maintained and how volunteers who do not perform at expected levels will be dismissed.
- o The arrangements that are made for project accountability by the subgrantee when volunteers are involved in project management. The liability of the CA for volunteer managers and staff in their subprojects should be carefully examined.

3. If doctors or paramedics are employed to work in CBD projects, even if they are specifically recruited to provide MCH services, they must be fully trained and motivated to promote and provide FP services.

### IV.9.3 User Perspective/Counseling

IV.9.3.1 Field Counseling. Although the concept of user perspective in FP is not fully developed, the CBD fieldworkers appear to have well-developed insights regarding user perspective. Whether these skills are attributable to training or experience is unclear.

Regardless of the origin of the skills, field workers do a good job in giving attention to the special needs of CBD acceptors. They generally provide counseling to determine the client's fertility, health and socioeconomic situation; present all methods and services in language understandable to the client; explain the use and potential side effects of all methods; allow the client to respond and ask questions freely; follow up appropriately; and provide services or refer elsewhere as appropriate.

While performing adequately among clients, however, fieldworkers tend to be hesitant about sharing their user perspective skills with supervisory/management staff, especially if sharing this knowledge and making suggestions about alternative ways of working seems to challenge orders from superiors.

IV.9.3.2 Follow-up. Follow-up is an important user perspective issue. Home visit schedules for contraceptive resupply in CBD projects were found to vary between subprojects, but follow-up in these projects appeared to be adequate. At most subproject clinics providing VS, however, there has been a decline in the percentage of clients returning for follow-up care over the past year. This could have serious implications in view of the need for medical expertise for stitch removal and in cases of minor complications such as wound infection. Furthermore very few IUD clients return for early post-insertion follow-up visits, much less for regular periodic checkups. This too could have negative consequences since copper-bearing IUDs, which are the predominant type of IUD in use in Bangladesh in recent years, require periodic removal and reinsertion to ensure that the action of the copper is maintained.

IV.9.3.3 Method Mix. A third client perspective issue relates to the availability of methods to suit all clients. BFPA clinics appeared to provide the full mix of methods. On the other hand, most BAVS clinics appeared to need more attention in this area. Rejected client registers were kept at all BAVS clinics visited. These records note the reasons for rejection and referral for medical services, if indicated; however,

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contraceptive counseling and distribution of alternative methods are not routinely recorded. When questioned, BAVS staff did not appear to be fully cognizant of user perspective as it related to the provision of alternative methods, especially for clients rejected because of medical contraindications to VS.

### Recommendations

1. Staff and management of all CA subprojects are urged to give full attention to user perspective at all stages of project planning and implementation, as well as for staff training programs and refresher courses.

2. CAs should encourage CBD subproject field staff to share user perspective insights with their colleagues and with the management of their subprojects, perhaps through the workshops or newsletter articles.

3. The CAs sponsoring clinical projects that provide VS and/or IUDs are urged to locate clients who have not returned for follow-up to determine

- o Where these clients are going for follow-up, if they are going at all;

Whether stitch removal for VS clients is being performed, and if so, where and by whom;

Whether copper IUDs are being replaced as prescribed and where; and

Whether any serious complications are going unattended due to incomplete follow-up at the clinic that provided the initial service.

4. CAs should be encouraged to refine or revise clinical follow-up guidelines (based on the findings in the surveys suggested above, if possible). If necessary, other NGOs having active field programs in the clinic catchment areas might be enlisted to cooperate with clinics by carrying out home visits for follow-up among the clients who do not return for clinical follow-ups.

5. As the number of home visits per client per year has implications for management and coverage as well as user perspective, this issue might deserve further study to determine optimal follow-up schedules based on both user and staff capacity perspectives.

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V. MAJOR RECOMMENDATIONS

## V. MAJOR RECOMMENDATIONS

In summary, a number of active, dynamic FP service delivery systems are being operated by USAID-funded CAs in Bangladesh. Numerous recommendations specific to certain issues, problem areas and/or CAs are noted throughout the preceding sections. These should be read and acted upon, if deemed appropriate, within the context in which they are presented. There are, however, three general principles that should govern USAID's approach to the CAs: continuing USAID support; strengthened CA central support systems; and more coordination among CAs. The four recommendations that grow out of these principles should be given special attention by USAID and the CAs. They are as follows:

o Continuing USAID support

1. USAID should continue to support the FP activities of CAs as complementary, adjunctive services within the national family planning program. This recommendation is made with the understanding that in areas or special populations presently served--e.g., urban areas where there is no evidence that the GOB is ready to ensure ongoing services--that the CAs continue and expand services appropriately to ensure complete coverage. Furthermore, the CAs should be required to share the results of their experience with others in the NGO community as well as to the GOB in an effort to strengthen and improve the national effort.

o Strengthened central support systems

2. CAs should continue to strengthen their central support systems rather than allowing rapid proliferation of small subprojects. This effort toward centralization should be accompanied by increased emphasis on program evaluation. Internal evaluation systems should be developed for present project models and innovations, and both prospective and retrospective OR undertaken, to gain insights into the most cost effective, impact-oriented and high quality service innovations for incorporation into future programming.

o Increased coordination among CAs

Some problems cannot be solved either by the CAs acting alone or by USAID acting on their behalf. Instead, what may be needed now is increased collaboration and coordinated efforts

among the CAs. Many problems are amenable to this approach. Collaboration could include the following:

- o New projects should be planned with an eye to avoiding overlap in types of services while still providing comprehensive coverage.
- o Interaction among multiple donors should be improved.
- o GOB efforts in FP at all levels should be taken into account, especially NGO impact on government policy statements, development of guidelines for NGO/GOB coordination in rural areas, and transfer of relevant findings to GOB programming.
- o CAs should share expertise among themselves and with other NGOs, to identify appropriate, user-oriented program innovations.
- o Additional TA needs and providers should be identified.
- o Links with non-FP MCH services should be improved. (However, prior to the addition of any MCH services to ongoing FP projects, the choice of which additional services are most appropriate should be researched.)
- o CA support and/or guidance to new NGO activities funded by non-USAID resources should be coordinated.
- o Logistics related to acquisition and distribution of commodities and printed materials, including bulk purchase arrangements, should be coordinated.
- o A clearinghouse/library should be developed for the collection of national and international materials, training curricula, research findings, program descriptions, service and clinical protocols, and management guidelines.
- o Regular exchange visits should be arranged for CA headquarters and subprojects personnel to other subprojects, including visits to the programs of other CAs.
- o A forum should be created for presentation of findings of the Population and Development Evaluation Project of the Planning Commission and other relevant research, e.g., studies by ICDDR,B and PIACT.
- o Management information systems should be standardized,

including the recording and reporting systems of both USAID and the GOB.

- o Project components or innovations for OR should be chosen and ranked in order of priority.
- o USAID and other donor regulations should be made clear through regular discussions and information should be exchanged regarding the availability of TA and training opportunities from AID/W and other donors.

Several of these and other concerns, such as training needs, are being addressed through a variety of CA and USAID actions. Coordination and collaboration, however, will be the key to the future health and success of the CA programming and therefore, to conclude this report, the two recommendations from Section IV.4 bear repeating.

3. USAID should explore providing whatever funds may be required to reactivate and strengthen FPCVO. The GOB, the World Bank and other donors should be involved in this process. FPCVO's mandate should continue to be to work with the NGO community on issues constraining its activities or otherwise affecting its full contribution to the national program. Such support might be conditioned on assurances that the NGO community is fully represented in this body.

4. A new mechanism should be created to allow the entire family planning NGO community to participate in an active forum that meets regularly to discuss and debate problems and issues of mutual concern and to exchange information about project innovations. Position papers, minutes and other documentation from the meetings of this forum could be put forward to the FPCVO for action. This mechanism should not itself be involved in implementing FP services projects. It could be established through a USAID grant to Voluntary Health Services Society or to a similar NGO.

## APPENDICES

APPENDIX A

Scope of Work for the Evaluation of the  
Non-Governmental Organizations (NGOs) Component  
of the Family Planning Services Project  
(No. 388-0050), Funded by USAID

## APPENDIX A

### Scope of Work for the Evaluation of the Non-Governmental Organizations (NGOs) Component of the Family Planning Services Project (No. 388-0050), Funded by USAID

#### BACKGROUND

1. Since 1981, USAID/Bangladesh has funded family planning services subprojects (community based distribution and clinical) through six NGO intermediaries under its Family Planning Services Project No. 388-0050 with grants/cooperative agreements totalling approximately \$16,000,000 (FY '81-'85). At present, the population NGO sector funds 81 subprojects at 254 sites in most of the 64 new districts of Bangladesh through these six intermediaries: Bangladesh Family Planning Association (BFPA), The Pathfinder Fund, The Asia Foundation (TAF), The Association for Voluntary Sterilization (AVS) and subgrantee the Bangladesh Association for Voluntary Sterilization (BAVS), Family Planning International Assistance (FPIA), and the Family Planning Services and Training Center (FPSTC).
2. The purpose of the current Family Planning Services Project was to support the Bangladesh Government's program to reduce fertility by increasing the prevalence rate of modern birth control methods. The expected Contraceptive Prevalence Rate was 28% (modern methods) by the end of CY 1987. The project purpose was to be achieved by concentrating resources on improving and expanding the delivery of family planning services through the existing Ministry of Health and Population Control (MOHPC) system, the Social Marketing Project (SMP), and NGO subprojects.
3. The current Family Planning Services Project was originally authorized on February 17, 1981. The last external evaluation of the Family Planning Services Project, which included an assessment of NGO family planning activities in relation to the overall family planning effort in Bangladesh, was conducted by APHA in August 1982. A more detailed evaluation of USAID-funded NGO family planning activities in Bangladesh was conducted by a separate consultant from June 1 to July 6, 1982. An evaluation of FPSTC was conducted from April 10 to April 29, 1984. Evaluations of AVS and Pathfinder's AID/W Cooperative Agreements (AID/DPE-0968-A-00-2001-00 under Grant AID/pha-G-1128 and Project 9320-0807 under Grant No. AID/pha-G-1138 respectively) were conducted in March/April 1985. An evaluation of FPIA's AID/W Cooperative Agreement and evaluations of TAF and BFPA's programs were conducted in November/December 1985.
4. Based on past evaluations, NGO program components, overall strategies and funding considerations, the Population NGO Strategy 1985-88 was developed.

OBJECTIVES OF THE EVALUATION5. OBJECTIVE A

TO UNDERTAKE A REVIEW AND ANALYSIS OF THE EXISTING USAID-FUNDED NGO FAMILY PLANNING OBJECTIVES, INPUTS, STRATEGIES, AND PROGRAMS AND THEIR CONTRIBUTION TO THE ACHIEVEMENT OF THE OVERALL PURPOSE OF THE FAMILY PLANNING SERVICES PROJECT.

6. To what extent have USAID-funded NGOs achieved the anticipated magnitude of outputs that were stated in the Project Paper, i.e. given the level of funding which they received and utilized? How have these outputs contributed to attaining the overall goal and purpose of the Project and the USAID/B Population Sector NGO strategies of 1981-85 ?
  - a. Particularly, given the 1981-84 NGO strategy of providing family planning services to urban areas, how effective have the NGOs been in meeting this goal? Is the emphasis on NGO activities in urban areas still appropriate?
  - b. How effective are the present modest "beyond family planning" interventions of some programs, such as the Pathfinder Fund's Mothers' Clubs and the basic MCH, clinical, and CBD services provided by FPSTC projects? Have these additional interventions added to or detracted from the effectiveness and efficiency of the delivery of family planning services?
7. Are the staffing levels of each intermediary (and at USAID/B) commensurate with the present program requirements in Bangladesh? Are the staffing level of sub-projects commensurate with program requirements?
8. What are the technical assistance requirements of sub-projects? Do the intermediaries adequately address the technical assistance requirements of their sub-projects?
9. What strengths does each intermediary have which should be shared with other NGOs or the Government, such as recording/reporting formats, workplans, training plans, innovative schemes, etc.?
10. Have the NGOs ensured Government and NGO cooperation and coordination at all stages and levels in order to maximize their effectiveness? To what extent have USAID-funded NGO sub-projects and activities influenced the family planning program of the Government? How have Government policies influenced NGO sub-projects?
11. What resources have been generated by NGOs under the Family Planning Services Project to offset AID assistance (including community donations of funds, facilities, and land etc.) and what is the potential in future for this?

