PD-AAX-109
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AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A = Add, C = Change, D = Delete — Amendment Number

DOCUMENT CODE: 3

2. COUNTRY/ENTITY: Bangladesh

3. PROJECT NUMBER: 388-0071

4. BUREAU/OFFICE: USAID/Dhaka

5. PROJECT TITLE (maximum 40 characters): Family Planning & Health Services.

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 12 DD 31 YY 92

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)
A. Initial FY 87 B. Quarter 3 C. Final FY 91

8. COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total						
(Grant)	(35,310)	( )	(35,310)	(177,750)	( )	(178,000)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1. 104						
Other U.S. 2.						
Host Country						
Other Donor(s)						
TOTALS						

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) 104	400	440		–		30,000		151,000	
(2) 104	500	510		–		5,310		27,000	
(3)									
(4)									
TOTALS									

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 410 | 420 | 450 | 460 | 530 | 632

11. SECONDARY PURPOSE CODE: 600

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	BR	RPOP	DEL	TX	PVOU	PVON	TNG
B. Amount	100,000	10,000	13,000	2,000	40,000	17,000	10,000

13. PROJECT PURPOSE (maximum 480 characters)

To improve the coverage and quality of family planning and maternal and child health services in Bangladesh.

14. SCHEDULED EVALUATIONS
Interim MM 03 YY 88 MM 12 YY 89 Final MM 04 YY 91

15. SOURCE/ORIGIN OF GOODS AND SERVICES: 000 941 Local Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a ____ page PP Amendment.)

Methods of Implementation and Finance are in accordance with acceptable Mission standards. Sufficient funding has been included to provide for adequate audit coverage.

George R. Jenkins, Controller

17. APPROVED BY
Signature: Bonnie Pounds, Acting
Title: Director USAID/Dhaka
Date Signed: MM 03 DD 30 YY 87

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
MM DD YY

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WASHINGTON, D.C. 20523

PROJECT PAPER

BANGLADESH

FAMILY PLANNING AND HEALTH SERVICES

PROJECT NO. 388-0071

MARCH 1987

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GLOSSARY

AID/W	Agency for International Development/Washington
AVSC	Association for Voluntary Surgical Contraception
BACE	Bangladesh Association for Community Education
BAVS	Bangladesh Association for Voluntary Sterilization
BDG	Bangladesh Government
BIDS	Bangladesh Institute for Development Studies
CA	Cooperative Agreement; also Cooperating Agency
CBR	Crude Birth Rate (Live Births Per Year Per 1,000 Population)
CDR	Crude Death Rate (Deaths Per Year Per 1,000 Population)
CPR	Contraceptive Prevalence Rate (Percentage of Women Using Contraception - Modern or Traditional - in a Given Time Period.)
CPS	Contraceptive Prevalence Survey
CWFP	Concerned Women for Family Planning
CBD	Community-based distribution
CYP	Couple-Years Protection
e(o)	Life Expectancy
EPI	Extended Program in Immunization
FPAB	Family Planning Association of Bangladesh
FP	Family Planning
FPCST	Family Planning Clinical Surveillance Team
FPIA	Family Planning International Assistance
FPSTC	Family Planning Services and Training Center
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
HA	Health Assistant

ICDDR,B	International Center for Diarrheal Disease Research, Bangladesh
IMR	Infant Mortality Rate (Number of Infant Deaths Per 1,000 Births)
IPPF	International Planned Parenthood Federation
MA	Medical Assistant
MCH	Maternal and Child Health
MIB	Ministry of Information and Broadcasting
MIS	Manzagement Information System
MO	Medical Officer
MO/CC/	Medical Officer, Clinical Contraception, Maternal
MCH	Child Health
MO/MCH FP	Medical Officer, Maternal Child Health Care and Family Planning
MIS	Management Information System
MOHFP	Ministry of Health and Family Planning
MMR	Maternal Mortality Rate (Number of Maternal Deaths Per 1,000 Births)
NGO	Non-Governmental Organization
NIPSOM	National Institute of Preventive & Social Medicine
NORAD	Norweigan Aid Agency
NPC	National Population Council
NSCPR	National Steering Committee for Population Research
NIPORT	National Institute for Population Research and Training
OR	Operations Research
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PIACT	Program for the Introduction and Adoption of Contracetpive Technology
PDEU	Population Development and Evaluation Unit

PF	The Pathfinder Fund
PPW	Population Planning Wing (Planning Commission)
r	Annual Rate of Population Growth
SFWV	Senior Family Welfare Visitors
SIDA	Swedish International Development Authority
SMP	Social Marketing Project
TA	Technical Assistance
TBA	Traditional Birth Attendant
TCC	Training Coordination Committee (of the NGO community)
TFR	Total Fertility Rate (The Average Number of Children Born Per Women by the End of the Reproductive Age Period 15-49).
TRRT	Technical Resources, Research, and Training
UFPO	Upazila Family Planning Officer
UHC	Upazila Health Complex
UFPO	Upazila Health & Family Planning Officer
UNFPA	United Nations Family Planning Program
UHFWC	Upazila Health Family Welfare Center
URC	University Research Corporation
VS	Voluntary Sterilization
WHO	World Health Organization

I. RECOMMENDATION AND SUMMARY

RECOMMENDATION

USAID recommends that the Family Planning and Health Services Project (FPHSP) be approved on grant terms for total five year funding of $178.00 million. USAID will obligate funds for support of Bangladesh Government (BDG) activities in family planning (FP) and maternal and child health (MCH) through annual Project Grant Agreements with the External Resources Division, Ministry of Finance. Funds for non-governmental organization (NGO) activities in FP/MCH will be obligated through Cooperative Agreements with international and national NGOs.

PROJECT SUMMARY

The FPHSP has four components: (1) Support for BDG FP Activities; (2) FP Social Marketing; (3) NGO FP Activities, and (4) Other MCH Activities. Component 1 and some activities under Component 4 provide direct support for BDG national FP and MCH programs. Components 2, 3, and some activities under 4 provide support to national programs through NGOs.

The goal of the FPHSP is to reduce current high levels of fertility and mortality that restrain the attainment of sustained development in Bangladesh. The purpose of the Project is to improve the coverage and quality of family planning and maternal and child health services in Bangladesh. The following objectives, set for 1991, will facilitate measurement of interim and end-of-project progress in achieving the project purpose:

Indicator	1991 Objective	1986 level
Contraceptive Prevalence Rate	40%	29.8%
Oral Rehydration Therapy Treatment (ORT) Rate	60%	20%
Effective Use Rate	75%	To Be Estimated
Coverage Rate--Urban Infant Immunization	65%	5%
Coverage Rate--Urban Female Immunization	60%	5%

During design of the FPHSP, USAID has identified several issues for regular attention during project implementation:

A fundamental project theme is promoting greater coverage and continued use of family planning and MCH services utilizing public and private sector mechanisms to improve service delivery. The FPHSP project design acknowledges the need to provide more effective services to "spacers" (relatively young couples wishing to delay births). Supplementary travel allowances to FP fieldworkers and establishment of new contraceptive/ORS sales distributorships in rural areas will ensure easier access to temporary FP methods. In addition, reimbursement payments for clinical procedures (VS and IUD) will continue to ensure that poor couples can take advantage of a full range of effective methods.

The project will pay particular attention to the quality of service delivery. Efforts will be made to ensure that clinical services are provided by well trained professionals in a manner that allows for appropriate client counselling and follow-up. Family planning clinical surveillance teams will confirm service quality and directly address inadequate standards. In the case of non-clinical temporary methods, the FPHSP will support efforts to enhance the quality and frequency of fieldworker-client contacts in BDG and NGO program areas.

The FPHSP will encourage the implementation of the BDG decentralization policy involving devolution of responsibility and resources for family planning and MCH to the Upazila (Sub-district) level. The project will also give regular attention to opportunities for administrative improvement in FP/MCH service delivery. Operations Research (OR) will test promising alternatives to current (1) record keeping and reporting sytems; (2) FP/MCH fieldworker performance standards; and (3) fieldworker-client contact patterns. The FPHSP will also support extensive training for MOHFP and non-governmental fieldworkers.

The FPHSP will continue to be concerned with upgrading the FP logistics system. TA consultants will assist with installation of new procurement, distribution, and information systems and will continue to coordinate US-based contraceptive procurements.

II. PROJECT BACKGROUND, GOAL AND STRATEGIES

INTRODUCTION

In Bangladesh, a predominantly rural population of 102 million lives in an area the size of Wisconsin under conditions of extreme poverty and deprivation. Even though over 80 percent of the population is rural based, the population density in Bangladesh (1800 per square mile) is only exceeded by the city states of Hong Kong and Singapore (BBS, 1986a). The majority of the population lives below the officially designated poverty line. Roughly half of the rural population is functionally landless and at least a third of the labor force is either unemployed or underemployed. While there has been some gradual improvement in educational attainment over the past two decades, literacy rates are still among the lowest in Asia. The 1981 Population Census reported that only 18.8 percent of all women over the age of 15 years were literate, while adult male literacy stood at 39.7 percent. Long-term development may prove difficult to sustain owing to population increase of at least 2.4 percent per annum, uncertain prospects for agricultural production, and a slowly growing industrial sector.

Nutritional deficiencies which induce and exacerbate disease and increase the high risk of early death are endemic in Bangladesh (Ahmed and Hassan, 1983). Malnutrition most severely affects children under five years of age and pregnant and lactating women. Miscarriages and stillbirths are common, a high percentage of babies are born with low birth weights, and many children are malnourished from birth. At present, fewer than 2 percent of all children receive basic immunizations or have regular access to medical care. The sex-biased distribution of available food among family members compounds the difficulties experienced by female children and mothers. Female children have almost three times the rate of malnutrition as males and a 45 percent higher mortality rate among the severely malnourished.

Infant mortality is officially estimated to be 125 per 1000 live births, but unofficial figures are usually higher. Expectation of life at birth is officially 50 years, the child mortality rate is 22 per 1000 (for ages 1-4 years), and the overall death rate is 15 per 1000. Maternal mortality, estimated at 6 per 1000 live births, is at least 100 times higher than rates for developed countries (BDG, 1985:372-78). Owing to the paucity of credible national morbidity and mortality data, it is not possible to assess whether health conditions are improving for the majority of the population.