12. OBJECTIVE B

TO MAKE RECOMMENDATIONS AS TO FUTURE ORIENTATION AND SCOPE OF NGO OBJECTIVES, STRATEGIES, AND PROGRAMS GIVEN CONTINUED AID ASSISTANCE TO BANGLADESH FOR FAMILY PLANNING SERVICES. THE RECOMMENDATIONS MAY REFER TO STRENGTHENING AND/OR RE-ORIENTING EXISTING OBJECTIVES, STRATEGIES, INPUTS, AND PROGRAMS AND/OR TO NEW OBJECTIVES, STRATEGIES, INPUTS, AND PROGRAMS.

13. Is the Mission NGO strategy (1985-88) appropriate given the capability of the NGOs, the USAID assistance objective, the BDG Third Five Year Plan, and other program constraints? Are there NGO activities described in the current project and in the 1985-88 USAID Population Sector NGO Strategy which should be deleted or given lower priority in a subsequent project? What are the constraints, including costs on new directions/strategies and how could these be overcome?

14. Should some programs with "excess capacity" provide services other than family planning? For example, should BAVS diversify and offer more MCH services? Should intermediaries devote a larger share of resources to other development activities? If so, what evidence is there that time will positively affect the attainment of family planning objectives?

15. What strategies are most effective to encourage adoption and continued use by various groups of eligible couples, i.e. newly married, pregnant, those with 1 or 2 children, etc? Should NGOs develop different strategies for geographical locations, i.e., urban, slum, or rural?

16. What type of data are required by USAID to adequately monitor the Intermediaries and sub-project performance? What type of data are needed by the intermediaries to monitor sub-project performance, and what data are needed by the sub-projects to manage and monitor their programs?

17. What (AID and Intermediary) administrative procedures and practices should be revised to make management more effective? (e.g. the development of multi-year proposals? consolidated umbrella projects).

18. The evaluation team should answer the above questions but nothing should limit the evaluation team from reformulating these or other questions and examining other issues considered to be important.

19. Methodology

A three-member evaluation team will spend approximately four-five weeks in January-February, 1986, evaluating the current and future status of NGO project activities in light of the

project objectives, strategy, and overall population program in Bangladesh. Because the relationship between USAID and USAID-funded NGOs has always been close, the evaluation will be undertaken in collaboration with the USAID-funded family planning NGOs.

20. Data can and will be gathered through interviews with relevant USAID and intermediary staff, selective subproject staff during site visits and through review of program reports and documents. The team will not be responsible for primary data gathering. Within the first week the team will prepare a plan of operation and discuss the methods they will use to conduct the evaluation. The P&H office and other Mission staff will have an opportunity to comment.

#### COMPOSITION OF NGO EVALUATION TEAM

21. The evaluation team will consist of three members, who will each deal with their specific areas of expertise, as follows:

<u>Area of Expertise</u>	<u>Suggested Name</u>
A. Experience in direct clinical and CBD family planning service delivery in LDCs and in the evaluation of these services; preferably a health practitioner, e.g. a nurse-midwife.	Dr. Miriam Labbock (Team Leader)
B. Management and training for FP service delivery.	Sallie Craig-Huber
C. Data collection for FPMCH service delivery and reporting purposes (Service Statistics); practical experience in design of simple record-keeping for clinics and CBD programs.	Ellen Blair

22. One consultant will serve as Team Leader. She will designate a rapporteur at the start of the evaluation who will be responsible for producing a coherent written report at the conclusion of the evaluation. In addition, the USAID/P&H Division's NGO Section Project Officer, Sigrid Anderson, will be associated with the evaluation team. That officer's responsibilities will include assisting the team leader and members with their work; advising the evaluation team of all administration/policy issues; briefing the team leader on his/her responsibilities and that of the team; and accompanying the team for interviews and field visits if requested.

23. Timing/Location: Evaluation services are expected to start on or about January 16, 1986 and be completed on or about February 14, 1986. The location of the assignment will be Dhaka, Bangladesh, with some site visits/field trips outside Dhaka.

24. Reporting Requirements: The evaluators will prepare a written draft report prior to departure from Dhaka summarizing findings and conclusions, and making recommendations concerning future directions. twenty-five copies of the final report will be submitted to USAID/Dhaka by ISTI within three weeks by pouch.

25. REFERENCE DOCUMENTS

- A. Family Planning Services Project Paper No. 388-0050, as amended, July 1984.
- B. Review of AID-funded Non-Governmental Family Planning Activities in Bangladesh, prepared for the Mid-term Evaluation, Family Planning Services Project, KeeKee Minor, June 1-July 6, 1982.
- C. Mid-term Evaluation of USAID Family Planning Services Project in Bangladesh (388-0050), Minkler, Henderson, Simmons, Ahmed, Ali, Voran, APHA, January 24, 1982.
- D. U.S. Assistance to the Family Planning and Population Program in Bangladesh 1972-1980, Pillsbury, Kangas, Margolis, APHA, April 1981.
- E. Evaluation of Family Planning Services and Training Center (FPSTC) Bangladesh, Epstein, Akhter, Harbison, April 10-29, 1984.
- F. USAID/Bangladesh Population Sector NGO Strategy, 1985-1988.
- G. In-house documents (NGO package)
- H. Evaluation of the Voluntary Sterilization Program, Quasem and Co., January-March 1985 and April-June 1985.
- I. An Economic Analysis of Family Planning in Bangladesh, Simmons, Rob, Bernstein, June 1985.
- J. Suggested programme components for Population Control under Third Five Year Plan, 1985-90, Population Control Wing, Ministry of Health and Population Control, June 1984.
- K. Evaluation of Pathfinder's Central Cooperative Agreement, August 1985.
- L. Evaluation of AVS' Central Cooperative Agreement (draft).

- M. Evaluation of FPIA's Central Cooperative Agreement (in process).
- N. MIS reports
- O. Mini-CPS/Pathfinder, Department of Statistics, Jahangir-nagar University, 1984.
- P. TAF and BFPA evaluations, Dec '85.
- Q. AVS Follow-up Survey, (draft Dec '85).
- R. VS Reimbursement Review Findings(Pillsbury, Knowles)

APPENDIX B

Major Issues for the NGO Evaluation

## APPENDIX B

### Major Issues for the NGO Evaluation

1. Administration
2. Quality of Services
3. Coverage
4. Urban/Rural Projects
5. Interactions -- USAID, NGOs, BDG
6. Alternative/Innovative Strategies
7. Expansion
8. Financial Considerations
9. User perspective
10. Central Support by NGOs

APPENDIX C

Interview Forms for Evaluation Field Visits

Field Projects (Interview Project Manager, if possible)

Unit Name: \_\_\_\_\_ Source(s) of Support: \_\_\_\_\_

Location: \_\_\_\_\_ Subvention: \_\_\_\_\_

Person Interviewed: Name: \_\_\_\_\_ Title: \_\_\_\_\_

Brief Project Description and Purpose:

A. Staff:

1. <u>Title</u>	<u>Number</u>	<u>Selection Criteria</u>	<u>Training (length of training, who gave training)</u>
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2. Do you get your operating funds on time? \_\_\_\_\_

3. Is your program fully staffed? \_\_\_\_\_

4. Are you able to adhere to the selection criteria? \_\_\_\_\_  
If not, what is the problem? \_\_\_\_\_

5. Have all workers received the training (above)? \_\_\_\_\_

B. Management:

1. How many ELCO's per FW? \_\_\_\_\_  
How is this determined? \_\_\_\_\_

2. Do you have program targets? (List by method)

3. How is the target set? (e.g. census, registration, BDG)

4. How is it updated?

APPENDIX C

Interview Forms for Evaluation Field Visits

Field Projects (Interview Project Manager, if possible)

Unit Name: \_\_\_\_\_ Source(s) of Support: \_\_\_\_\_

Location: \_\_\_\_\_ Subvention: \_\_\_\_\_

Person Interviewed: Name: \_\_\_\_\_ Title: \_\_\_\_\_

Brief Project Description and Purpose:

A. Staff:

1. <u>Title</u>	<u>Number</u>	<u>Selection</u> <u>Criteria</u>	<u>Training</u> (length of training, who gave training) _____
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2. Do you get your operating funds on time? \_\_\_\_\_

3. Is your program fully staffed? \_\_\_\_\_

4. Are you able to adhere to the selection criteria? \_\_\_\_\_  
If not, what is the problem? \_\_\_\_\_

5. Have all workers received the training (above)? \_\_\_\_\_

B. Management:

1. How many ELCO's per FW? \_\_\_\_\_  
How is this determined? \_\_\_\_\_

2. Do you have program targets? (List by method)

3. How is the target set? (e.g. census, registration, BDG)

4. How is it updated?

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5. List all data collection instruments (assess redundancies) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. How do you assess percentage of targets reached?

7. (Does data collection allow: assessment of number of users by method by month of use? \_\_\_\_\_)

Date/time to resupply/follow-up? \_\_\_\_\_)

8. How often do you report service data? \_\_\_\_\_; Commodity data? \_\_\_\_\_; Financial data \_\_\_\_\_; To which agency(s)? \_\_\_\_\_.

9. How do you use the reported data? (Supervision? Worker dismissal? Others?)

10. Workplan -- How do fieldworkers carry out daily tasks?

C. Supervision

1. How often is the supervisory contact between:

Contact                      Content of Contact                      Frequency?/Last?

Central Office -  
Program Manager

Program Manager -  
Supervisor

Supervisor - FW

Others:

Are records kept on supervisory visits? \_\_\_\_\_

2. How often must FW come to the office? \_\_\_\_\_

How long does it take your FW to travel to the office? \_\_\_\_\_

to the work site? \_\_\_\_\_

D. Logistics:

1. Do you know the monthly consumption of each commodity? (List amount)  
\_\_\_\_\_

2. When was the last time you received less than the amounts ordered? \_\_\_\_\_

3. (Observe stock for FIFO, expiration dates)

4. Are commodities centrally or locally procured? \_\_\_\_\_

E. Materials:

1. What materials do you use in refresher training?

2. What materials do your FWs use in their work?

F. Other Activity:

1. Describe all other present activities in detail: (Observe data on other activities and comment on targets of services, monitoring of services, etc.)

2. What are the other "Social Services" or other ways you could get services to clients? What are client's desires?

G. Income Generation:

1. Describe efforts in detail (starting date, extent, who receives income generated: individual, community, or program?)

2. Are income generating projects limited to family planning acceptors?

3. What are staff requirements and time involved?

H. Interaction:

1. What other groups of workers or what other organizations are providing F.P. services or are promoting F.P. in your project area?

2. How does your organization collaborate with others?

3. Are there cross referrals? How often?

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Field Worker Interview

Name : \_\_\_\_\_ Number of years as a FW \_\_\_\_\_  
Unit : \_\_\_\_\_ Previous Occupation \_\_\_\_\_  
Organization : \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Parity \_\_\_\_\_  
Marital Status \_\_\_\_\_ FP Status \_\_\_\_\_

- A. Training:
1. When? (How long after status FW?)
  2. Where?
  3. How many days?
  4. How many refresher courses have you had?

- B. Activities: Main Tasks -- Define activity and frequency  
(List, and indicate which FW enjoys best)

(By team or individual?)

- 1.
- 2.
- 3.
- 4.
- 5.

- C. Supervision:
1. How often does your supervisor speak with you about your work? (where, content)
  2. How much (percentage) of your time is in the office doing paperwork?
  3. How much (percentage) of your time with clients is spent doing paperwork?
  4. How long does it take you to get to the office? to your first client?