The basic problem in Bangladesh is simple but potentially overwhelming; too many people living on too small a land area, with insufficient infrastructure, natural resources, capital and technical skills to significantly increase real per-capita income and achieve improvements in health, employment, environmental quality, and general living standards. Development efforts have become, in essence, attempts to stay ahead of the population growth rate and prevent social and economic deterioration.

Projections show that population growth will continue in Bangladesh for a long time to come even under the most optimistic scenario. Should fertility and the current official growth rate of 2.4 percent per year be maintained, the population will double (to about 200 million) by 2010 and continue to spiral upward to nearly 360 million by the year 2050. Even if fertility and the growth rate fall rapidly, the high "population momentum" associated with the young age structure of the population will sustain continued population growth into the 21st century. Assuming that replacement level fertility is reached by 2035, the population of Bangladesh will only become stationary by the 21st century, at which time the total population is projected to be 454 million (World Bank, 1984:254).

The Government of Bangladesh (RDG) faces severe constraints in its efforts to implement an effective family planning program. While commitment of the highest government officials to a strong family planning program is unquestionable, inconsistent administrative policies, weak infrastructure, a poor distribution system and cultural constraints affecting the autonomy and mobility of women have affected the program.

The national family planning program has experienced numerous setbacks since its inception in 1972 (including a decline in program performance in 1985), but the overall trend has been a gradual increase in the level of contraceptive use. When the program was launched in 1972, fewer than 10 percent of married couples in the child-bearing ages were practicing contraception. According to the 1985 Contraceptive Prevalence Survey (CPS), 29.8 percent of all eligible couples were practicing either modern or traditional methods of contraception (Mitra and Associates, 1987). There are indications that a modest reduction in fertility has occurred between 1981 and 1985; namely, a decline in the total fertility rate from 6.3 to 5.6 (a decline of about 11 percent).

In the long run, development assistance will likely have little impact unless Bangladesh is able to substantially reduce its rate of population growth. Family planning and other health programs, particularly maternal and child health (MCH) services, must be addressed in a coordinated fashion at the same time as the country strives to develop its agricultural, industrial and human resource sectors.

RELATIONSHIP TO USAID STRATEGY

A central element of the USAID Country Development Strategy for Bangladesh consists of funding for programs that promote the limitation and spacing of births. While major support is provided for public and private sector family planning activities, USAID is also providing assistance for additional MCH interventions such as oral rehydration therapy and immunization services. USAID is also interested in identifying mechanisms that generate greater demand for family planning and MCH services; (e.g. through information, education and communication (IEC) initiatives and by promoting higher female educational attainment, employment outside the home, and postponement of early marriage).

The effort to reduce current high levels of fertility and mortality complements the other development strategies that are central to the USAID program of assistance in Bangladesh; namely, increasing food security and expanding employment. Fertility reduction and increased agricultural productivity are both essential in order to generate higher per capita food production and consumption and reduce diseconomies associated with continued land fragmentation. USAID is promoting greater agricultural productivity through the development and dissemination of agricultural technologies (including new HYV inputs and fertilizers), improvement of irrigation and flood control facilities, enhancement of rural infrastructure (e.g. through village electrification and feeder road programs), and the promotion of market-oriented public policies.

Employment creation is crucial for the generation of higher per-capita income in Bangladesh. The USAID employment strategy encourages increased on-farm employment through the promotion of HYV technologies and greater intensity of production (multicropping), off-farm employment through the expansion of small and medium size enterprises, building rural infrastructure, and expanded educational and employment

opportunities for women. However, if overall levels of unemployment and underemployment are to be significantly reduced within the next thirty years, diminution in labor force size will need to complement future job creation efforts.

NATIONAL POLICIES, GOALS AND STRATEGIES

The Government of Bangladesh continues to view reduction in the rate of population growth as its highest development priority and remains committed to achieving this objective through an effective public and private sector family planning and MCH program. The BDG program provides a wide range of contraceptive choice to married couples in a manner as acceptable and convenient as possible for the client. The program is totally voluntary and the BDG is firmly opposed to coercion or pressure on couples to accept contraception or use any particular method.

In the 1985-90 Third Five Year Plan (TFYP), the BDG readily admits that it has fallen short of the demographic objectives formulated in the Second Plan (1980-85); namely, reducing the birth rate to 32, the death rate to 12 and increasing the contraceptive prevalence level among eligible women to 37.5 percent. However, in projecting future growth of contraceptive use and reductions in fertility, the BDG remains optimistic. The TFYP adopts the following goals for the year 1990: increasing overall national contraceptive prevalence to 40 percent (from 29.8 percent in 1985), reducing the birth rate to 31, the death rate to 13, and the population growth rate of 1.8 percent.

In addition to the demographic targets established in the TFYP, a BDG MCH Task Force has developed a "National Strategy for a Comprehensive MCH Programme" which presents health targets for the year 1990 adopted by the Ministry of Health and Family Planning (MOHFP, 1985). The specific targets established include: reducing the infant mortality rate to 100 (from an officially estimated 125 in 1985), the child mortality rate from 22 to 12 (per 1,000 children aged 1-4), the maternal mortality rate from 6 to 4 (per 1,000 births), and raising life expectancy from 50 to 54 years.

These objectives are to be reached by implementing four intervention strategies; namely,

- Family Planning (FP);
- Expanded Programme of Immunization (EPI);
- Oral Rehydration Therapy (ORT);
- Safe Birth Practices (SBP).

The objectives established for EPI, ORT and SBP coverage are as follows:

- o 90 percent of the infant and child population provided with ORT services;
- o Basic immunization (DPT, measles, TB and polio) to 80 percent or more of all children;
- o 65 percent of the population covered with primary care health services and;
- o 50 percent of expectant mothers provided with ante-natal examinations and delivery by a trained birth attendant.

USAID considers these goals laudable, but believes they may be overly ambitious, especially with regard to the provision of MCH services. However, the emphasis on reducing infant, child and maternal mortality as well as fertility is appropriate, and the focus on FP, EPI, ORT and SBP as primary interventions sound.

PUBLIC AND PRIVATE FP/MCH PROGRAM STRUCTURE (1981-86)

Existing FP and MCH services are offered through the following public and private sector resources.

1. With support from the World Bank, a network of government clinics and health centers is being built to provide a full range of family planning and MCH services, the goal being one sub-center in each Union (average population 20-25 thousand), with referral to larger more complex centers at the Upazila level (average population 250 thousand). According to recent BDG information, 1500 Union Health and Family Welfare Centres (UHFWC) are functional and another 480 will be added through conversion of other existing facilities (e.g. rural dispensaries). After construction of 1,000 UHFWCs in the plan period 1985-1990, nearly 75 percent of all unions will have such a center.

2. A staff of about 28,000 at Upazila and Union levels provide door-to-door services, recruit new family planning and EPI clients, resupply current users of temporary contraceptive methods and distribute ORT packets. This staff includes 13,500 female Family Welfare Assistants (FWAs), 10,000 male health assistants (HAs) and 4,500 Family Planning Assistants (FPA)s. An additional 10,000 FWAs will be be trained and assigned to the government's FP/MCH delivery system over the next five years.

3. Approximately 90 non-governmental organizations (NGOs) are engaged in FP and MCH activities throughout Bangladesh. These organizations function primarily in urban and peri-urban areas, but are currently extending services to rural areas as well.

4. A USAID sponsored private sector sales effort, the Social Marketing Project (SMP), was designed to make inexpensive modern contraceptives and ORT packets widely available in retail outlets throughout Bangladesh.

The primary implementation strategies currently being pursued by the Government of Bangladesh are as follows:

- The functional integration of all health and family planning activities at the Upazila and Union levels;
- Gradual expansion of MCH services through family planning field delivery mechanisms;
- Increased utilization of NGOs and voluntary community groups to provide services;
- Greater emphasis on domiciliary services in public and private sector programs.

The Ministry of Health and Family Planning (MOHFP) has an extensive family planning service delivery network that has the potential to provide free or low cost services to the rural poor, particularly in remote areas. The public sector predominates in the delivery of clinic-based family planning methods such as voluntary sterilization (VS), IUD and injectable services and provides non-clinical spacing methods, primarily oral pills and condoms. The Social Marketing Project (SMP) utilizes private sector promotional and marketing techniques to expand the availability of condoms, oral pills and foam tablets. The SMP currently sells its products at subsidized prices through an established network of 25,000 retail outlets nationwide. Finally, NGOs use a wide range of approaches for delivery of services, including both clinic-based and community-based programs, in which female fieldworkers deliver birth-spacing methods and limited MCH services door-to-door and make referrals for clinical methods and immunizations.

FP/MCH PROGRAM RESULTS (1981-86)

The 1981-84 USAID Family Planning Services Project (FPSP), and the 1984-86 Amendment to that Project, concentrated resources on improving and expanding the delivery of family planning services through the MOHFP system, social marketing, and NGOs. The overall objective of the project was to increase the prevalence rate for modern family planning methods and reduce the rate of population growth.

The FPSP contraceptive prevalence objective, as amended in July, 1984, was the attainment of a 25 percent prevalence rate for modern methods among all eligible women (currently married women aged 15-49) by December, 1986 (and 28 percent modern method use by December, 1987). According to the 1985 Contraceptive Prevalence Survey (conducted in early 1986) the following performance levels were achieved:

TABLE 1
CONTRACEPTIVE PREVALENCE RATES

1. Percent of All Eligible Women (Currently Married Women Aged 15-49) Using Contraception

	1983	1985
Modern Methods	13.8%	18.4%
Traditional Methods	5.5%	6.9%
All Methods	19.3%	25.3%

2. Percent of All Couples Using Contraception (Adjusted for Underreporting of Male Methods Eligible Women Respondents)

	1983	1985
Modern Methods	16.2%	22.9%
Traditional Methods	5.5%	6.9%
All Methods	21.7%	29.8%

Modern Methods are Pills, Condoms, IUDs, Foams and Jellies, Injectables, Vasectomy and Tubectomy. Traditional Methods are Abstinence, Safe Period, and Withdrawal.

While 1985 CPS estimates are not inclusive for the period through December, 1986, it is not likely that the modern method contraceptive use objectives of the FPSP (1981-86) were achieved. This outcome can be attributed in part to disappointing program performance during the last quarter of 1984 and much of 1985. Over this period, the number of VS and IUD clients served by MOHFP facilities and workers declined by about 48.8 percent and .7 percent respectively. Condom distribution fell by 27.4 percent, pill distribution declined by 11.3 percent, and foam tablet and Emko distribution dropped by 63.6 percent and 15.7 percent respectively. While the decline in provision of VS services is apparent in both BDG and NGO programs, serious systemic problems impeding service delivery within the MOHFP will require priority attention in the near future.

MAJOR DONOR ASSISTANCE IN POPULATION AND HEALTH

In the population and health sectors, USAID assistance has been focused on upgrading and improving access to family planning services. In the future, significant support will be provided to the provision of other complementary MCH interventions. Major funding for family planning is also provided by the World Bank and UNFPA. Other donors giving assistance to the BDG in its family planning and MCH programs include the Asian Development Bank, several international NGOs, and bilateral donors; namely, the United Kingdom, Japan, Canada, Norway, Sweden, Australia, Japan, Denmark, the Netherlands, and West Germany.

In past years, UNICEF and WHO have taken the lead in providing assistance in health. These UN agencies, along with the World Bank, will continue to have substantial influence in the design and implementation of health care programs (including MCH interventions) in Bangladesh. However, UNICEF provides no support for family planning while WHO has only marginal involvement.

Cooperation between USAID and other major international donors has been excellent. A local consultative group of donors meets quarterly with BDG officials to discuss problems and insure smooth coordination of all inter-related donor supported projects. In addition, a special committee meets monthly for coordination of logistics support and there is frequent informal consultation among donors.

PROJECT RATIONALE

Given the objectives of the BDG in the population and health sectors, the 1987-91 Family Planning and Health Services Project (FPHSP) has two main goals:

- To assist Bangladesh in efforts to reduce fertility and the rate of population growth;

- To assist Bangladesh in reducing current high levels of infant, child and maternal morbidity and mortality associated with closely spaced and other high risk births, immunizable childhood diseases and dehydration due to diarrhea.

The FPHSP will increase the availability and use of modern contraception and promote the adoption of other effective MCH interventions (particularly early childhood and maternal immunization services, oral rehydration therapy, and vitamin A supplementation). Pursuit of the dual goal of reduced fertility and lower mortality among children and mothers should encourage balanced demographic change at the household level; namely, fewer children will be born and more will survive to live productive lives and avoidable maternal deaths will be reduced.

The underlying rationale for this approach is based on overwhelming evidence that family planning and MCH technologies, when effectively deployed, can substantially reduce fertility and mortality. It has also been demonstrated that high use levels for FP/MCH technologies can be achieved within the social and economic context of Bangladesh.

Recent research conducted by the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) has provided evidence that effective family planning service delivery can reduce fertility as well as infant, child and maternal mortality in areas that have not experienced substantial social and economic development. When latent demand for culturally appropriate family planning services is effectively met, the result is an increase in contraceptive prevalence and lower fertility and mortality among the most vulnerable segments of the population; namely, mothers and children.

In order to sustain increases in contraceptive prevalence over the long term in Bangladesh, it is likely that socio-economic change affecting the demand for contraception will be required. For example, improved female literacy and educational attainment have been viewed in other environments as requisites for major sustained declines in fertility and mortality. In addition, improved infant and child survival

are, in the long run, likely to be crucial factors in altering the high fertility norms still prevalent in most Bangladeshi families. However, the strength and temporal dimension of what is commonly referred to as the "child-survivorship hypothesis" is not immediately apparent within the present socio-economic setting of Bangladesh.

The overall goals of the FPHSP include both fertility and mortality reduction. Research findings indicate that in severely impoverished settings such as rural Bangladesh (characterized by high fertility, nutritional deprivation and limited access to modern health care) family planning interventions can have a substantial positive impact in reducing childhood and maternal mortality. Reducing high risk births (i.e. births to women under age 18 and over age 35, parity four births and above and births occurring at intervals of less than two years) has been shown to significantly improve maternal and child health (e.g., see Trussell and Pebley, 1984; Phillips, et al., 1984b; Koenig, et al., 1986a,b). Taking into account cost, feasibility of implementation and potential impact on mortality and morbidity, USAID has identified improved access to family planning services as the intervention likely to have the greatest impact on MCH in the near future.

In designing FP and MCH service delivery strategies, it has often been maintained that offering comprehensive MCH interventions simultaneously with family planning services will lead to higher contraceptive prevalence. The credibility of family planning workers and their acceptance in local communities is thought to be enhanced if they provide curative health services. While the intuitive logic of this view is undeniable, there appears to be little empirical evidence from Bangladesh to support it. In fact, operations research findings from the ICDDR,B program area in Matlab tend to support an opposite conclusion; namely, that when family planning fieldworkers providing the standard minimal package of MCH services are trained to provide a wider range of MCH care, their effectiveness in family planning suffers and contraceptive prevalence declines, at least in the short run (Phillips, et al., 1984(b) and DeGraff, et al., 1986). Family planning fieldworkers can successfully take on additional MCH tasks, but only if these are added slowly, in a carefully phased manner, so that workers are not overwhelmed. The best strategy appears to entail the provision of comprehensive family planning services through female fieldworkers (with good clinical backup at Upazila level Health and Family Welfare Centers), and then to add time-intensive MCH services in stages.

Essential elements of the FPHSP strategy are as follows:

1. Support for Public and Private Sector Family Planning and MCH Services

The FPHSP will promote greater coverage and continued use of family planning and MCH services utilizing public and private sector mechanisms to improve service delivery. The project will encourage the implementation of effective service delivery strategies; namely, door-to-door provision of contraceptive information and supplies, service delivery to women by women (preferably from the same local community), and follow-up support to clients. Attention will be given to enhancing logistical procedures that encourage adequate and timely provision of contraceptive supplies to field workers, to improving the recruitment and training of FP/MCH personnel and to strengthening the MOHFP reporting system and program analysis capabilities of the MIS (Management Information System) Unit.

In addition to the promotion of family planning as a significant health intervention, other MCH interventions will receive greater support in the future. This strategy, coordinated with other donor assistance, currently promotes four health interventions; namely, child spacing, immunization, oral rehydration therapy (ORT) and nutrition (primarily vitamin A supplementation). Persistently high levels of maternal mortality in Bangladesh may require additional program efforts (e.g. safe birth practice training and improved referral systems for pregnancy complications and ante-natal care) which USAID will consider supporting in coordination with other donors.

2. Enhancing the Range of Contraceptive Choice

USAID will continue its efforts to make a full range of contraceptive methods readily available, to disseminate information about all methods, and to ensure adequate counselling of potential VS clients to promote informed choice. While there is growing demand for temporary methods that promote birth spacing (particularly among younger women) the number of couples wishing to cease all childbearing remains high. For most of these couples, VS has been the method of choice. Therefore, USAID will continue to ensure that quality VS services are available while, at the same time, strengthening other clinical methods (e.g. the IUD and eventually NORPLANT) and increasing the availability of condoms and pills, thereby allowing couples greater access to birth-spacing methods.

In addition to the growing number of couples wanting to delay or space their pregnancies, analysis of the 1985 Contraceptive Prevalence Survey indicates that a substantial proportion of those wanting no more children preferred a temporary method. In order to meet the needs of both spacers and limiters, increased attention will be given to making information and services concerning non-terminal methods of contraception widely available. This will be supported through better information and improved outreach by the BDG delivery system, expanded NGO service delivery, targeted distribution strategies utilizing social marketing and improvements in the distribution system for contraceptives within Bangladesh.

3. Improving the Quality of Care

On the basis of numerous studies conducted in Bangladesh and elsewhere, it is clear that the quality of care is a major factor affecting initial adoption and continued use of family planning and health services. Clinical services must be provided by well trained persons in a setting that is conducive to a positive medical outcome. Appropriate counselling and follow-up are critical for ensuring that potential medical complications are seen and properly treated. In the case of temporary methods, frequent client-worker contacts, preferably in the home, are essential.

Under the proposed project, USAID will expand its efforts to enhance the quality of both surgical and non-clinical contraceptive services. This will include continued monitoring of the qualitative aspects of the voluntary sterilization and IUD programs, in-service training for both public and private sector personnel, and provision of technical and commodity support to help ensure proper sterile conditions. With respect to non-clinical methods, USAID will support efforts to enhance the quality and frequency of fieldworker-client contacts. Through information, education and communication (IEC) initiatives, USAID will assist efforts to improve public awareness and knowledge of non-terminal methods of contraception.

A significant component of USAID's proposed FPHSP will incorporate operations research as a tool for improving both the availability and quality of BDG and NGO services. For example, studies will be supported that identify means of ensuring proper follow-up of IUD acceptors and alternative approaches to delivery of domiciliary-based family planning services. Operations research will also be used to help diagnose and resolve issues related to logistics (e.g. transportation for fieldworkers); supplies (e.g. more efficient distribution systems); FP/MCH service delivery (e.g. time use appraisals of FWA and HA work routines); and MOHFP reporting and program analysis capabilities.

4. Encouraging Upazila Level Involvement in Family Planning and MCH Service Delivery

USAID will encourage the implementation of the BDG decentralization policy involving devolution of responsibility and resources for family planning to the Upazila level. This strategy is consistent with USAID's long-standing goal of making family planning and MCH services accessible at the village and household level. Through the FPHSP, USAID will assist the BDG in operationalizing its policy of decentralization by channelling FP and MCH funding to the Upazila level.

Over the coming years, the BDG expects that the locally elected Upazila Chairman and Parishad (Committee) will play an increasingly important role in implementing family planning and health programs. Under the proposed FPHSP, USAID will support efforts to train selected members of the Upazila Parishads and administration in family planning program organization and provide assistance in the design, administration and management of FP/MCH programs at the Upazila level. An additional element of the decentralization policy that will require attention is the nature of existing coordination mechanisms between upazila and union level health workers.

PROGRAM OBJECTIVES OF THE USAID FAMILY PLANNING AND HEALTH SERVICES PROJECT

FPHSP objectives and program priorities are essentially consistent with the goals and implementation strategies articulated by the BDG in its Third Five Year Plan and National Strategy for MCH. However, USAID believes that official BDG population and health objectives may be overly ambitious given the relatively short five year planning period under review (1985-90 in the BDG TFYP).