CLINIC

Name of Facility : \_\_\_\_\_

Organization : \_\_\_\_\_

Source(s) of Support : \_\_\_\_\_

Name and Title of Person Interviewed: \_\_\_\_\_

A. Staff: (List all job category titles and the number, include field agents)

1.	<u>Category/No.</u>	<u>Type of Training</u>	<u>% of time in primary task</u>	<u>Sex</u>
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2. Are there other specific assignments for each category during down time? (List)

B. Activity: (List monthly or last year's number of procedures/rejections/follow-up removals)

1.	<u>IUD</u>	<u>F. STER</u>	<u>M. STER</u>	<u>INJ</u>
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Procedures

Rejections

Follow-up

Dropout/Removal

2. Follow-up: When, and what percentage of each of the above, are followed up? How?

3. Timing of IUD insertion -- Interval? Menstrual?

4. Reason for rejection:

IUD (Reasons, percentages)

F. STER (Reasons, percentages)

M. STER

INJ.

5. What alternative methods are offered? (Observe records of other methods/referrals) How is counseling done?
6. Are there other services you would wish to offer clients? What are the constraints?
7. Is there another facility nearby that offers similar services?  
Name \_\_\_\_\_ Sponsor \_\_\_\_\_
8. What mutual planning/referrals/interaction has there been or are planned between your facility and others?
9. Who (which other) agents/FW bring clients to your clinic?
10. Do clients (what percentage) stay overnight? \_\_\_\_\_ What provisions?
11. Do you receive government funds for reimbursement on time?

C. Facility: (Possible elements to check)

1. IUD: Equipment sterilization? Privacy? Sufficient equipment to not limit patient flow? Types of IUDs?
2. Sterile: O.T: Cement or tile? Resuscitation equipment? Name of ligation procedure \_\_\_\_\_; Silk or reabsorbable closure? Is atropine/diazepam/lidocaine/naloxone present?

Are antibiotics/pain killers standard? (Records?)

3. What is the average length of time from entry to exit for a patient:  
in busy times? \_\_\_\_\_  
in low use time? \_\_\_\_\_

What percentage of this time is services? \_\_\_\_\_ is  
waiting? \_\_\_\_\_

What are the bottlenecks/hold ups at busy times?

D. User Perspective:

1. What is your counseling procedure?
2. How is informed consent assured?
3. Who accompanies/attends clients? What accommodations are made for them?
4. Do clients get full BDG reimbursements or is a part given in kind?
5. Why do clients choose your clinic? Who do they go elsewhere?

APPENDIX D

Persons Met/Site Visits

APPENDIX D

Persons Met / Site Visits

I. Bangladesh Government

Mr Manzoorul Karim - Secretary, MOHPC

Mr Mustafa Jamal Khan - Deputy Secretary (Coord), MOHPC

Col. Abdul Latif Mallik, Director General,  
Directorate of Population Control

Dr Atiqur Rahman Khan, Joint Chief, Population Section,  
Planning Commission.

Mr S.R. Chowdhury, Director, MIS, Directorate of  
Population Control

Dr S. Waliullah, Director, NIPORT

II. NGOs

AVSC - Gary Newton

Ahmed Al- Kabir

Dr Noel McIntosh (Consultant)

Linda Tietzen (Consultant)

Pathfinder - Dr M. Alauddin

Habibur Rahman

Mosleuddin Ahmed

Daniel Pellegroni

Karen Eng

TAF - Dick Fuller

Geoff Taylor

Coleen Compton

FPSTC - Abdur Rouf  
Milon Bikash Paul

BFPA - Alamgir Kabir  
Kazi Anisur Rahman  
Mozammel Hoque  
Mizanur Rahman

FPIA - Abul Hashem

CWFP - Mustari Khan

IUCW - Peter Amacher

BAVS - Dr Azizur Rahman  
Dr Sultana Begum  
Dr Salahuddin Ahmed

III. Subproject  
AVSC/BAVS

Barisal  
Bhola  
Bogra  
Brahman Baria  
Chittagong  
Comilla (2 visits)  
Dhaka - Headquarters and Rayerbazar  
Kishoreganj  
Mymensingh  
Rangpur  
Sylhet  
Tangail

BFFA - Clinics /Branches

Barisal  
Bogra  
Chittagong  
Comilla (2 visits)  
Dhaka  
Mymensingh  
Sylhet  
Tangail  
Field Projects

- 1) Traditional Healers - Chittagong  
Sylhet  
Tangail
- 2) UVAPA - Rangpur  
Sylhet

FPIA - IUCW Projects

Babiganj - Madhabpur Upazilla  
Brahman Baria - Kasba Upazila  
Other Projects (See also FPSTC list)  
Barisal - RDFP Headquarters and Gournadi Upazilla

FPSTC - Brahman Baria (Concerned)\*  
Chittagong (Isphita)  
Dhaka (Anirban)  
Kishoreganj (Utsharga)\*  
Mymensingh (Sherhura Samity)\*  
Nilphamari (Milon)  
Sylhet (Kayal Samity)\*

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\* FPIA - funded

Pathfinder - CBS Projects

Bhola  
Kishoreganj  
Maulvi bazar  
Rangpur  
Saidpur  
Srimongol Upazilla  
Other Projects  
Srimongol Labor Department Clinic  
Saidpur Railway Clinic

TAF - CWFP Projects

Barisal  
Chittagong  
Dhaka  
Sylhet  
Tangail  
Other CBD Projects  
Chandina Upazilla \_ BAMANEH  
Comilla - Dedicated Women

IV. Other Organizational Contacts

Bangladesh Women's Health Coalition - Sandra Kabir  
CARE - Margaret Tsitouris  
Ford Foundation - Charles Bailey  
ICDDR,B - Marge Koblinsky  
Mike Koenig  
Overseas Development Administration (U.K.) -  
Christopher Allison  
Susan House  
PIACT/Bangladesh - Yusuf Chowdhury  
UNFPA - Hesse Gaenger  
UNICEF - Flora Sabanda

APPENDIX E

Summary of Site Visit Interviews

APPENDIX E

Summary of Site Visit Interviews

Staffing:

Type of Project

Sites:	<u>CBD</u>					<u>CBD/Clinic</u>			<u>Clinic</u>			
	a	b	c	d	e	a	b	c	a	b	c	d
Doctor							$\frac{1}{2}$			$1\frac{1}{2}$	2	$\frac{1}{2}$
Manager	2	1	1	1	1	1	1	1				
Paramedic/Nurse						2	1	2	6	3	7	4
Counselor								1	2	1	2	$\frac{1}{2}$
Supervisor	7	2	3	1	3	1	2	3				
Administrator/Other						2			2	1	2	$\frac{1}{2}$
Fieldworker	22	8	8		17	15	8	8				
Volunteer/Parttime	20				50			100				

CBD:

Fieldworker Training: 3,5,7 or 10 days

Parttime Worker Training: 3 or 7 days

Elcos per Fieldworker: 500-1,000

Elcos per Parttime Worker: 150-250

Percent of time doing paperwork: 50% average

Method of pill distribution: 1 cycle x 1 visit, then 3 cycles  
 1 cycle x 2 visits, then 3 cycles  
 1 cycle x 2 visits, then 2 cycles  
 1 cycle x 6 visits, then 3 cycles  
 1 cycle each time  
 3 cycles each time

Stock of commodities: Varied from good running balance to no records

Visits from CA Headquarters: Every 2,3 or 4 months

Clinics:

	<u>Procedures</u>			
	Tubectomy	Vasectomy	IUD	Injection
Procedures/month	9-100	5-140	0-25	0-10
Percent rejected	15-35%	20-34%	Few	Few
Waiting time	Not recorded since clients who come expect to spend the day		No reported delays due to equipment or staff shortages	

APPENDIX F

USAID/Bangladesh: Population Sector Strategy  
(1985 - 1988)

## APPENDIX F

### USAID/BANGLADESH POPULATION SECTOR NGO STRATEGY, 1985-88

A. Background: USAID/Bangladesh has funded the family planning services subprojects through non-governmental organizations (NGOs) under its Project No. 388-0050 since 1981. After a planning and start-up phase during 1981-82, by June of 1983 USAID had funded over 50 new NGO Community Based Distribution (CBD) subprojects at 95 locations. By March, 1985, the population NGO sector (excluding the Social Marketing Project)\* has expanded through six intermediaries\*\* to fund 81 subprojects at 254 sites in most of the 64 new districts of Bangladesh.

The USAID/Bangladesh NGO strategy of 1981 called for development of NGO family planning subprojects to supply contraceptives for retail sales through SMP, to provide family planning services by community-based distribution (CBD), and to

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\*The Social Marketing Project (SMP) was established and still functions through an agreement between an American non-profit firm, Population Services International (PSI) and the Bangladesh Government (BDG), represented by the Ministry of Health and Population Control (MOHPC), which controls the SMP Board by virtue of majority representation. SMP has grown exponentially and has become one of USAID/Bangladesh's more successful projects. Because its budget, including the value of contraceptive commodities, is greater than that of all other NGOs combined, and because it operates independently of the other NGOs and has its own distinct set of management and program concerns (condom gap, marketing strategies, alternative products, corporate form, etc.), a strategy for SMP is beyond the scope of this paper.

\*\* Bangladesh Family Planning Association (BFPA), The Pathfinder Fund, The Asia Foundation (TAF), The Association for Voluntary Sterilization (AVS) and subgrantee the Bangladesh Association for Voluntary Sterilization (BAVS), Family Planning International Assistance (FPIA) and the Family Planning Services Training Center (FPSTC).

provide clinical voluntary sterilization (VS) services at an expanded number of subprojects and sites throughout Bangladesh, but concentrated first in urban and semi-urban areas (district and the then sub-divisional towns). NGO subprojects were to deliver quality FP services in an innovative and cost-effective manner, which could be replicated by other family planning service providers, such as the Bangladesh Ministry of Health and Population Control (MOHPC) or other NGOs. NGO subprojects were (and are) to be characterized by community involvement, effective management and field-based supervision, use of a large number of fieldworkers, primarily women, to perform door to door outreach services to motivate clients, intensive training for all levels of staff, registration of all eligible couples, systematic resupply and follow-up of acceptors, availability of the entire range of contraceptive choices to acceptors, and maintenance of accurate service statistics to facilitate the regular monitoring of performance.

The 1981-84 strategy thus called for NGO proposals for projects, primarily in urban areas, which were innovative, defined as resulting in more effective and /or less expensive service delivery than existing approaches, which maintained necessary medical and administrative standards, and which offered potential for replication by other providers, whether MOHPC or other NGOs. The purpose of the USAID/Bangladesh population NGO sector, to provide family planning services of adequate quality and standards through innovative subprojects demonstrating potential for replication, remains basically unchanged; but the

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1985-88 strategy calls for consolidation and improvement of existing subprojects instead of unlimited expansion, and selective expansion of new subprojects through competition with existing ones under established criteria for measuring quality, as explained below.

The rapid expansion of the NGO sector to its present size indicates that the 1981-84 strategy, restated in the 1984 Project Paper for Extension of Project No. 388-0050, has been a sound and successful one. As consequences of the successful and rapid expansion of the population NGO sector, the USAID/Mission and the intermediaries jointly face the following questions largely dictated by concerns of cost and quality:

- (a) can the NGO sector continue to expand at its past rate, or do budgetary limitations require a period of consolidation of existing projects, with selective approval of new projects under stricter criteria, and competitive evaluation of on-going projects to determine which ones are more cost-effective?
- (b) For newly-developed NGO subprojects which may not have been able to maintain adequate medical or administrative standards at all times, can subproject management and intermediary staff bring their standards up to acceptable levels by closer supervision, retraining, and periodic evaluation?
- (c) How will the intermediaries and AID choose between promising new proposals, and ongoing subprojects that have frequent lapses in acceptable standards?

(d) Do USAID and the intermediaries have sufficient staff to monitor all NGO subprojects? How can the NGO project development, approval, and monitoring process be made more efficient?

B. Cost and Quality Concerns: The concerns of cost and quality require that the NGO sector enter a period of consolidation, review and improvement of existing projects with selective expansion of innovative new projects, and competitive evaluation of on-going projects under established norms for acceptable quality and cost effectiveness.