The major component of the FPHSP project will be continued support for family planning in Bangladesh. As is shown in Table 2, USAID anticipates that contraceptive prevalence in Bangladesh will reach 40 percent by 1991; one year later than anticipated in the TFYP. Modern method use is projected to reach 33.6 percent of all eligible couples while traditional methods will account for 6.4 percent of contraceptive use. These prevalence objectives are ambitious, but achievable given effective and timely program implementation.

TABLE 2
PROJECTED TREND IN CONTRACEPTIVE PREVALENCE

Percent of All Couples Aged 15-49 Using Contraception(1)

	1986	1991
Total	29.8	40.0
Modern	22.9	33.6
Traditional	6.9	6.4

In addition to family planning, the FPHSP will provide funding for the national MCH program. Two major MCH interventions to be supported are oral rehydration therapy (ORT) and immunization. USAID believes that the following treatment and coverage rates can be realistically attained by 1991:

- o 60 percent of all diarrhoeal episodes in children aged 0-4 treated with ORT;
- o 65 percent of children aged 0-1 immunized against measles, whooping cough, diphtheria, polio, tetanus, and tuberculosis in the four urban municipalities of Dhaka, Khulna, Chittagong and Rajshahi;
- o 60 percent of women aged 15-44 immunized against tetanus in the four urban municipalities of Dhaka, Khulna, Chittagong and Rajshahi.

Projected demographic change over the period 1986-91 is shown in Table 3. Given an increase in contraceptive prevalence (modern plus traditional methods) from 29.8 percent in 1986 to 40.0 percent in 1991, a decline from 83.5 to 83 percent in the proportion of women currently married, a modest reduction in the duration of postpartum ammenhorea (from 19.5 to 19 months) and a constant induced abortion rate of .2 abortions per woman by age 49, the total fertility rate should decline from 5.6 to 4.8.

1/. 1986 Contraceptive Prevalence Estimates are from the 1985 Contraceptive Prevalence Survey (Mitra and Associates, op cit., 1987). The 1985 CPS eligible women and couple samples were actually drawn over the period January-July, 1986. Therefore, there is no inconsistency in using 1985 CPS estimates as measures of program achievement in 1986.

Slow gradual improvement in mortality is anticipated, with life expectancy increasing from 52 to 53 years between 1986 and 1991. As has been the case in other South Asian countries over the recent past, female mortality (particularly among infants and children) may decline more rapidly than male mortality, although it is expected that Bangladesh will continue to experience excess female mortality beyond 1991. Much of the mortality decline projected over the period 1986-1991 will result from reduction in infant and child mortality. Improvements in the coverage and quality of family planning and MCH services will probably be a significant factor in this decline.

Given the anticipated change in fertility and life expectancy outlined above, it is possible to estimate levels and trends in the crude birth rate, crude death rate and annual rate of population growth between 1986 and 1991. The crude birth rate will likely decline from 38.9 births per 1000 population in 1986 to 35.5 in 1991. The crude death rate is expected to decline from 14.6 deaths per 1000 population in 1986 to 13.5 in 1991. The rate of out-migration from Bangladesh is insignificant in demographic terms.

The off-setting effect of declining fertility and mortality results in a rather modest reduction in the annual rate of population growth between 1986 and 1991; namely, from 2.4 percent per annum in 1986 to 2.2 percent in 1991. Given a total population of 101.6 million in 1986, the population of Bangladesh is projected to be 113.4 million by March, 1991. (Long-term demographic trend analysis is presented in the Technical Analysis in Annex II).

TABLE 3
PROJECTED DEMOGRAPHIC ESTIMATES FOR THE PERIOD 1986-91

	1986	1991
Total Population (1000)	101553	113359
Annual Growth Rate	2.4%	2.2%
Crude Birth Rate	38.9	35.5
Crude Death Rate	14.6	13.5
Total Fertility Rate	5.6	4.8
Life Expectancy	52	53
Infant Mortality Rate	128	123
Child Mortality Rate	24	21
Maternal Mortality Rate	6	5

1/ The 1986 total population estimate of 101.6 million (as of March, 1986) was obtained through a projection of the 1981 census population (corrected for a 3.2 percent undercount) that incorporated a decline in fertility from 6.3 to 5.6 and an increase in life expectancy from 51 to 52 years. This projection is roughly consistent with the mid-year 1986 BDG total population of 102.9 million reported in the BDG Third Five Year Plan.

III. PROJECT COMPONENTS

The 1987-91 Family Planning Services Project (FPSP) contains four major components: (1) Support for BDG FP Activities, (2) FP Social Marketing; (3) NGO FP Activities; and (4) Other MCH Interventions. (An overview of Project Components and Sub-Components is provided in Table 4).

Component I
SUPPORT FOR GOVERNMENT FAMILY PLANNING ACTIVITIES

A. Information, Education, and Communication Services
(FY 87-91: $5.07 million)

Evaluations of the 1981-86 Family Planning Services Project (FPSP) in 1983 and 1986 encouraged USAID to support IEC activities in order to ensure informed choice by clients, promote sustained use of family planning methods, and more quickly achieve contraceptive prevalence goals. The MOHFP subsequently requested USAID and UNFPA assistance to redesign and reinvigorate IEM Unit activities of the Family Planning Directorate. Sub-component activities require collaboration with the Health Education Unit of the Health Directorate, the Ministry of Information and Broadcasting, the Social Marketing Project, and NGOs, among other actors. While many IEC activities are being implemented by these agencies, there is no coherent communications strategy to coordinate family planning, immunization, oral rehydration, safe birth practices, and nutrition messages to ensure that they are mutually reinforcing. Most media messages are for a literate public while the target audience is overwhelmingly illiterate. Media materials exist for the non-literate population, but need to be improved in content and design.

Numerous studies indicate that virtually all adults recognize family planning symbols, messages, and products. FPHSP assistance will emphasize design of messages in FP/MCH that are targeted on specific practices and audience segments. Specifically, USAID will support audience research and audience segmentation; message development; creative use of a wider variety of communications channels; improved communications training; and wider dissemination of service provider, fieldworker, and client educational materials. USAID will also support operation of IEM mobile audio-visual units; folk singing troupes and other communication techniques for rural illiterates; design and distribution of bill boards, posters, refresher training materials, and user materials. In addition, national and local workshops on population and FP/MCH themes will be organized for newly-elected Members of Parliament, community leaders, and other decision-makers.

Table 4

PROJECT COMPONENTS AND SUB-COMPONENTS

Component or Sub-Component	Intended Output of Component or Sub-Component	Assistance Provided	National Implementing Organization	Planned Funding ($ million)
Component 1: SUPPORT FOR BDG FAMILY PLANNING ACTIVITIES.	Strengthen capacity of MOHFP to deliver FP services through clinics and CBD			
Sub-Components:				
A. Information, Education, & Communication Services.	Increase knowledge of, demand for, full range of FP services.	TA support for research, training & innovative field prog.	IEM Unit. Buy-ins-POS/AED.	5.07
B. Clinical & Community-Based FP Services o - VS o - IUD o - NORPLANT o - Fieldworker Mobility	Provide access to full range of FP methods by reimbursing unusual costs associated with clinical treatment. Increase mobility, effectiveness of FP workers by enhancing travel allowance.	Reimbursement to MOHFP for payments to clients, helpers provides reimbursement to MOHFP for additional travel costs of workers.	MOHFP requests reimbursement from USAID.	15.23
C. FPO Training and Upazila Family Planning Grants	Support decentralization of FP services by training FP workers/ local leaders and providing block grants.	Training costs. Block grants, TA.	FPMT buy-in FF Works with MOHFP & Upazila Parishads.	3.57
D. Contraceptive Commodities & Logistics o - Commodities o - Logistics Support	Provide MOHFP, NGOs & SMP with contraceptives related commodities TA to improve logistic system.	Contraceptives, other commodities. TA.	AID/W procures at request of USAID. Logistic Advisors under TA Contract.	37.52
E. National Family Planning Headquarters	Support administrative coherence in FP program by providing national headquarters.	20 story, 140,000 sq.ft. building. A&E and construction services.	MOHFP. American A&E firm. Local construction firm.	5.00
F. Research, Monitoring, & Training o - CPS o - VS/IUD o - Monitoring o - Strengthening the MIS o - Demographic Forecasting o - Research--New Methods Service Delivery o - The ICDDR,B Extension Project o - OR & Diagnostic Stud. o - TRRT	Monitor impact, quality of ongoing national FP program through biennial CPSs, quarterly VS/IUD monitoring, MIS; Improve planning through accurate demographic forecasting; Field testing of promising FP methods; OR on innovations in administration and CBD--Training for MOHFP personnel.	Research costs. Training costs TA.	MOHFP, BFRP, URC, ICDDR,B; Population Council, Local Consulting firms, etc.	14.03

Component 2: SUPPORT FOR SOCIAL MARKETING	Make retail market effective channel for delivering contraceptives ORS.			
A. FP Social Marketing	Make contraceptives available at retail shops all over Bangladesh with increasing efficiency.	Contraceptives CA with PSI provides TA, OE, etc.	SMP/PSI	16.47
Component 3: NGO FP ACTIVITIES	Complement, extend range and availability of FP/MCH services available from MOHFP through support for NGO activities.			
Sub-Components:				
A. FPAB	Expanded CBD coverage Testing of innovative CBD strategies.	Contraceptives, Training, OE, etc.	FPAB	2.62
B. BAVS/AVSC	Improved standards of care in VS. Widespread adoption of safe birth practices.	Training, OE, etc.	BAVS/AVSC	5.41
C. FPSTC	Expanded higher quality CBD coverage. Effective coordination of NGO activities.	Contraceptives, Training, OE, etc.	FPSTC	7.50
D. FPIA	Expanded CBD coverage Testing of decentralization strategies.	Contraceptives Training, OE, etc.	FPIA	8.25
E. PF	Expanded CBD coverage Testing of decentralization strategies.	Contraceptives, Training, OE, etc.	PF	12.00
F. TAF	Expanded CBD coverage Testing of strategies for NGO/MOHFP/Local gov. cooperation. Field testing of female education programs.	Contraceptives, Training, OE, etc.	TAF	18.00
Component 4: SUPPORT FOR MCH ACTIVITIES	Lower mortality and morbidity of infants, children, and mothers.			
Sub-Components:				
A. ORT Social Marketing	Make ORS available at retail outlets all over Bangladesh with increasing efficiency; establish village distributorship scheme.	ORS sachets procured by SMP. CA with PSI provides TA, OE.	SMP/PSI	15.00
B. Municipal Immunization Program	Effectively extend EPI to Dhaka, Khulna, Chittagong & Rajshahi.	Commodities, TA Equipment, Training.	4 Municipal Gov'ts. Assisted by TA contractor, MOHFP	10.00
C. Innovative MCH	Reserve funding for innovative MCH research & other delivery activities defined at later date.	Training, TA, OE, etc.	MOHFP, NGOs, Local Consultants, etc.	2.00

B. Clinical and Community-Based Family Planning Services and Voluntary Sterilization Reimbursements
(FY 88-91: $1.65 million)

USAID has reimbursed the MOHFP for payments made to individual voluntary sterilization (VS) acceptors, helpers and providers of vasectomy and tubectomy services since 1981 with the purpose of improving access to, and quality of, VS services in Bangladesh. Payments make clinic-based methods available at little or no cost to the client, thus broadening overall access to family planning and expanding the range of feasible contraceptive options. Men and women who choose VS receive Tk.175 ($5.80) in compensation for work loss, travel and food expenses. Helpers, who accompany clients to clinics and assist with personal needs and child care receive Tk.45 ($1.50) to compensate for transportation and food costs. Service providers are compensated for surgical and aftercare services and for working after hours - Tk.20 ($0.66) for physicians and Tk.15 ($0.50) for assistants.

In addition to support for payments, USAID has funded several related activities which improve access to and safety of VS services. These include training, production of educational materials, technical assistance to service providers, and provision of surgical equipment and supplies.

USAID supports only a portion of the costs of providing VS services in Bangladesh. The World Bank Consortium and UNFPA provide support for medicines, clinical equipment, surgical apparel, and the operational costs of the FP Clinical Services Surveillance Team. These donors will continue to support such costs over the next several years. The BDG also provides some financial support for the surveillance team and other operational costs.

USAID support of VS services in Bangladesh is conditioned upon continued program compliance with medical quality and voluntarism standards. USAID concerns have been made clear by inclusion of Conditions Precedent and Covenants in the FPHSP which require continued implementation of a sterilization surveillance system acceptable to USAID and scrupulous conformity to informed consent procedures. VS compensation payments, particularly client payments, are one of the most closely monitored and thoroughly evaluated aspects of the Bangladesh Population and Family Planning Program. A major external evaluation of the VS compensation system published in September, 1986, concluded:

The client reimbursement payment does not coerce people to have the operation and does not appear to be an important influence on the decision as to whether to get sterilized. Rather, its importance appears to be in enabling an individual to have the operation relatively soon once the decision has already been made (Pillsbury and Knowles, 1986).

USAID will arrange a follow-up external evaluation in 1988 to again scrutinize the effect of payments and their relationship to client access, satisfaction and voluntarism. Client payments improve the convenience and safety of services by allowing clients to act earlier on their decision to seek sterilization; making available faster, more comfortable modes of transportation to and from the clinic; improving nutrition during the post-operative period; and increasing the likelihood they can take adequate post-operative rest. All of these factors reduce risk of VS-associated medical complications and facilitate recuperation.

Experience has shown that forecasting demand for sterilization in Bangladesh is extremely difficult. For example, none of these recent developments were foreseen; an unprecedented level of demand between October, 1983 and October, 1984 followed by a dramatic decline in sterilizations at BDG and NGO clinics beginning in late 1984 (and continuing to the present) and a significant shift in the sterilization method mix away from tubectomy towards vasectomy. In 1980, the vasectomy:tubectomy ratio was 1:9 while in 1986 it was 1:0.7. On-going research may explain some of these developments and improve our ability to predict future performance levels.

The following conditions have been considered in estimating budget requirements for 1987-1991:

1. Deliberate work slowdowns by family planning workers disgruntled by integration of family planning and health programs at the upazila level appear to have contributed substantially to the 1984-86 decline in sterilizations, although late 1986 and early 1987 performance may have picked up somewhat.

2. Previous program success has led to relatively high sterilization prevalence in some areas of the country. In these areas, demand for permanent FP methods may be "plateauing".

3. Ongoing improvements in availability and quality of other family planning services, particularly IUDs and injectables have led to shifts in demand and method mix in favor of non-permanent spacing methods.

4. The relative importance of sterilization will continue to decline as spacing is better understood by clients as a health measure and as services become more accessible.

USAID will continue to support research on determinants of demand for sterilization. This work may explain or confirm some of these developments and improve the ability of the BDG and USAID to predict future performance levels. BDG projections in the TFYP will be constantly monitored and evaluated in light of this research. Program changes in reimbursement strategies, information and education campaigns, and new product introduction will be proposed over the life of the FPHSP as appropriate.

IUD Reimbursements
(FY 88-91: $0.97 million)

At the request of the BDG, USAID has supported certain local costs of IUD services provided by MOHFP and NGO programs since 1982, including reimbursements for compensation payments made to IUD clients, helpers, and providers. Payments are made under the same rationale applied to VS payments. They make a clinic-based method available to acceptors at little or no cost, thus broadening overall access to family planning and expanding the individual's range of contraceptive options. At present, payments are made as follows: women who choose the IUD receive Tk.15 ($0.50) in compensation for travel expenses; fieldworkers receive Tk.15 ($0.50) in compensation for "non-routine services"; and providers (physicians or Family Welfare Visitors) receive Tk.5 ($0.17) for follow-up services rendered.

To complement quantitative findings from annual evaluations, IUD users are being included in qualitative studies funded annually by USAID which explore influences on the IUD decision-making process (including payments, the quality of counseling, and satisfaction with IUD services).

At the end of 1987 there will be approximately 986,400 improved IUDs (Copper T, series 380A) in country, sufficient to meet projected demand for two years. USAID will procure adequate supplies during the FPHSP to maintain an 18 month stock in-country at all times. A consulting group, PATH/PIACT, has recently been commissioned (with FPSP funding) to work with the MOHFP and NGOs to design and implement a strategy for safe, successful introduction of the new Copper-T IUD 380A in Bangladesh. Educational materials will be disseminated to both users and providers.

NORPLANT Reimbursements
(FY 89-91 $0.04 million)

The Bangladesh Fertility Research Project (BFRP) and Family Health International (FHI) are currently undertaking clinical trials of NORPLANT with FPSP funding. The trials will be expanded during FY 87 with funds available under the FPHSP. The BDG will decide in 1988-89 whether to pursue wide-scale introduction of NORPLANT in the MOHFP program.

USAID anticipates supporting a major expansion of NORPLANT-related training in 1988 and procuring requisite equipment and supplies needed for efficient, safe introduction of NORPLANT. If future research supports the position that payments facilitate access (and there is a request from the BDG) USAID may reimburse the MOHFP and NGOs for payments made to NORPLANT and injectable clients, providers, and helpers. USAID has budgeted separately for reimbursements and other costs associated with NORPLANT adoption beginning in FY 90. Before that time, funding for FHI/BFRP research and AVSC/BAVS training will cover necessary costs.

Fieldworker Mobility: Transportation Support
(FY 87-91: $12.57 million)

Senior Family Welfare Visitors (SFWVs), Family Welfare Visitors (FWVs), Family Planning Assistants (FPAs) and Medical Assistants (MAs) play a key role in providing technical support for Family Welfare Assistants (FWAs), Health Assistants (HAs) and Traditional Birth Attendants (TBAs). The ability of supervisors and fieldworkers to do their jobs is seriously constrained by lack of travel funds, a problem particularly acute during the monsoon when circuitous routes and costly forms of hired transport are needed. Under the FPHSP, USAID will supplement present reimbursable monthly travel allowances of MOHFP fieldworkers up to the following levels based on actual travel time delivering family planning services; namely, SFWVs - Tk.600; MAs, FWVs, FPAs and FWAs - Tk.200.

The BDG may propose using a portion of this budget item to enhance worker mobility in other ways. One possibility is to acquire transport on a hire-purchase basis, as has been done in ICDDR,B Extension Project areas. Another possibility is assistance to fieldworkers for subsidized purchase of bicycles and motor cycles.

C. Training and Financial Support for Upazila Family Planning Initiatives
(FY 87-91: $3.57 million)

From 1980-82, USAID supported a training program in Indonesia for 300 Upazila Family Planning Officers (UFPOs) and a small number of other FP officials. The training upgraded UFPO skills in field supervision and stimulated community participation in FP programs. In 1986, the MOHFP and USAID agreed to re-establish the training program in order to reflect the BDG's current emphasis on strengthening elected local government and decentralization of central ministry functions to the upazilas.

Over the next 5 years, additional UFPOs will be trained and, starting on a pilot basis, Upazila Teams will be sent to Indonesia for training. Each Upazila Team will have 5-6 members including the elected Upazila Chairman, the appointed Upazila Nirbahi Officer, the UFPO, and the UHFPO. In addition, a representative of a local NGO, a district family planning officer, or an appointed female member of the Upazila Parishad may be included. One intended outcome of Indonesian training is the development of better working relationships among elected and appointed officials, all of whom will travel and learn together.

The FPHSP will also make available modest Family Planning Block Grants to supplement limited family planning funding currently available to Upazila Parishads. These funds will be used to implement proposals developed by Upazila Teams and approved by Upazila Parishads. The MOHFP and USAID are collaborating to develop mechanisms for defining acceptable criteria for channelling Block Grants to Upazila Parishads.

UFPOs, (who have been particularly diligent in ensuring good local communications, community participation, improvements in quality of local services, and adequate contraceptive supplies), will be given priority for participation in this program. In Indonesia, participants will learn from the successes and failures of an effective family planning program in a Muslim country known for enthusiastic participation of elected and appointed local officials, active community involvement, and full participation of women. Careful attention will be given to the transfer of relevant aspects of the Indonesian experience to Bangladesh.

Follow-up workshops in Bangladesh will emphasize lessons learned in Indonesia, with particular stress on planning for community involvement, IEC, couple registration, record-keeping, and supervision. Each Team will analyze population data from its own Upazila prior to developing Action Plans that will utilize FP Block Grants.