1. The planned USAID budget for the two remaining U.S. fiscal years under Project No. 388-0050 calls for approximately \$6.5 million in obligations per year in order to provide funding for all NGO subprojects through 30 September 1989, the Project Activities Completion Date (PACD) of the project. While it is possible that a follow-on USAID Project could provide some additional funding starting in FY 87 or FY 88, this is conjecture at this point. Typical NGO subprojects at individual sites cost under \$10 - \$15,000 in the first full year of operation, and cost \$20 - \$40,000 per site in succeeding years. Budget projections for each intermediary show that the majority of funds planned for obligation to each is heavily mortgaged to carry already approved subproject activities through the PACD. Hence the intermediaries must be selective in developing new subproject proposals

and should seek to develop subprojects which will not be merely clones of current models, but contain some innovative elements, such as a new target population (e.g. teenagers, husbands, newlyweds, garment workers, landless, etc), a new delivery method (e.g. Depot holders, Hat bazaars, Social and Mother's Clubs, provide broader range of family planning services, systematic effort to decrease the number of dropouts, strengthen referral systems to other health care facilities, linkage to MOHPC workers, etc.), a new geographic area (such as rural, rather than semi-urban areas), an attempt to reach a resistant population, (such as the more conservative areas of Noakhali, Bhola, etc.), or increase information, education and communication efforts (e.g. respond to rumors with facts, advertise service availability, public meetings, etc.)

2. The need to establish and maintain adequate quality of services also requires consolidation of the NGO Population Sector. "Adequate Standards" encompasses a range of requirements which define what a well-run, successful CBD or VS subproject should contain, and by which an individual subproject can be evaluated. In general, a subproject meeting adequate standards would have at least the following elements:

a. Fieldworkers: Sufficient number of female fieldworkers to deliver effective, frequent services to women in their homes; fieldworkers adequately trained, supervised and compensated; fieldworkers deployed in

sufficient numbers to provide intensive regular motivation, counselling,\* education, referral and follow-up care, maternal health and family planning.

- b. Management and Supervision: Adequate numbers of staff at all levels; all staff with adequate training; hierarchy and authority clearly established, with sufficient operational decision-making authority properly delegated; supervisors actively supporting field work, validating performance and assessing program needs; appropriate paramedical backup.
- c. Medical Standards: Properly trained professional staff; all necessary equipment for clinical procedures available and functioning properly; premises clean and orderly; emergency and back-up protocol clearly understood; and a respectful and professional relationship with clients.
- d. Recordkeeping System: Simple effective methods that assist fieldworkers and supervisors in their daily work while providing service statistics necessary to evaluate the subprojects' performance; track new and continuing contraceptive acceptors; and generate data necessary to compare relative efficiency of subprojects.

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\* Counselling should include discussion of the broad range of contraceptives now available (pills, condoms, injectables, IUDs, VS, foam, norplant, natural, etc.), should provide the most effective suitable method for each individual client, and should emphasize continuation by active users as well as recruitment of new acceptors.

- e. Commodities and Logistics: All contraceptive commodities in adequate supply; a procurement system in place which provides for reordering in a timely fashion; logistics and commodity resupply system adequate to continually resupply NGO fieldworkers at their work sites; and a referral system for contraceptive commodities not provided by fieldworkers in place.
- f. VS Voluntariness: Staff understands and implements all aspects of AID's requirements for informed consent, consent forms, and voluntariness of VS.

In the 1985-88 consolidation phase of the NGO program, USAID intermediary and subproject staff should identify weaknesses in individual subprojects and take remedial measures to correct the problem and bring the subprojects up to acceptable standards. Examples might be: training of physicians in new surgical techniques; replacement or repair of old equipment; periodic inspection by central office staff of medical standards and clinic management; continuous retraining of supervisors and fieldworkers in the benefits and side-effects of all family planning methods; and, in broadening their skills, to include counselling on all family planning methods; periodic audits of the service statistics and the financial records of subprojects; review of record keeping and reporting, supply of commodities etc. There will be an emphasis in the evaluation of the non family planning components of each project to determine if they

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are cost-effective and if they add to the acceptance of family planning. Further steps which each intermediary should take to remedy weaknesses in existing subprojects will be identified through the USAID/Bangladesh NGO Population Sector Evaluation scheduled for FY 86.

3. Termination of Subprojects That Fail to Meet Adequate Standards, or That Have Abnormally High Costs per Acceptor.

At some time during the consolidation phase, USAID and the intermediaries should review the relative performance of all current subprojects to determine which have been unable to meet the minimally adequate standards for either a CBD or a clinical VS project despite appropriate guidance and remedial measures. At that point, we should be prepared to disapprove refunding of substandard subprojects in order to make room in the overall NGO budget for new innovative proposals, and additions to expansion of proven subprojects. To make these difficult choices, comprehensive standard checklist of adequate standards for NGO CBD and VS subprojects should be developed.

C. Special Areas for Innovative New Projects, or Improvement of Existing Subprojects. Beyond meeting minimal adequate standards for performance, the NGO sector should as a whole be able to produce selected new projects, or improve existing subprojects by the addition of innovative new elements. The following is a partial, illustrative listing.

WS

1. Rural Area Subproject. Until recently, the BDG had restricted NGO subprojects to urban and semi-urban areas, defined loosely as areas around the old district and subdivisional (now new district) towns. The MOHPC has granted permission to several NGOs to operate projects in rural areas, therefore, NGOs are encouraged to develop a small number of selected projects for implementation in rural village areas, as one of a range of possibilities for new innovative programming. This does not mean, however, that USAID-funded NGOs should abandon their bases in the urban areas, nor attempt to "cover" large areas of rural Bangladesh. Since modern method contraceptive prevalence in urban areas in Bangladesh is only 29%,\* the BDG should continue to give full responsibility to NGOs for delivery of family planning services in these areas. The NGOs, in turn, should pay greater attention to providing thorough coverage, including follow-up of eligible couples and clients in all urban/municipal areas. USAID funding at a level sufficient to support NGO population subprojects for significant portion of the country outside of urban areas will not be available, and it is the responsibility of the Bangladesh Government (BDG), through MOHPC, to operate a country-wide family planning program in all districts and rural upazillas for universal demographic and geographical coverage.

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\* 1983 Contraceptive Prevalence Survey (Total method users 35.7 percent)

2. Institutionalization and Self-Support. Though self-sufficiency is not a realistic goal, mature NGO subprojects should be encouraged to seek local community financial support, in cash or in kind, for several reasons. This would give the community a stake in the project, and the project the abilities to pay costs disallowed or not supported by donors, and to carry on its functions between grants. For the BAVS clinics, for example, the clinics need land donated or purchased by the local community in order to provide sites for permanent clinic buildings. Likewise, clinical and CBD projects may be able to initiate fee for service schemes or generate local donations to pay for basic MCH drugs and supplies.

3. Subprojects Funded by Other Donors. Other donors, such as UNICEF, the World Bank and ODA, may be able to fund innovative population NGO subprojects beyond those USAID has the resources to support. Intermediaries and individual subprojects should look for funding opportunities for activities complementary to their USAID-funded subproject activities.

D. Replication: Collaboration with MOHPC

1. One of the goals of the 1981 strategy statement was to develop NGO CBD and VS projects that provided models that could be replicated by other NGO groups and the MOHPC. The NGO intermediaries have been successful in attaining this goal in a limited sense, as they have multiplied their own subprojects up to a total of 254 to date. Because USAID

funding for this sector is finite, and becoming heavily mortgaged, the idea of replication takes on new meanings. Development of new innovative projects, simultaneous with periodic evaluation and upgrading of old successful projects and the defunding of unsuccessful ones, will involve the continual development of new techniques for making family planning service delivery more cost effective, techniques which should be shared among the NGO community. In other words, instead of copying previously successful projects wholesale, the successful elements of new and old projects should be replicated by other NGO subprojects, e.g., the FPIA/TAF-funded Concerned Women for Family Planning's supervisor and fieldworker field area rotation system, BAVS' surgical and counselling techniques, FPAB's Traditional Healers and Voluntary Agencies volunteer models, The Pathfinder Fund's high ratio of female fieldworkers to supervisors, FPSTC's client cards and field records, and the TAF-educational models or other techniques have proven to be cost effective methods for reducing fertility.

2. Collaboration with the MCHPC. As stated above, the NGO sector cannot cover or carry the family planning program to the majority of rural villagers in Bangladesh; this is the responsibility of the MCHPC. One of the original tasks of the NGOs was to develop new techniques on a small scale, which if proven successful, could be adopted by the country-wide MCHPC program. An example is the NGOs' success in maintaining higher contraceptive prevalence rates than the

BDG by using a larger female fieldworker-to-client ratio.

The BDG has approved a plan to increase the density of female fieldworkers based upon ICDDR,B FP-MCH project data showing a positive correlation between higher fieldworker-client ratio and increased contraceptive prevalence rates. Additionally, there have been some instances of NGO/MOHPC joint programming and collaboration, notably by FPSTC-funded NGOs, which have held mobile family planning clinics jointly with the MOHPC. Another example of successful MOHPC/NGO cooperation is the splitting of wards equally between FPIA subproject and MOHPC fieldworkers in Barisal District.

If the MOHPC is ever to benefit from the pioneering efforts of the NGOs, a collegial, cooperative relationship built around such joint efforts will have to be established. The relationship should be founded on the realization that there remains a vast number of people in Bangladesh not yet receiving adequate family planning services, more than enough for both the BDG and NGO sectors, so that cooperative exchanges of information, rather than competition for territory, can benefit both types of projects. Intermediaries are encouraged to submit suggestions and proposals for funding which enhance BDG/NGO family planning service delivery through collaboration and joint programming.

E. USAID and Intermediary Monitoring Considerations.

Both the USAID Population & Health Office and officers of the intermediary organizations recognize that if the number of individual subprojects increases indefinitely, if each subproject requires annual resubmission and approval by several separate offices within the BDG, USAID and the intermediary, and if the number of USAID staff remains the same or is reduced, the USAID-funded NGO sector can become too complex to monitor and administer in a meaningful way and effective people become stretched too thin. Possible ways to avoid this are:

- (a) submission of multi-year proposals, or refunding proposals under specified dollar amounts, which need not be re-approved every year (although any party could exercise a right to terminate a subproject, if it failed to meet specified standards);
- (b) development of larger subproject proposals with subsidiary service centers at a number of sites, instead of a separate proposal for each individual site, e.g., the FPIA-funded Rural Development and Family Planning Project operated throughout Barisal District, which operates about 10 sites, but is considered only one "subproject" for purposes of review and approval.
- (c) development of a standard checklist of "adequate standards" for CBD and VS subprojects by which each subproject site could be periodically checked.

Intermediaries are encouraged to submit suggestions for the

more efficient and effective approval and monitoring of subprojects by themselves and by USAID, as the number of subprojects and sites continues to increase.

May 15, 1985

APPENDIX G

CAs' Objectives, Strengths, and Strategies/Plans

APPENDIX G

CAs' OBJECTIVES, STRENGTHS, AND STRATEGIES/PLANS

<u>NGO</u>	<u>Organizational Objectives</u>	<u>Perceived Strengths<sup>1</sup></u>	<u>National Strategies/Plans</u>
AVSC/BAVS	1) To improve quality of VSC services provided by BAVS, NGOs and BIDG. 2) - To increase safety of VSC - To increase client satisfaction - To increase supply of services	- Provision of surgical contraceptive services - Internal evaluation (SPDT) - Self reliance campaign - Regional medical supervision by BAVS for quality assurance	- Appended
BFPA	- To promote FP education and provide services to supplement/complement the national program through increased participation of volunteers, youth, women, and other groups - To demonstrate innovative projects with long term objective of self-sustainable services for rural communities.	- Innovative services and IEM - Historical presence and experience - Resource development activities	- BFPA Work Program/Budget 1986 - General strategies appended - USAID-funded project objectives appended
FPPIA	- To concentrate the use of available funds to appropriately expand services provided by existing projects - To expand programming to new NGOs to develop innovative service programs and to develop and expand pilot approaches - To build a local management capability in planning, administration, performance assessment and financial management skills	- Innovative strategies for underserved areas or target groups	- Appended

<sup>1</sup> As perceived by the CAs themselves, by other CAs, by USAID and/or by the evaluators.