This program will begin in mid-1987 with FPSP funding. About 200 UFPOs will be trained as individuals or members of Upazila Teams. 60 upazilas will eventually participate in this program. With 5 members on each team, about 300 Team members will be trained. In total, around 450 Upazila elected and appointed officials, UHFPOs, and UFPOs will be involved.

D. Contraceptive Commodities and Logistics

Commodity Assistance

(FY 88-91: $53.7 million required; USAID-FPHSP: $36.72 million; and second donor, to be identified, $17.0 million)

USAID has been the largest donor of contraceptives to the Bangladesh FP Program since 1973. Since 1981, it has provided approximately $50.0 million worth of condoms, oral pills, IUDs, foam, catgut, surgical equipment and supplies, drugs, and surgical apparel. With the exception of catgut and surgical apparel procured regionally or in Bangladesh, other contraceptive commodities were procured by AID/W and delivered to the MOHFP Central Warehouse or to SMP for distribution.

USAID will continue substantial commodity assistance under the FPHSP but will seek to attract a second donor to share costs for the 1988-91 period. There have been some indications that CIDA will be in a position to assist the Bangladesh program with additional commodity support. In establishing commodity projections, USAID has consulted with the MOHFP and other donors. USAID has projected a requirement of $53.7 million from 1988-1991 for procurement and delivery of contraceptive commodities and has budgeted $36.72 million for AID/W procurement under the FPHSP. Requirements for each commodity have been developed on the basis of current performance and anticipated improvements in service delivery by the MOHFP, NGOs, and the SMP over the 1987-91 period. USAID anticipates the need to supply NORPLANT and possibly injectables to MOHFP and NGO clinics from FY 90 (subject to approval of NORPLANT and/or injectables by the U.S. Food and Drug Administration and a decision by the Government of Bangladesh to introduce the method into the program).

USAID Assistance for the Logistics System

(FY 87-91: $0.80 million)

Since his arrival in October 1984, USAID's Logistics Management Advisor has developed and supervised three annual rounds of a National Physical Inventory of Contraceptives, Surgical Equipment and Drugs, and MCH materials; organized a Logistics Management Information System for the Central Warehouse (including installation of a microcomputer, development of software programs, and training in their use);

organized the revision, translation, and printing of the MOHFP Supply Manual; organized and implemented logistics training for 1100 storekeepers and field officers; analyzed annual contraceptive requirements and prepared and processed AID commodity procurement orders; monitored shipping and receipt of AID-procured commodities in country on behalf of the MOHFP and USAID; monitored distribution of USAID and other donor-funded commodities; and coordinated development of an Upazila Storeroom renovation and construction program.

In spite of these accomplishments, much remains to be achieved in logistics management. The 1985 and 1986 Physical Inventories found that 35 percent of FWAs held no condom stocks and 29 percent were without oral pill stocks on the date of inventory. Problems of managerial inexperience, inadequate training, and lack of initiative are endemic in the logistics system. Utilizing FPHSP funding, USAID will continue to retain the contract services of an expatriate Logistics Management Advisor (FY 88-91). In addition, USAID will contract for an expatriate Logistics Training Advisor (FY 88-91) and a Bangladeshi Logistics Management Information Specialist (FY 88-92). Through design of new management systems and regular monitoring of commodity distribution and other assistance, the Logistics Advisory Team will provide vital services to MOHFP, USAID, and other donors.

Filling of vacancies awaits approval of an MOHFP document which has been under review for more than a year. USAID will press for quicker action on staffing since understaffing will reduce the effectiveness of USAID assistance to strengthen the commodities management and distribution system. USAID will encourage the MOHFP to create two more national posts; namely, an Assistant Director for the Logistics Management Information System and an Assistant Director for Logistics Training. USAID funds will be made available to provide salary support for these posts on a declining scale for three years (100%, 50%, 25%).

Logistics training provided to District and Upazila officers is presently inadequate. Only three days of orientation are devoted to this subject and no refresher courses are offered. USAID will support expansion of this training effort. Training curricula and audio-visual support equipment have already been procured or developed with FPSP funding. Continuation of annual commodities inventories is essential for project monitoring. USAID will therefore provide funding for four additional annual surveys (1988-91). Other logistics studies (e.g. to test stocks of in-country contraceptives for durability) may also be undertaken with this funding.

Movement of commodities is generally hampered by the absence of a vertically integrated national transport plan. Under the FPHSP, USAID will work with the MOHFP to identify

critical weaknesses in the supply chain and develop a National Commodities Transport Plan to strengthen the system at key levels and ensure adequate, timely resupply of commodities to frontline fieldworkers.

E. National Family Planning Headquarters
(FY 87-91: $5.00 million)

The Bangladesh FP Program is one of the BDG's major development initiatives. It is staffed by highly trained civil servants responsible for managing thousands of fieldworkers, and coordinating with hundreds of indigenous NGOs and more than a dozen bilateral and multilateral donors.

Management is shared between the Minister, Secretary, and other FP Directorate senior staff located at the Bangladesh Secretariat and FP Directorate staff dispersed throughout Dhaka in rented offices. This situation is not conducive to effective program management. Offices housing the Management Information System are located in a dilapidated market on a noisy throughfare. Computer facilities are damp and dreary and miles away from the offices of maintenance personnel. The National Institute of Population Research and Training (NIPORT) had difficulty finding adequate premises and finally displaced an MOHFP health clinic. Due to lack of space, the IEM Unit must store bulk printed materials in small occupied offices.

Transportation between the Bangladesh Secretariat and most Directorate offices (and among individual Directorate locations) often takes more than thirty minutes in each direction. Officers frequently spend more time commuting than conducting useful business. Telephone communications among offices are erratic and meetings are too often missed. This inefficient arrangement has a debilitating effect on program management and efficiency.

The MOHFP has requested USAID funding for design and construction of a National FP Headquarters. The plan is to construct a building large enough for all headquarters offices of the FP Directorate and some Ministry personnel. The building will also supplement inadequate training space in Dhaka by adding classrooms, conference facilities, and a small auditorium. A population library will be established on the premises for use by MOHFP employees, students researchers, and consultants. Conference facilities can be rented out, and proceeds used to maintain the building and pay utilities. The ground floor will have room for rental space that will offer a further source of income for recurrent costs. A parking garage will be constructed below ground.

USAID will support construction as a major contribution to orderly program management and coordination. USAID will contract with an Architecture and Engineering firm for all

aspects of design planning and construction monitoring under 941 procurement procedures. Construction will be done by a contracted Bangladeshi firm beginning in early FY 90, and is expected to be completed by FY 91.

F. Research, Monitoring, and Training

Contraceptive Prevalence/Mortality-Fertility Surveys
(FY 87-91: $1.67 million)

USAID has provided funds for National Contraceptive Prevalence Surveys (CPSs) in 1979, 1981, 1983, 1985, and 1987. Because of the uneven quality of MOHFP and NGO statistical reporting systems, and the variety of sources of contraceptive supply, the CPS is an essential instrument for assessing family planning performance in Bangladesh. In addition to its utility as a periodic global indicator of program progress, the CPS also has day-to-day administrative applications. It provides a basis for periodic adjustment (and re-interpretation) of MIS figures, and through estimation of unmet need, provides guidance on procurement decisions for contraceptives and other products.

Earlier surveys were carried out, with MOHFP approval, by an independent Bangladeshi research firm under contract to USAID. The contract for each CPS has been awarded competitively. Technical standards have been excellent and the activity has served to strengthen local research capacity. The FPHSP will continue to fund CPSs in 1989 and 1991 and, as linked activities to the 1987 and 1991 CPSs, will provide supplementary support to fertility and mortality studies. USAID will rely on AID/W technical assistance projects to ensure that standard fertility/mortality and MCH survey modules are made available for implementation in Bangladesh. FPHSP funding will also be provided for a series of mini-CPSs in areas where FP NGOs are active. These surveys will provide essential information on NGO performance. (See Data Collection, Monitor and Evaluation Plan in Annex I).

Clinical Services Monitoring--Quality of Care, Voluntarism, and Access
(FY 87-91: $1.35 million)

A comprehensive system for monitoring clinical program impact and compliance with BDG and donor policies for medical quality and voluntarism in sterilization and IUD services is already in place, established in part with FPSP funding. It has two main components: data collection and analysis, and direct program surveillance. Several mechanisms generate data on a monthly, quarterly, annual, and biennial basis, and permit continuous monitoring of key indicators of quality of care, voluntarism, access to services and program impact. Key

elements of the system are (1) a USAID-funded quarterly external evaluation survey of the national VS program and (2) an annual external evaluation survey of the IUD program.

USAID is currently exploring several ways to make the quarterly VS survey more accurate and useful in program monitoring. For example, consideration is being given to the adoption of stratified sampling to ensure that the survey addresses aspects of the system not fully understood at present (e.g. selection of explicit sub-samples of clinics that perform fewer than 40 sterilizations per quarter; of individuals with home addresses in "non-contiguous" upazilas, etc.); introduction of new questions which address voluntarism, client satisfaction and payment effects in greater detail; development of improved administrative feedback procedures which ensure that deficiencies are identified and addressed by the MOHFP and NGOs; and merging the VS and IUD surveys so that both VS and IUD clients and service providers are sampled quarterly.

An essential element of the VS/IUD monitoring system is the Family Planning Clinical Surveillance Team (FPCST), formerly the Voluntary Sterilization Surveillance Team. The FPCST monitors VS, IUD, and injectable services provided in both BDG and NGO clinics. Effective functioning of the FPSTC will continue to be a USAID Condition Precedent for VS and IUD reimbursements to the MOHFP for client, provider, and helper payments. Temporary suspension of VS reimbursements in late 1986 demonstrates USAID seriousness in requiring compliance with this CP. (No funds will be provided for reimbursements while the FPCST lacks a full complement of expatriate advisors and functioning vehicles.)

USAID will continue to monitor closely BDG compliance with AID Policy Determination 3, and quality of services through such mechanisms as surveys and focus group interviews, attendance at FPCST monthly meetings, and USAID field visits. In addition, two supervisory MOHFP cadres (the district level Medical Officer/CC and the Upazila level Medical Officer/MCH) have major responsibility for overseeing VS, IUD and injectables service delivery and will receive project-funded travel allowances and refresher training. USAID will also continue to employ one personal services contractor under the FPHSP responsible for monitoring voluntarism and quality of clinical services.

The World Food Program has included questions in its monitoring system to ensure that no food inducements are made with respect to sterilization. In addition, BAVS/AVSC, PF and FPAB will continue to monitor quality of care, indicators of voluntarism, access to services, and impact of the NGO clinical program through medical and program staff field visits and special studies funded under the FPHSP.

Strengthening the Management Information System of the MOHFP Population Service Statistics Cell
(FY 87-91: $0.75 million)

The MOHFP Management Information System (MIS) at the Population Service Statistics Cell collects statistics on acceptance and use of contraception for BDG and NGO family planning programs. The MIS provides monthly performance data, a valuable tool for program management. At present, monthly reports are prepared and distributed on contraceptive acceptance data (by upazila and district) for both government and NGO programs; monthly inspection accounts of field visits by senior officers; monthly summaries of all FP Directorate activities; and a report to the President's Secretariat on clinical services, Upazila Health Complex construction, and service delivery activities.

The FPHSP will provide technical assistance to the MOHFP to strengthen the capacity of the Population Service Statistics Cell. An important objective of this technical assistance will be to assist the MOHFP in assessing the effectiveness of supervisory systems in client outreach and quality of worker-client interactions. Technical assistance will be made available to the Population Service Statistics Cell through collaboration with the ICDDR,B MCH/FP Extension Project's long-term MIS Intern and other short-term consultants. This support will include assisting in the design and introduction of two new data systems: one for collection of management information in eight specially selected upazilas and another in 40 urban wards. Special attention will be given to low-performing upazilas and wards.

ICDDR,B Extension Project researchers have developed an alternative system which encourages more frequent worker-client contact visits and relies less upon method-specific and worker-specific targets for monitoring performance. This system has improved worker motivation and job performance in pilot areas. TA provided to the Population Service Statistics Cell under the FPHSP by the Extension Project and the

University Research Corporation, an AID/W contractor, will assist in modifying the national MIS system by incorporating elements of the experimental system and by replacing method-specific targets with coverage objectives and other measures which clearly reflect quality of care.

The World Bank will also provide support to the MIS unit for development and modification of the service statistics system, with particular attention given to incorporation of MCH services into the MIS reporting system. USAID assistance to the MIS unit will be carefully coordinated with World Bank support.

Strengthening Population Forecasting and Development Planning by the Planning Commission
(FY 87-91: $0.58 million)

The Population Development and Evaluation Unit (PDEU) is an element of the Population Planning Wing of the Planning Commission established to analyze population and health issues relevant to development planning in Bangladesh. Specifically, the PDEU is responsible for 1) evaluation of the quality of demographic statistics generated by the BBS, BIDS, ICDDR,B, and other organizations; 2) assessing demographic trends that can be attributed to specific development programs; and 3) increasing effective use of demographic information in national, regional, and local planning. The PPW establishes national program objectives for population and health (including goals set in the TFYP), formulates national population policies, and coordinates planning of BDG and NGO implementation strategies in population and health.

For several years, PDEU activities were supported by UNFPA. However, due to budget constraints, UNFPA will not support the PDEU beyond December, 1986. USAID and Planning Commission officials are currently discussing possible arrangements for support of the PDEU under the FPHSP. Ties will be established between the PDEU and the INPLAN project of the Office of Population, AID/W. INPLAN provides Third World Planning Ministries with technical assistance in population and development planning, including sector-specific planning techniques that incorporate information on population size, distribution and growth; appropriate microcomputer hardware; and in-country and US-based training in national and regional planning. FPHSP funds will be used to provide necessary technical resources to strengthen PDEU data analysis, forecasting, strategy development, and planning activities.

The PDEU should play a more useful role in national planning since evaluation activities will increasingly be oriented toward the analysis of administrative and technical effectiveness of FP/MCH service delivery in Bangladesh; e.g., 1) progress and problems in FP/MCH functional program integration, including factors affecting FP/MCH worker motivation; 2) comparison of high-performing and low-performing upazilas and 3) evaluation of the role of Upazila Parishads in population and family planning.

Research on New Contraceptive Methods and Improved Service Delivery
(FY 88-91: $0.22 million)

Support under the FPHSP will be channelled through Family Health International (FHI) to its affiliate, the Bangladesh Fertility Research Program (BFRP), to carry out research on 1) the safety and effectiveness of presently-used and new contraceptive methods, 2) appropriate strategies for introduction of new contraceptive methods into the national program, and 3) opportunities for improving quality of care for existing clinical methods. FPHSP support will enable BFRP to place greater emphasis on analysis of data and dissemination of findings from clinical and epidemiological research.

BFRP/FHI will collaborate closely with the Technical Review Committee of the MOHFP, medical societies and research institutes in Bangladesh and eminent Bangladeshi physicians and scientists. BFRP's main clinical research activity under the FPHSP will be an expansion of ongoing NORPLANT trials. Support for an additional three year program will enable BFRP to further evaluate the safety, efficacy and acceptability of NORPLANT in Bangladesh.

The ICDDR,B MCH/FP Extension Project
(FY 87-91: ICDDR,B-$4.62 million; Population Council-$2.36 million)

Since 1977, the International Center for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), with financial and technical support from USAID and other donors, has conducted an Operations Research project in Matlab Thana. The project evaluates demographic and health effects of FP and MCH services and identifies specific causes of program success. One important finding is that when previously unmet demand is substantially met by a high-quality family planning program, contraceptive prevalence increases and fertility and mortality decline substantially, even in the absence of significant social and economic development. Key features of the field service program are:

- Enough trained female fieldworkers to permit bi-weekly visits to women's homes to effectively meet women's needs for FP counseling, re-supply, follow-up and ancillary MCH care;

- A broad range of modern contraceptive methods offered by fieldworkers at the household level, with referral for clinical services;

- A strong supervisor-to-worker relationship and an MIS system designed with the needs of the fieldworker in mind;

- Additional gender-appropriate FP and MCH tasks carefully and gradually phased in, after planning, training, and evaluation.

The ICDDR,B MCH/FP Extension Project, supported by USAID with technical assistance from the Population Council, was launched in 1982 to test the transferability of key components of the Matlab system to the MOHFP field program. Two upazilas (Sirajganj and Abhoynagar) were selected as field test areas. Performance of workers in those areas has improved, and contraceptive prevalence rates have risen significantly since 1983. The Extension Project has now been formally asked by the MOHFP and CIDA to advise on, and participate in, recruitment and phased deployment of 10,000 female fieldworkers who will be added to the MOHFP system nation-wide by 1990. This will mean a major commitment of Project resources outside of two field test Upazilas as well as continued work in those areas. The Extension Project will have the opportunity to improve the performance of newly-deployed FWAs by influencing recruitment procedures, training, and supervisory relationships in areas to which new FWAs are assigned.

Extension Project staff will also continue to work with the MOHFP through a Steering Committee and on various task forces to institutionalize new policies and administrative practices. An Extension Project Intern with expertise in FP/MCH program analysis and MIS systems will be deputed to work half-time with the Director, MIS, Population Service Statistics Cell, MOHFP. Dissemination efforts of the Extension Project will be intensified and expanded under the FPHSP so that the MOHFP, NGOs and donors are fully aware of Project research results and policy recommendations. An Associate Director in charge of liaison with the BDG and donors, assisted by a Communications Specialist, will collaborate to prepare short policy briefs for key national and international policy makers; organize periodic workshops on Project innovations such as simplified record keeping, injectable contraceptive programs, etc; and closely collaborate with four divisional Management Development Units to be established in 1987 under the World Bank Project. These activities will carry Extension Project innovations beyond field test areas to other districts and upazilas.

As new problems arise, the Extension Project will continue to re-define its research agenda. Current efforts include a study of declines in sterilization acceptance in the MOHFP system; estimations of unmet need for FP in Extension areas; evaluation of alternative strategies for the Expanded Program of Immunization in rural Bangladesh; evaluation of the Matlab tetanus toxoid immunization program; and determinants of variation in household visits by FWAs.

Personnel, data processing costs, in-country transportation, materials and supplies, printing, rental of premises and utilities for the Extension Project will continue to be supported under the FPHSP through ICDDR,B, and USAID will extend its buy-in to the AID/W contract with the Population Council for provision of TA to the Extension Project. Two Population Council consultants are employed on the Matlab and Extension Projects. One, a demographer, will continue full-time as Project Director during 1987-91; another demographer/data analyst will work half time during 1987-89. In addition, another full-time position will be supported to assist with Extension Project management (recruitment, hiring, supervision) and communications/liaison activities. The Population Council will also continue to provide short-term specialized consultants and two post-doctoral fellows per year with FPHSP funding. Consultant funds will also be used to support continued collaboration with the University of Michigan as well as to provide specialized consultants from other institutions in support of Extension Project needs. The post-doctoral fellows will, to the extent possible, be Bangladesh nationals currently working or studying abroad who will be brought back to work at the ICDDR,B for periods of at least two years. Similarly, FPHSP funds will be used to enable the Population Council to administer a fellowship program for Bangladeshi Extension Project staff identified as strong candidates for further professional training abroad.

Other Operations Research (OR) and Diagnostic Studies
(FY 87-91: $1.63 million)

In addition to OR conducted under the ICDDR,B MCH/FP Extension Project, USAID, in collaboration with the BDG and other institutions, will commission additional OR and diagnostic studies critical for implementation and expansion of the Bangladesh Population and Family Planning Program. Several pilot projects in Bangladesh have demonstrated that access to a range of quality family planning services results in CPRs close to 50 percent. The FPHSP will support OR efforts to field test cost effective modifications of current BDG and NGO program systems and implementation strategies.

A topic of major interest will be worker motivation based on quality of care criteria. Mechanisms will be tested to recognize and compensate workers and supervisors for providing improved services to a large number of couples; providing accurate information on all available methods; counseling in a sensitive, humane manner; and ensuring ready access to a broad range of contraceptive methods.

Another important topic will be identification of constraints to even greater levels of modern contraceptive use in high performing areas. A third area for investigation is the effectiveness of traditional methods of contraception in Bangladesh. A fourth issue will be the effect on fertility and mortality if exceptionally long birth intervals are reduced (e.g. in areas where the length of breastfeeding is in decline).