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CAs' OBJECTIVES, STRENGTHS, AND STRATEGIES/PLANS (continued)

<u>NGO</u>	<u>Organizational Objectives</u>	<u>Perceived Strengths</u>	<u>National Strategies/Plans</u>
FPSYC	<ul style="list-style-type: none"> <li>- To encourage coordination among and provide TA to NGOs</li> <li>- To develop service projects with local NGOs</li> </ul>	<ul style="list-style-type: none"> <li>- Coordination of FP activities of local NGOs</li> <li>- Participation of local opinion leaders in project management</li> <li>- Information flow to BDG and to field workers</li> <li>- Training for field supervisors and management training</li> </ul>	<ul style="list-style-type: none"> <li>- Appended</li> <li>- Program Scheme               <ol style="list-style-type: none"> <li>1) Established 52 sub-projects</li> <li>2) Expansion of these sub-projects with addition of new elements (e.g. MCH, income generation)</li> <li>3) Expanding project coverage to new areas</li> </ol> </li> </ul>
PF	<ul style="list-style-type: none"> <li>- To develop and support innovative projects in CBD and CBS, adolescent fertility, women's activities and training of FP personnel.</li> <li>- To assist governments to implement national FP programs through intensified field activities</li> </ul>	<ul style="list-style-type: none"> <li>- Project management</li> <li>- Collaborative NGO planning</li> <li>- Innovative impact demonstration</li> <li>- Internal evaluation systems</li> <li>- Work plans for CBD field staff</li> </ul>	FY 82-83 last available strategy
TAF	<ul style="list-style-type: none"> <li>- To provide FP services, education, and information to people in project areas</li> <li>- To provide related loans, income generation opportunities and institution strengthening through projects</li> </ul>	Integrated population and development projects	Submitted at time of Annual Report to USAID

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BANGLADESH COUNTRY STRATEGY (AVSC)

I. GOAL OF AND STRATEGY FOR AVS INVOLVEMENT

Based on health, development, and human rights rationale, and acting in response to specific requests from the Government of Bangladesh (GOB) and local organizations, the long-term goal of the AVS program is to assist in the institutionalization of safe, voluntary, efficient, and affordable surgical contraception services as a component in the health and family planning program of Bangladesh. This goal will be implemented through a program of financial and technical assistance to the key institutions involved in vsc-related service, training, and research but primarily the Bangladesh Association for Voluntary Sterilization (BAVS).

The AVS program will be based on three objectives; to increase the safety of vsc services, to increase clients' satisfaction with services, and to increase the supply of services. As long as safety and satisfaction remain the twin prominent concerns of the program, demand for services will very likely increase. In response to demand for services, AVS will continue to assist BAVS, the GOB, and other NGOs to increase the supply of services.

The top priority in further improving the safety of services is to expand vsc-related training. This will be done at two levels, first, by improving the quality of vsc training received by medical students while in medical school and second, by providing refresher training to government physicians routinely providing vsc services in the field. Both training projects will involve financial and technical assistance from AVS to the Ministry of Health and Population Control (MOHPC) and will emphasize clinical skills and knowledge which will prevent vsc-attributable mortality and morbidity. In addition to playing a central role in the provision of refresher training to GOB physicians, BAVS will continue to provide clinical training to NGO personnel, will continue to disseminate information on medical quality and safety via publications and professional gatherings, and will continue to refine medical components of the BAVS program for possible replication nationally. The main government mechanism for quality control of vsc services is the Sterilization Surveillance Team (SST). While BAVS safety monitoring procedures and materials have already been of some assistance to the SST in developing systems and materials for the GOB program, there is still scope for further collaboration between BAVS and the SST on a range of vsc-related safety, surveillance, and training issues. AVS will work to foster this collaboration. With the addition of short-term international medical expertise to the Asia Regional Office (ARO) and the possible addition of permanent medical capability, AVS will be in a position to increase direct medical technical assistance to NGOs, the GOB, and BAVS to further refine training, surveillance, and technical assistance capabilities.

While continued improvements in the safety of services should lead to improvements in client satisfaction, attention to several other areas should also increase satisfaction; foremost of which is counseling. AVS's priority will be to provide the requisite financial and technical assistance to further refine counseling services and training at BAVS to enhance their replicability in GOB and NGO programs and, at the same time, AVS will

undertake an assessment of national counseling training needs and develop a project proposal to help meet these needs. In addition, assistance will be given to BAVS and select local research organizations to help determine through programmatic evaluation and survey research, the specific elements in a service delivery program which contribute to enhanced client satisfaction. The feasibility of adding two new program components to the BAVS service delivery system will be explored under the assumption that their availability will have a positive impact on client satisfaction. First, access to long-term but non-permanent contraceptive services may lead to greater overall use of family planning and increased satisfaction with vsc when and if it is ultimately chosen. Second, access to preventive and curative health services catering to the children of vsc clients may lead to increased satisfaction among vsc acceptors. Efforts will also continue to increase the extent to which BAVS meets the needs of rejected vsc requestors, particularly those for whom the medical condition which caused their rejection can be feasibly treated.

As long as safety and satisfaction are central objectives in the vsc program, demand for services is expected to be sustained and is likely to increase. The AVS priority in this regard is to help equip BAVS to meet demand over the long-term by increasing BAVS' organizational longevity through a variety of activities intended to lead to greater self-sufficiency. Three basic approaches are being taken; improving the efficiency of the existing program, diversifying financial support, and acquiring BAVS-owned land and facilities. Efficiency, the short-term priority, will be improved through cost reductions, increasing the utilization of current clinical facilities, more closely aligning the level of resources with the level of demand through program research on the volume and pattern of demand, improving client flow and scheduling, collaborative planning with the GOB and other NGOs to minimize duplication of services and more evenly distribute vsc services nationally, and finally, by relocating or replacing BAVS clinics which after focused technical assistance from AVS and BAVS fail to reach a minimum level of efficient service activity. Related to the question of efficiency and long-term viability, is the level of quality to be maintained by BAVS relative to the GOB. In terms of facilities, staffing, and equipment needed to maintain acceptable quality, BAVS will need to re-examine its current requirements to ensure the most efficient and easily replicable system is developed over time. AVS will also assess the personnel, equipment, and facilities needs of other major NGO vsc service providers to determine whether AVS support might help increase the supply and quality of services offered by them.

The attainment of many of the above-mentioned objectives depends, to a large extent, on the further development of BAVS' institutional capacity -- particularly in the areas of program evaluation and financial management. AVS will continue to provide training and financial and technical assistance to help build this capacity to the point where BAVS can more fully assume its role as the national resource for expertise, standards, and models regarding vsc medical quality, counseling, training, and cost-efficiency.

( more )

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FAMILY PLANNING ASSOCIATION OF BANGLADESH

2 NAYA PALTAN, DHAKA - 2

LIST OF DISTRICTS TO BE VISITED BY THE USAID EVALUATION TEAM

PROJECT TITLE: Use of Voluntary Agencies in Population Activities (UVAPA)

DESCRIPTION OF THE PROJECT:

The Project "Use of Voluntary Agencies in Population Activities (UVAPA)" was started in later part of 1981 initially with 60 clubs having 300 volunteers. Twelve districts were covered under this phase. In 1982 the project was expanded to 8 districts with 40 clubs, which included 200 volunteers. Later on in July, 1984, another 100 clubs with 500 volunteers were covered.

The main objective of the project is to promote family planning and contraceptive use through the volunteers of local level volags (Voluntary Organizations). The target per volunteer is 8 acceptors including 1 (one) sterilization per month. The youths of the clubs are engaged in Community Development and Recreational Activities. The youth have good rapport with local people and have spare time to work for family planning promotional activities. Each volunteer is paid a nominal pocket allowance of Tk. 100/= per month. A Field Work Supervisor has been engaged to supervise the project. The potentiality of these group of volunteers has been very effective for the success of the programme.

<u>Sl. No.</u>	<u>District address with contact person</u>	<u>Grades</u>	<u>Contact person at the Programme Level</u>	<u>Name of Clubs</u>
1	Rangpur, G.L. Roy Road Mr. A.K.M. Shafiqur Rahman District Project Officer	I	Mr. Mohd. Mojibur Rahman Field Work Supervisor	1) Chetona Sangha, Kadirabad, Rangpur 2) Pally Unnayan Samaj Kallyan Samity, Joirampur 3) Tarun Sangha Pathagar, Damodarpur 4) Samaj Kallyan Samity, Numitary 5) Mahila Kallyan Samity, Mahigonj (Chakbazzar) 6) Jagaron Jub Sangha, Kalibari 7) Samaj Sahittyta Sangskriti Gusthi, Kursha 8) Sunity Protishtha Samity, Bakshigonj 9) Palli Seba Sangha, Monipur 10) Nari Kallyan Samity, Darmodash

FAMILY PLANNING ASSOCIATION OF BANGLADESH

2 NAYA PALTAN, DHAKA - 2

LIST OF DISTRICTS TO BE VISITED BY THE USAID EVALUATION TEAM

PROJECT TITLE: Utilization of Traditional Healers in Family Planning

DESCRIPTION OF THE PROJECT:

The project "Utilization of Traditional Healers in Family Planning" commenced in the year 1981 initially in 10 Upazillas with 500 Traditional Healers. Later on in July 1984, 10 more Upazillas with 500 healers were included under the project. The main objective of the project is to promote family planning and contraceptive use through traditional, rural healers and to provide family planning services. The target per healer is 8 acceptors, including one sterilization per month.

The traditional healers by virtue of their profession are in fact opinion leaders in their areas and are definitely a potential group to help promotion of family planning motivation and service delivery effort. Each healer is paid a nominal pocket allowance of Tk. 100/= per month. To ensure frequent supervision of the project, a field work supervisor has been engaged. The project has a positive impact on the community.

Sl. No.	District address with contact person	Grades	Contact person at the programme level	Name of Upazilla	
1	Rangpur, G.L. Roy Road Mr. A.K.M. Shafiqur Rahman, D.P.O.	I	Mr. Khaled Mosarraf Hossain F.W.S.	Pirgachha	C-17
2	Mymensingh, 15/B C.K. Ghosh Road Mr. Abul Kalam Azad, D.P.O.	I	Mr. Khitish Chandra Karati F.W.S.	Trishal	
3	Rajshahi, C-160 Shipai Para Mr. Shariful Islam, D.P.O.	II	Mr. Gazi Golam Mowla F.W.S.	Charghat	
4	Noakhali, Harinarayanpur Mr. Mohd. Akhtaruzzaman, D.P.O.	I	Mr. Mohd. Abdur Rashid F.W.S.	Senhagh	
5.	Dinajpur, Munshipara Mr. Mohd. Abdul Jalil, D.P.O.	II	Mr. Md. Muslim F.W.S.	Biral	

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Family Planning International Assistance

FPIA/APRO

1986 Plan Update

BANGLADESH

OBJECTIVE # 1: Concentrate the utilization of available funds to appropriately expand services provided by the International Union of Child Welfare in conjunction with the Ministry of Social Welfare, the Barisal Mukti Judha (Freedom Fighters) Association, and the Family Planning Services Training Center; provide a final but reduced year (1984-1985) of support to Concerned Women for Family Planning. It is expected that with support estimated at \$1,191,864 these agencies will serve approximately 263,000 people between 1984 and 1986.

PROGRESS. Satisfactory. Continuation proposals prepared and approved for International Union of Child Welfare (IUCW), Mukti Judha and Family Planning Services and Training Center (FPSTC). The Concerned Women for Family Planning (CWFP) program was extended for five months. Total obligation was \$1,160,261.

\*CHANGES. Due to insufficient core Cooperative Agreement (CA) funds, requested and received agreement from USAID/Bangladesh to support continuation proposal for CWFP with FPIA, USAID/Bangladesh Add-on funds. This was effective 1 December.

STATUS. CWFP and FPSTC will be continued in 1986 with bilateral funds. The FPIA Add-on grant from USAID/Bangladesh will continue support to FPSTC. The Asia Foundation/Bangladesh will assume total support for CWFP. FPIA will continue support to IUCW and Mukti Judha with core CA funds in 1986.

OBJECTIVE # 2: Use additional source of funds from USAID/Bangladesh to expand FPIA programming to new NGOs to assist the GOB to implement its plan to involve Union Parishad Population Committees in the national family planning strategy and to support two mature but model NGO projects which will serve, on a nation wide basis, 175,000 clients.

PROGRESS. Four new projects were developed and one was obligated. A continuation final year, proposal for CWFP was prepared and approved.

\*CHANGES. The criteria for subgrant support under the USAID/Bangladesh "Add-on" grant was changed to the following:

- 1) Develop for GOB and NGOs alternative cost effective service delivery models which have the following components:
  - a. Field workers assigned to a manageable population in their catchment area so that they can provide personalized attention to all of their clients.
  - b. Institutionalize family planning services by building up local infrastructures and preparing them to eventually take up the responsibility of providing family planning services to the members of their community.

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Family Planning International Assistance

FPIA/APRO

1986 Plan Update

BANGLADESH

\*CHANGES (continued)

- 2) Develop and expand, as appropriate, pilot approaches that involve upazilla leadership to participate in the development and management of family planning information, education and services in support of GOB's national population program.

\*STATUS. USAID through AID/W added on an additional \$600,000 to the PPFA/FPIA CA for 1985-86. For the period 1986-87, USAID/Bangladesh proposes to award an additional 1.2 million for the FPIA Bangladesh program. The FPIA Dhaka Sub-Office (DSO) was established by May 1985. Staffing was completed by August 1985. An additional four projects are under development. It is expected that the three projects developed in 1985 but not obligated by the end of the year will be approved within the first quarter of 1986. All projects meet, as appropriate, the criteria listed above in the section "Changes."

PROBLEMS. FPIA is challenging the Government of Bangladesh Population Control Division GOB/PCD to approve projects that reduce the catchment area assigned to each outreach worker and, in one instance, with the project number Bangladesh-32, to serve a population that is reached through a service agency instead of a population living in one geographic area.

OBJECTIVE # 3: Build a local management capability in planning, administration, performance assessment and financial management skills through technical assistance and strategy grants.

PROGRESS. FPIA supported RITs for 8 participants from 4 projects. In addition, the Project Director of FPSTC, provided ten days of technical assistance to the Sri Lanka-10 project and set up and delivered a ten days training program for staff from four APRO projects in managing microprojects.

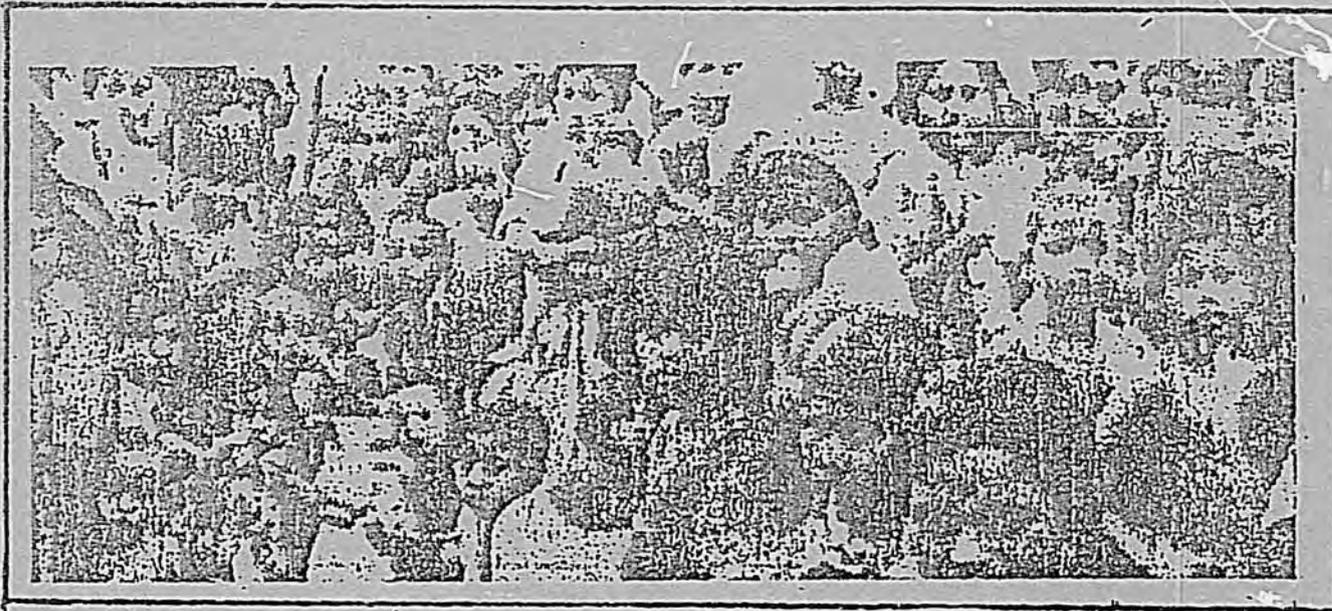
CHANGES. The focus of the invitational travel and technical assistance is to improve program skills of project management and staff so that strong administration is combined with innovative service delivery programs. Also it is to develop income generation capability that ranges from providing assistance to secure other donor funds to requiring community support for on-going programs.

PROBLEMS. Service delivery requirements require full attention of family planning managers. Additional staff or consultants to handle income raising issues should be provided.

## FPSTC

### WHAT NEXT ?

Though there are some problems and limitations, the Centre has plans to further develop its activities through arranging proper training facilities and developing an Information Centre for all NGOs, through collecting related informations, books, and periodicals from national and international agencies. It is also intended that the number of projects for providing financial assistance will be raised to 42 by 1984 and size of a few projects will be enlarged. For better understanding and sharing of experiences of NGOs, FPSTC is going to start mutual visit programmes for the staff of the projects. The Centre is striving for developing of a long term financial plan so that its continuous dependence on donor agencies may be reduced.



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APPENDIX H

Central Support Systems and Processes  
for Each Cooperating Agency

APPENDIX II

Central Support Systems and Processes for Each Cooperating Agency

ASSOCIATION FOR VOLUNTARY SURGICAL CONTRACEPTION (AVSC)/BANGLADESH ASSOCIATION FOR VOLUNTARY STERILIZATION (BAVS)

<u>ORGANIZATIONAL LEVELS</u>	<u>PROJECT REVIEW/APPROVAL</u>	<u>SUPPORT ACTIVITIES</u>	<u>REPORTING</u>
Sub-projects (Branches)	Develops annual workplan jointly with BAVS		- Branches submit performance, financial and I&E reports to Headquarters monthly
NGO Headquarters (BAVS)	Develops consolidated grant proposal for all bilateral funding which includes implementation guidelines	- Medical supervision/quality care - Sets annual targets for each clinic - Recruits professional staff for subprojects	- Consolidates, reviews and submits above reports to Regional and New York offices of AVSC quarterly
AVSC (Dhaka Regional Office)	Submits to USAID and AVSC/NY for approval	- Provides monitoring/evaluation services - Assists with development of systems.	- 6-monthly reports to USAID
AVSC/NY	Approves consolidated bilateral proposal		

INTERNAL EVALUATION MECHANISMS

- Special Program Development Team (SPDT) composed of representatives of BAVS volunteers and staff and AVSC Regional staff uses review system to identify low performance clinics based on cost/case and cases/month.
- Developing a system to evaluate field agents' performance.

BANGLADESH FAMILY PLANNING ASSOCIATION (BFPA)

<u>ORGANIZATIONAL LEVELS</u>	<u>PROJECT REVIEW/APPROVAL</u>	<u>SUPPORT ACTIVITIES</u>	<u>REPORTING</u>
Subproject			- Prepares monthly service reports
Branch	Suggests guidelines for future project proposals		- Compiles and submits service and financial reports to national headquarters monthly
Headquarters (Dhaka)	Prepares and submits annual workplan and budget to IPPF London	- Recruits and appoints project management personnel - Undertakes periodic evaluations of projects	- Submits financial reports every six months and annual service reports to IPPF - Reports every six months to USAID for projects handled by USAID
IPPF (London)	Reviews proposals and if approved provides funding	- TA for training - Commodity logistics	- Reports to donors annually

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INTERNAL EVALUATION MECHANISMS

- Monthly monitoring of project reports.
- Spot verification of client records by DFOs and project supervisors.
- Annual analysis of performance reports against targets.

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FAMILY PLANNING INTERNATIONAL ASSISTANCE (FPIA)

<u>ORGANIZATIONAL LEVELS</u>	<u>PROJECT REVIEW/APPROVAL</u>	<u>SUPPORT ACTIVITIES</u>	<u>REPORTING</u>
Subproject	Prepares response to questionnaire about organization and activities for FPIA/Dhaka		- Submits service and financial reports every four months to FPIA/NY with copies to Dhaka and Bangkok
NGO Headquarters (ICW, RDPF, etc.)	Prepares projects outline and negotiates Preliminary Understanding Record with FPIA/Dhaka		- Same as above (if consolidated project with several sites)
FPIA/Dhaka	Develops proposal on site with potential grantee.	- Provides TA on the following: Proposal preparation, design of recordkeeping systems management, training, project manual review and other on request.	
FPIA/Bangkok	Reviews proposals (using checklist). Forwards to FPIA/NY with copies to USAID for concurrence and FPIA/Dhaka to forward to PC wing and to grantee to forward to ERD.	- Provides TA and review of management and administration to ensure compliance with FPIA terms and conditions every second year of subproject funding.	- Submits annual report to USAID on performance of FPIA/Dhaka
FPIA/NY	Reviews proposal and, if approved, sends to AID/W for approval along with USAID concurrence.	- requested	Provides TA as and when

INTERNAL EVALUATION MECHANISM

- Review and analysis of all program and financial reports with feedback to grantees by FPIA/Dhaka.
- Routine client verification and annual client characteristics survey.
- Prior to negotiating continuation funding, FPIA makes assessment of all aspects of project performance including management capability and records/reporting systems.

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FAMILY PLANNING SERVICES AND TRAINING CENTER (FPSTC)

ORGANIZATIONAL LEVELS

PROJECT REVIEW/APPROVAL

SUPPORT ACTIVITIES

REPORTING

Subproject

FPSTC Program Officer works with NGO to prepare subproject proposal

- Monthly reports to headquarters

FPSTC Headquarters

Reviews and finalizes proposal for submission to Scrutiny Committee

- Trains subproject staff  
- Provides regular TA visits for monitoring, evaluation and audit

Reports:

- to FPFA every four months  
- to USAID every six months and annually  
- to EDG monthly (MIS)

Scrutiny Committee

Reviews proposals and rejects or recommends for approval to Governing Body.

Governing Body

Reviews and approves final proposal.

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Internal Evaluation Mechanism

- Regular project officer visits for monitoring, evaluation and audit to each subproject.

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THE PATHFINDER FUND (PF)

ORGANIZATIONAL LEVELS

PROJECT REVIEW/APPROVAL

SUPPORT ACTIVITIES

REPORTING

Subproject

Local organizational executive committee approaches PF/Dhaka with project idea/proposal

Reviews quarterly performance

- Monthly and quarterly service reports to Dhaka

PF/Dhaka

Prepares proposal with local NGO. Submits for approval to ERD and and PCW.

- Assists with staff recruitment, monitoring, training and financial management.

- Quarterly service reports to Boston.  
- Six-monthly service reports to USAID.

PF/Boston

Approves proposal, submits to USAID for approval

- TA to PF/Dhaka on monitoring and financial management.

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INTERNAL EVALUATION MECHANISMS

- Project managers do regular spot checks to verify clients.
- Quantitative target achievements reviewed in quarterly project managers meetings. This includes acceptor targets and 12-month continuation targets of 50-60%.

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THE ASIA FOUNDATION (TAF)

<u>ORGANIZATIONAL LEVELS</u>	<u>PROJECT REVIEW/APPROVAL</u>	<u>SUPPORT ACTIVITIES</u>	<u>REPORTING</u>
Subprojects	Submits proposal or letter to explore project possibilities to TAF	- Develops recordkeeping system and forms for subproject with guidance from TAF staff and operations manual	- Monthly service reports to NGO headquarters or TAF/Dhaka - Monthly report to Dep. Dir. FP
NGO Headquarters (CWFP, etc.)	Same as above, for a number of subprojects	- Provides regular monitoring	- Consolidate monthly reports for submission to TAF/Dhaka
TAF/Dhaka	TAF representative visits project to discuss project idea and gives simple task, e.g. couple registration  Reviews task and prepares final proposal for approval in Dhaka if less than \$40,000.	- Refresher training for field staff - Ongoing internal evaluation	- Compiles monthly MIS report and commodity report to EFPA. - 6-monthly reports to USAID/
TAF/San Francisco	Reviews and approves projects of more than \$40,000.		

INTERNAL EVALUATION MECHANISMS

- Program officers do field evaluations every 4 months, using standardized form, of all aspects of the project.
- Feedback given in the field at the end of each visit, followed up by a letter which reviews findings and corrective actions agreed upon.
- Followup actions reviewed at start of next field evaluation/monitoring visit.

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APPENDIX I  
USAID/NGO COOPERATIVE AGREEMENT BUDGETS

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APPENDIX I

USAID-NGO COOPERATIVE AGREEMENT BUDGETS

NGO	Total Amount Current Agreement	Budget Breakdown (%)					Prog. Support	Admin	Indirect Costs
		Subprojects	Training	IEC	Evaluation				
AVSC/BAVS	\$6,467,550	92.8	2.3	---	---	---	4.9	---	
TAF	3,692,432	72.6*	1.3**	---	0.7	6.5	---	18.9	
BFPA	975,000	86.2	3.1**	---	0.5	---	10.3	---	
FPPIA	1,200,000	69.9 <sup>(a)</sup>	---	---	---	---	25.1 <sup>(b)</sup>	4.9	
FPSTC	1,150,000	70.4	10.6	---	---	4.2	14.7	---	
PF	2,400,000	58.3	5.0	2.1	2.3	11.8	---	20.5	

Notes:

- a) Includes subproject indirect costs (5%)
- b) Salaries, fringes, consultants, travel and "other direct" costs
- \* Includes 15.8% of total agreement for Female Scholarship Program
- \*\* Foreign training only

APPENDIX J

GOB Circular on NGOs

## APPENDIX J

GOVERNMENT OF THE PEOPLE'S REPUBLIC OF BANGLADESH  
MINISTRY OF HEALTH AND POPULATION CONTROL  
BANGLADESH SECRETARIAT, DHAKA.

No. PC/S-2(Coord)/104/83/441.

Dated 4-12-1983

### C I R C U L A R

In order to facilitate working of the Non-Government Organisations/Voluntary Organisations in conformity with the over-all objectives of the Population Control Programme and ensure better coordination, it has been decided to set guidelines as follows :

(1) Classification.

An organisation constituted on voluntary effort primarily with the objective of supplementing the Government policy/programme in Health and Population Control Sectors and functioning with the approval of the Government having operational and financial flexibility will be covered within these guidelines. For the purpose of convenience of identification, Non-Government Organisations/Voluntary Organisations are classified as follows :

(i) Foreign

An organisation originating in a foreign country and operating in Bangladesh with prior permission. (viz. Radda Barnen, New Life, Centre, Lutheran Mission etc.).

(ii) National level :

An organisation having 10 or more branches originating in Bangladesh (viz. FPAB, BAVS, CHCP, CWFPF).

(iii) Local level :

An organisation working in a particular area employing at least 10 workers/volunteers (viz. Atmanivedita Mahila Sangstha, Palashipara Samaj Kalyan Samity etc. )

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**(3) Pay and Service Structure :**

- (a) All Non-Government/Voluntary Organisations will adopt their own service rules, prepare job description of their workers and manage their organisation.
- (b) Non-Government Organisations operating with foreign donation shall not employ anybody without clearance as prescribed vide No. 12-Circular-4/82 (Nira - III)/89(150) dt 17. 1. 1983 of M/o. Home Affairs.
- (c) The administrative cost of a Non-Government Organisation Project should not normally exceed more than 10% of the total budget. The pay and salary of the field workers involved in the Population Control Programme shall, however, be considered as operational cost.
- (d) TA and DA of Non-Government Organisation projects will be regulated as per guidelines prescribed for FPSTC.

**2. Registration/Affiliation :**

Non-Government/Voluntary Organisations operating with foreign donation will have to be registered with the Department of Social Welfare on the recommendation of Standing Committee as per provision of the Foreign Donation ( V. A. ) Regulation Ordinance 1978 as amended in 1982. There will be no registration from the Directorate of Population Control. For the purpose of monitoring, there will be a system of affiliation. National level organisations will have to obtain the affiliation from the Director General, Directorate of Population Control and local level organisations will be affiliated by the Deputy Director, Family Planning of each district. No organisation will be allowed to operate in Population Control Programme without prior affiliation from the concerned authority.

**3. Procedure of approval of project :**

All Non-Government/Voluntary Organisations will have to submit a project proposal spelling out the details of their operational plan, objective, budget etc. to the Population Control Wing of the Ministry of Health and Population Control for approval.

Projects under FPSTC and Projects operating with the assistance of Subvention Grant have to follow the procedure as prescribed by the Governing Body of FPSTC and Subvention Committee. For refunding also, approval will be necessary. No Non-Government Organisation Project will go on operation with the foreign assistance without the clearance from External Resources Division. For a particular organisation/project/scheme funding from a particular source will be preferred.

**4. Programme operation :**

- (i) Non-Government/Voluntary Organisations may operate in urban and rural areas with the permission of the Government as per rules under the Foreign Donation ( V. A. ) Regulation Ordinance. The plan of operation will have to be submitted to the Government well ahead of time,

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- (ii) Clinical contraceptive programme will require the specific approval of Technical Committee.
- (iii) All Non-Government/Voluntary Organisations operating in the Population Control Programme will maintain proper record of their operation, performance, books of accounts etc. and conduct annual audit. Competent authority in the Population Control Programme will verify the same annually or as and when required for public interest.
- (iv) A copy of project proposal of Non-Government Organisations will have to be submitted to the affiliating authority of the Population Control Wing.

**Supply of Contraceptives :**

Non-Government and Voluntary Organisations will get the supply of contraceptives from the Government free of cost. The channel of distribution of contraceptives to approved Non-Government/Voluntary Organisations will be guided as per approved system of the Ministry of Health and Population Control.

**6. Contraceptive Target of Non-Government/Voluntary Organisations :**

(a) **Target of Community-based Distribution (CBD) Projects and Clinic-based Projects :**

There will be two separate sets of Contraceptive Target for Community-based Distribution Projects and Clinic-based Projects.

(b) **Separate Target for new and old Projects :**

In view of the fact that the workers of the old projects are to undertake follow-up activities to ensure minimum drop-out, there will be separate target of contraceptive performance for new and old projects. For the purpose of identification of new and old projects, a project during the first year of its operation will be regarded as new one and from the second year, it will be considered as an old project and contraceptive targets will be fixed up accordingly.

(c) **Targets for old projects :**

The targets for the old project per worker per month will be as follows :

Sterilization	— 2
IUD	— 2
Condom	— 2
Pill	— 3
Injectables/others	— 1
Total	— 10

Each old project will have to provide follow-up services to their continuing users of contraceptives and the question of drop-out in a particular project will have to be taken into consideration for refunding of a particular project.

(d) The target for new project per worker per month will be as follows :

Sterilization	— 2
IUD	— 2
Condom	— 4
Pill	— 6
Injectables/others	— 1
Total	— 15

(e) Clinical Target :

The monthly target per clinic for Sterilization will be as follows :—

(i) BAVS	— 300
(ii) FPAB	— 200
(iii) CHCP & others	— 100

All the clinics should, however, provide minimum standard and perform IUD and Injectables as far as possible. Special projects under the Ministry of Health and Population Control like Mohammadpur Fertility Services & Training Centre etc. will perform their target as per project document.

(f) Worker Population Ratio :

Normally at least one full-time worker will be deployed for every 5,000 population and there will be about one supervisor for five workers. The project will remain responsible for complete coverage of services in the area assigned to the project by the Government. In case any project is unable to deploy adequate number of field workers in the project area, it will surrender the relevant portion of the area so that the same may be given to any other Non-Government Organisation. On the other hand, any on-going project having more workers than the ratio as indicated above may be allocated additional adjoining area provided the performance of the project is satisfactory.

(g) Monitoring & Reporting :

- (i) Upa-Zilla Family Planning Officer and Deputy Director, Family Planning will report the performance of Non-Government Organisation Projects operating in their areas separately to avoid duplication in reporting the performance of Government workers and Non-Government Organisation workers. MIS Unit will also separately indicate the performance of Non-Government Organisations in their monthly report.
- (ii) *Referral* should not be accepted as *performed* in clinical method. While reporting the performance of Sterilization, IUD, MR and Injectables, reports received from the clinics should be considered as the cases *performed*
- (iii) Follow-up activities should in no way be recorded as cases performed.

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**7. Training/Seminar of Non-Government Organisation Programme :**

Training will be part of any Non-Government Organisation Programme. All personnel of Non-Government Organisations/Voluntary Organisations will have to obtain prior permission from the Ministry of Health and Population Control and ERD for obtaining training/attending seminar abroad with foreign donation.

**8. Evaluation :**

All Non-Government Organisations/Voluntary Organisations should have a built-in mechanism for evaluation of their own project. Deputy Director, Family Planning will also meet all organisations once in every month to evaluate their performance. Government may direct any authority to evaluate the performance of any organisation. The performance of organisations receiving fund from the Subvention Committee will be evaluated by FPSTC.

**9. Supervision :**

Supervision of the activities will be done by the management of those organisations. Registration/Affiliation authority may, however, inspect the activities of any Non-Government Organisation/Voluntary Organisation and recommend/suggest measures as felt necessary.

**10. Winding-Up :**

In case of winding-up/termination of a Non-Government Organisation/Voluntary Organisation, assets and liabilities of the project will be disposed of as per provision of the project or as per instruction to be given by the Government.

11. The method-specific contraceptive target for NGOs primarily and actively involved in the Population Control Programme has been worked out and enclosed herewith. All concerned are, therefore, requested to follow the guidelines as mentioned above and take necessary steps for the achievement of targets as shown against each. Their future funding as well as awards etc. will be evaluated on the basis of performance and achievement of the targets.

Sd \_\_\_\_\_  
( A. B. M. Ghulam Mostafa )  
Secretary  
Ministry of Health and Population Control.

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APPENDIX K

USAID/CA Service Statistics Reporting Forms

APPENDIX K

USAID/CA Service Statistics Reporting Forms

Reporting Month: \_\_\_\_\_ Return by: \_\_\_\_\_

Funding Agency: \_\_\_\_\_ SEE ATTACHED INSTRUCTIONS

Project Title and Locations: \_\_\_\_\_

Table 1: Active Users of Temporary Methods

(This table should be based on information taken from client cards or Registers. If your project only keeps distribution data, do not complete this table.)

	Total Number of Users Active this month (including new users)	New Users this Month
Pill		
Condom		
IUD Referred*		
IUD Performed		
Injection Referred*		
Injection Performed		

\* See instructions below for clinical cases referred and performed

Table 2: Sterilizations Referred or Performed\*

	Sterilizations this Month
Vasectomy Referred*	
Vasectomy Performed*	
Tubectomy Referred*	
Tubectomy Performed*	

- \* Cases referred by your workers to another clinic should be listed under referred
- \* If a field worker referred a case to your own project clinic, list this case under performed only.
- \* Do not include rejected cases.
- \* Do not list any cases under both referred and performed.

Table 3: Distribution of Contraceptives to Acceptors

	Total amount distributed this month
Pills (cycles)	
Foam (vials)	
Condom (pieces)	
Injection (doses)	
IUD (insertion)	

Please tick:

\_\_\_\_\_ numbers in table 3 are  
based on distribution  
records

\_\_\_\_\_ numbers in table 3  
are estimates

Instructions for AID Monthly Report

Table 1: Active Users of Temporary Methods

Include in the first column all family planning clients covered during the reporting month by a temporary method of contraception provided or referred by your project. Include new users who started at any time during the month. Do not include dropouts. However, a client supplied in a previous month who had adequate supplies to provide protection against pregnancy in the reporting month should be included. Pill, condom and foam clients resupplied in previous month who had adequate supplies through the end of the reporting month should be included; injectable clients who received an injection in either one or two months prior to the reporting month should be included; IUD clients who had an IUD inserted prior to the reporting month, which was still in place at the end of the reporting month should be included as an active user; a woman who had an IUD expelled at any time should not be included. Patients who received two months of supplies three months ago, and who have not been resupplied should not be counted. Include all new and continuing users.

In the second column of Table 1, list all new users, for the reporting month by method.

Table 2: Sterilizations Referred or Performed

Sterilization this month: In the first column include all sterilization clients served by your project during the reporting month. Indicate whether the cases were referred by workers in your project to another clinical facility for surgery or whether your project performed the surgery in its own clinic. Do not include rejected cases. Do not list any case as both referred and performed.

Table 3: Contraceptive Distribution for Current Month

If you have accurate information on contraceptives distributed to clients by your project from your project records, use this information, and tick that numbers are based on distribution records.

If the contraceptive distribution data you provide are only an approximate estimate and not backed up by commodity records please tick below table 3 that numbers are estimated.

TABLE 2  
STERILIZATIONS, REFERRED AND PERFORMED

	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
VASECTOMY (REFERRED)						
VASECTOMY (PERFORMED)						
TUBECTOMY (REFERRED)						
TUBECTOMY (PERFORMED)						

TABLE 3  
TOTAL MONTHLY DISTRIBUTION OF CONTRACEPTIVES

	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
IUS (CYCLES)						
AM (VIALS)						
AM (TABLETS)						
INDOMS (PIECES)						
INJECTION (DOSES)						
IOD (INSERTIONS)						

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SUMMARY FORM FOR AID-FUNDED NGOs, JULY-DECEMBER, 1984

TABLE 1A  
ACTIVE USERS OF TEMPORARY METHODS

	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
PILL						
CONDOM						
FOAM						
IUD (REFERRED)						
IUD (PERFORMED)						
INJECTION (REFERRED)						
INJECTION (PERFORMED)						

TABLE 1B  
NEW USERS (RECRUITS) OF TEMPORARY METHODS

	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
PILL						
CONDOM						
FOAM						
IUD (REFERRED)						
IUD (PERFORMED)						
INJECTION (REFERRED)						
INJECTION (PERFORMED)						

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APPENDIX L

Suggestions for Measuring Project Impact  
Based on Contraceptive Prevalence Calculations

## APPENDIX L

### Suggestions for Measuring Project Impact Based on Contraceptive Prevalence Calculations

There are several reasons to strengthen impact orientation to FP service statistics--two of these reasons are of special importance for the CA programs in Bangladesh. Prevalence of contraceptive use, the most commonly accepted basis for assessment of FP service impact, could be readily derived from all existing CA management information systems. An increase in CPR has been shown in many countries and programs to be directly associated with decreased maternal, infant and child mortality. This finding has been confirmed in Bangladesh studies undertaken by the ICDDR/B (Phillips, et. al., December 1985). With the present emphasis on functional integration of MCH and FP in Bangladesh, it is important to continue and strengthen the documentation of health impact as reflected by an increased CPR.

Secondly, the present target systems of the GOB stresses only new acceptors. This target system has limited application and may be inappropriate in ongoing, "mature" projects where a reasonable level of prevalence has been achieved. Such targets can lead to the temptation to artificially cycling clients off and on methods to have a continuing supply of "new" acceptors. This target distracts from an emphasis on appropriate methods and on spacing. It can also create an unhealthy competition between workers in a single area, each vying for any available new acceptors while follow-up for continuing users and clients of surgical methods may be neglected.

A series of steps are suggested to address these issues and to assist with the conversion of existing record keeping and reporting systems to prevalence-based systems. A consultant or consultants, having significant experience in FP MIS and the design and use of simplified service data forms, should be identified to assist with this effort. TA should be provided by this consultant, working with each CA individually, to aid in the simplification and adaptation of their MISs in accordance with the existing USAID/CA data form (Appendix K) and using prevalence as a management measure. The consultant could be requested to document any suggested modification as well as their potential time and cost savings. This must be carried out with

- |  |  |
|--|--|
| 2. Multiply by 0.18 to find an estimate of eligible couples, or eligible women, e.g, if the population is 1,126 in 1986 there are approximately 203 eligible couples (N.B. there were 180 in 1981)   | 2. Multiply by the percent of the population who are married women, e.g. 100% of a mothers club, 50% of a group of married couples, 18% of families. |
| 3. If a registration listing is used, an attempt should be made to register approximately the same number as calculated in Step 2 above. This is the denominator.  | 3. This is the denominator.  |
| 4. Calculate the number of users at one point in time (number of persons who have O.C. or condoms in hand to cover that month, number of women with an IUD or injectable coverage, and number of couples of reproductive age who are sterilized) | 4. Same.   |
| 5. Divide the result of "4" over the result of "3" ( $4 \div 3 =$ prevalence)-- this is the prevalence.  | 5. Same  |

It should be noted from the foregoing, if couple or household registration is carried out, the goal should be to identify approximately the same number of potential clients as determined by the above calculations. Careful spot checking should disclose missed populations. In special population programs, the number of eligible couples may equal the total fertile aged persons in that population, e.g. total workers in a factory. However calculated, the total number of eligible couples should become a part of regular MIS reports. Prevalence is then calculated at the local level by dividing the number of contraceptive users by the total eligible couples.

This calculation can be carried out for the individual worker, for an entire program, or for all USAID-funded CAs. If such a system is established, the target should be increased prevalence rather than new acceptors.

The MIS system, and the consultant involved in the rationalization of each CA's system, should maintain flexibility in systems to be used by special worker groups--volunteer, part-time, and semi-literate workers should have more limited service delivery and data collection responsibilities. Their supervision and data input might be designed to rely more on periodic surveillance rather than daily or weekly monitoring. BFPA and TAF have made efforts in this direction. The BFPA UVAPA and Traditional Healers recording system is excellent. TAF has made an effort to produce client forms for use by illiterate TBAs. It may be more appropriate for illiterate workers to concentrate on distribution data and to have monitoring by periodic surveillance and spot checks rather than attempting a complex copy of the reporting system used by literate workers. This latter approach feeds readily into Table 3 of the USAID/CA form (Appendix K) and therefore is compatible with the system as well.

The same consultant might be requested to identify elements of proposed changes in existing systems that merit evaluation or testing through retrospective or prospective OR. Interaction with the GOB at all stages of this consultancy and any resulting OR efforts is strongly recommended to support changes in GOB attitudes and policies related to acceptor targets and MISs used by the NGO community.

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APPENDIX M

BAVS Reporting System for 1986

## APPENDIX H

## BAVS REPORTING SYSTEM FOR 1986

Sl. no.	Old system	Frequency	New system(effect from Jan./86)	Frequency	To be sent
1.	Weekly Performance Report.	Weekly	Deleted.		
2.	Project Performance Report.	Monthly	This three combined together & a new format developed with the heading of Project Performance & Rejection Report.	Monthly	By the 2nd of the next month.
3.	Contraceptive Performance Report.	Monthly			
4.	Rejection Report.	Monthly			
5.	Upazila Performance Report.	Monthly	To be continued.	Monthly	-do-
6.	Complication Report.	Monthly	To be continued.	Monthly	-do-
7.	Equipment Problems Report.	Monthly	To be continued.	Monthly	-do-
8.	Financial Report.	Monthly	To be continued.	Monthly	-do-
9.	Statistical Report for Male clients.	Monthly	Combined together into one.	Quarterly	By the 3rd of the 4th month.
10.	Acceptors' Characteristic Report(Male).	Quarterly			
11.	Female Statistical Report.	Monthly	Combined together into one.	Quarterly	-do-
12.	Acceptors' Characteristics Report(Female).	Quarterly			
13.	I.L. . C. Progress Report.	Monthly	Combined together into one.	Quarterly	-do-
14.	I.L. . C. Financial Report.	Monthly			
15.	First Follow-Up Report.	Monthly	To be continued.	Monthly	By the 12th of the next month.

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APPENDIX N

FP Field Worker Consensus  
(by Pathfinder's Rangpur CBD Worker -- Fancy Das)

## APPENDIX N

### FP Field Worker Concerns (by Pathfinder's Rangpur CBD Worker -- Fancy Das)

The following represents responses (translated from written Bengali) from Fancy Das, a field worker in Pathfinder's CBS project in Rangpur, to questions posed by the evaluation team:

#### 1. Problems in the field

- o The clients sometimes become sick. We cannot stand by them by providing medicine and as such they become dissatisfied with us.
- o Sometimes we do not have money in the IUD fund, and the clients have to go home without money. At the same time, other organizations make the payments on the spot. The clients do not accept our word that we will make the payment later. They become irritated and we become the victims of the problem.
- o Duplication of work by various organizations leads to various problems.

#### 2. Training

- o There is no doubt that training was very useful to us. We have gained knowledge and experience in various subjects such as methods of FP, human reproduction, process of conception, how contraceptives help to prevent births, etc. We disseminate information, knowledge, and experience gathered during the training among the eligible couples during group meetings. The clients listen to us very attentively and it facilitates our work in FP. We shall have to pay attention to the survival of the clients' children in the process of caring for the clients.
- o Training should be arranged at one or one and one-half year intervals in order to see the results in practice. It is true that monotony weakens our zeal to work. If we are able to travel outside for training, we learn new things, our minds become fresh and we can work with double energy after returning from the trip.

- o The training should be arranged either in Dhaka or outside Dhaka but not in the project site, because we should know the working process in various places/situations. We learn many things from the new faces and situations. We can evaluate ourselves and our morale goes up.
  - o Regarding areas of training needed, we need adequate knowledge on who should not get IUDs and how to prescribe contraceptives for whom and how to deal with clients whose husbands have bad character.
3. Is there any change in the eligible couples over the period of time you have worked? If so, what changes have you made in your working process.

This question is very critical and I would like to address the issue through an example:

I can remember my first motivational visit 2-1/2 years ago to one eligible couple. As I entered the gate, an elderly woman came out the house and told me "What do you want? Excuse me but we do not give alms." I assumed that she might be the mother-in-law of the house. I controlled myself and replied in a soft tone "I have not come to beg but to gossip with you." Meanwhile a young woman came out of the house and I decided she might become an acceptor. I spoke with her for a while and came to learn that the elderly woman was her mother-in-law. Meanwhile, the mother-in-law reappeared and said "we do not even gossip in our spare time." I begged her pardon and left saying that I would come again.

The following day, while passing the house, I found the mother-in-law leaving the house wearing a "Burka" (veil). I greeted her and asked where she was going. She said she was going to the doctor. I suggested she come to the doctor in our project office and she agreed. The doctor prescribed medication for the lady and I purchased a small quantity for her and wished her goodbye for that day. The following morning I visited the mother-in-law in her home where I was warmly welcomed. I had a very cordial discussion, including family planning, with the family members.

Presently, I am working in that area. The environment has changed and I have coped with the situation. I have influence in my area and have the full confidence of my clients. I do not have trouble working as I had in the early days of my job. I work with delight now. The clients are like my relatives and I can note a positive change in the field.

4. Advantages and disadvantages of working in the rural area

It is true that there are some advantages of working in the rural area but the disadvantages are many--the density of eligible couples is less, communication is rough and it will be difficult to work during the rainy season. Moreover, the rural people are conservative and religious and as such motivation will be a difficult task.

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