Other topics of interest for diagnostic studies include methods for measuring unmet need for FP services; causes of recent declines in demand for VS and increases in demand for other clinical methods; reasons for change in the tubectomy/vasectomy "mix"; and time-in-motion studies of fieldworkers participating in household-based FP and immunization service delivery at fixed clinic sites so as to determine whether they can effectively participate in delivery of both interventions.

Technical Resources, Research and Training
(FY 88-91: $0.90 million)

When the FPSP was amended in 1984, a budget line was added to fund new activities proposed by the Bangladesh Government, as well as unanticipated consultancies, evaluations, and training opportunities for Government personnel. A 1986 evaluation found this to be a highly effective arrangement and recommended an enhanced budget for these purposes in the new FPHSP.

A variety of training activities (short-term and long term; US-based, third country and in-country) in population, family planning, and MCH subjects will be supported under the TRRT budget line. Training opportunities will be made available to MOHFP and other BDG middle and senior managers; university faculty and recent graduates in appropriate fields; and to members of professional organizations in population and MCH. (Funds for NGO TRRT are built into The Asia Foundation Cooperative Agreement and will be administered by TAF on behalf of other NGOs and USAID).

USAID will fund training in population, family planning, and MCH mainly from the U.S. Government's Population Account, and supplement that funding with additional resources from the

Health and Child Survival Accounts. Funding from the latter account will specifically support training in primary health care; health interventions such as immunization, diarrhoeal disease control and prevention of respiratory infections; and maternal and child nutrition. Training funded under TRRT will focus on development of planning, implementation, evaluation, and research skills, and will update knowledge in specific technical areas.

USAID will sponsor at least two short-term in-country workshops or courses each year to be designed and implemented by a local university, institute or professional association in collaboration with U.S. counterpart organizations. Likely topics include demographic survey and analysis techniques, focus group interview skills, and quality control issues. Some support to strengthen computer capabilities and libraries of universities and other institutions working in FP and MCH will be considered.

The MOHFP and USAID will collaborate to develop a Training Plan for 1987-91. Requests for training, unanticipated consultancies, evaluations, research, or other special projects will be discussed between the MOHFP and USAID for funding under TRRT. In some cases, USAID may suggest alterations in original proposals before giving final approval. TRRT funds will also be used to support major FPHSP evaluations in 1988-89 and 1991 as well as special project assessments required by the BDG and USAID.

Component II
FAMILY PLANNING SOCIAL MARKETING
(FY 87-91: $16.47 million)

The Social Marketing Project (SMP) has provided subsidized contraceptives (condoms and pills) through commercial outlets since 1975. It was supported directly by AID/W until 1981 when USAID began to fund it under the FPSP through a Cooperative Agreement with Population Services International (PSI). Under the FPHSP, USAID will continue to fund management and technical assistance to the SMP; national personnel costs; transport, other equipment and supplies; and evaluation research.

SMP has concentrated on promotion, marketing, and sales of two brands of pills, three brands of condoms, and foaming tablets. These commodities are also sold through a wide variety of stocklists and retailers, including pharmacies, grocers, "paan" shops, and private physicians and rural medical practitioners. SMP has also supported a generic advertising campaign in support of FP and product specific advertising campaigns.

In 1985-86, several consultants appraised various aspects of the SMP. One analysis (Laing and Walker, 1986) found that the "condom gap" (the difference between SMP condom distribution figures and condom prevalence reported in the CPS) was narrower and not as serious as had been thought. Also, recently available data suggests that SMP pills and condoms are effectively used and have moderately high continuation rates (Chowdhury, et al., 1986). Furthermore, it has been confirmed that, compared with the BDG service delivery system, SMP is a relatively cost effective mechanism to provide contraceptives in Bangladesh (Simmons et al., 1986).

The Laing-Walker assessment indicates that adequate management information is not generally available for SMP decision making. They strongly recommended that SMP accelerate development of an internal MIS, pursue a retail store audit and consumer intercept study, and carry out segmented market surveys in order to develop appropriate strategies for subgroups of potential customers. Specific strategies are needed for conversion of non-users to users; encouraging sustained use by current users; encouraging adoption of other suitable methods by those who have discontinued use; and encouraging birth spacing by younger couples of low parity.

SMP sales targets are currently defined by overall volume, but should in the future be related to SMP brand share within a given market. Precise sales targets as well as detailed price, distribution and advertising strategies will be planned for each SMP market segment. Where there is insufficient information on target groups, additional market and attitudinal research will be undertaken. SMP will also establish an in-house analytical capability to use such data in more sophisticated planning.

From 1987, SMP will continue to refine its generic family planning information campaign, concentrating on overcoming resistance to adoption of family planning and stressing benefits of delaying births, child spacing, and family limitation. SMP will, in particular, place greater emphasis on increasing pill sales and decreasing user discontinuation. Additional SMP products may also be distributed; namely, a progesterone-only pill, new condoms, and pregnancy test kits.

Component III
NGO FAMILY PLANNING ACTIVITIES

In 1985-86, the BDG invited NGOs to play an increasing role in providing services in rural areas. With careful planning, NGO workers can complement activities of BDG workers, thereby improving coverage of households in rural areas. NGOs

are flexible and can respond quickly where services are particularly limited. Through local affiliates, national NGOs have already developed good working relationships with Upazila Parishads, Union officials, community leaders, religious leaders, and the medical community. NGOs in Bangladesh have also pioneered development of clinical and community-based services in urban areas, and will continue to play a major role in municipal service delivery. Close BDG-NGO collaboration in support of national FP and MCH programs is a model in South Asia.

At present, six USAID-assisted Cooperating Agencies (national or international NGOs) in turn support 90 sub-projects run by indigenous NGOs at 350 sites throughout Bangladesh. From 1981, physical expansion of programs with USAID assistance resulted in the six NGO Cooperating Agencies (CAs) increasing their eligible couple coverage five-fold and their active user totals by ten-fold. In 1986, NGOs accounted for about 15 percent of eligible couple coverage and 22 percent of active users nation-wide. Mini-CPSs conducted in six sub-project areas have verified prevalence rates of 33-65 percent.

AID has supported NGO family planning efforts for more than a decade, at first through AID/W grants and contracts. Since 1981, USAID has provided FPSP funding for family planning activities of several major NGOs. From 1981-84, the USAID NGO strategy was to replicate and expand project models of community-based distribution (CBD) and clinical services in urban and peri-urban areas. The 1985-88 USAID NGO strategy emphasized consolidation and improvement of existing projects; expansion to rural areas; and improvement of NGO management, evaluation, and training.

USAID subscribes to the position that strong public and private sector service delivery presents individuals with a <u>choice</u> of facilities. In any municipality in Bangladesh, and in many contiguous rural areas, poor clients can choose between MOHFP and NGO facilities which are free of cost, or can buy conventional contraceptives at low cost from SMP shops. This situation contributes to voluntarism by supporting individual <u>options</u>.

The main elements of the USAID NGO Strategy for 1987-91 are:

1. <u>NGOs will continue to concentrate on urban areas</u>, improving quality of service and increasing continuation rates and the CPR by creating management systems that permit fieldworker home visits to clients once every two months; rationalizing urban coverage and making it more cost-effective by re-assigning areas among NGOs to avoid duplication; and undertaking limited urban expansion, enlarging existing

projects by incorporating contiguous areas for coverage, and focusing on sub-sets of the population: young males, the soon-to-be married, and recently arrived job seekers in urban areas.

NGOs now provide coverage to 80 percent of urban wards. Since some wards are not yet covered, and rural-urban immigration is contributing to annual urban growth rates of 4-8 percent, both absolute coverage and intensity of coverage must be improved in urban areas. It is anticipated that the urban CPR will increase from 37 to 50 percent by 1991 and that NGOs will be major contributors to that accomplishment.

2. NGOs will gradually expand services in rural areas, in close collaboration with Government outreach efforts. NGOs already have considerable involvement in rural areas. Five of USAID's six Cooperating Agencies work in rural upazilas. A variety of models for BDG-NGO collaboration are evolving and, if deemed successful in FY 87-88, will be expanded with FPHSP and possibly other donor assistance.

Through management improvements and phased geographical expansion, NGOs can cover 25-30 percent of eligible Bangladeshi couples by 1991. Furthermore, they can share their experience in IEC, training, supervision, and record-keeping with Upazila-level MOHFP staff. In several areas, FPIA and TAF have already worked out local systems for collaboration between NGO and BDG workers.

3. NGOs will collaborate with the BDG and local government in efforts to decentralize family planning activities to the Upazila level. In several areas, NGOs have already been working closely with Upazila Parishads. These efforts will be expanded during the FPHSP project period. The Pathfinder Fund will coordinate planning workshops in Bangladesh for Upazila teams after returning from Indonesia and transfer block grants to selected Upazila Parishads for support of local family planning initiatives.

4. NGOs will continue to emphasize training for their fieldworkers by participating in an NGO Training Coordinating Committee. FPHSP funds will be used to strengthen fieldworker and management training offered by FPSTC and CWFP.

5. NGOs will focus on improving sub-project management systems, including simplifying client-based record-keeping, maintenance of medical standards, efficient handling of commodities, and intensified monitoring of voluntarism. Increased attention will be paid to younger clients of lower parity, particularly to those spacing second and third births. Mini-CPSs will be developed to monitor use, and studies on continuation and quality of care will be designed.

6. NGOs will give further emphasis to MCH activities, in a phased manner. At present, five of six Cooperating Agencies support MCH activities other than FP in their sub-projects. The level of MCH activity varies greatly, ranging from referral to nearby immunization points, to direct provision of a full range of MCH services. NGOs plan to extend MCH services in a phased, coordinated manner, thereby avoiding negative impact on family planning activities.

The FPHSP will provide support to NGOs through the six existing Cooperating Agencies. The CAs will in turn provide direct support for CBD and clinical activities of local, indigenous NGOs throughout Bangladesh, in both urban and rural areas. USAID may seek out one or more additional CAs in order to further expand CBD coverage and test other approaches to service delivery. In addition, NGOs that provide public and private sector support services (e.g. FPSTC coordination services; BAVS training of MOHFP medical officers; FPSTC and Concerned Women in Family Planning (CWFP) training for NGO fieldworkers and managers; PF workshops for Upazila officials) will continue to receive assistance for these activities.

A. Family Planning Association of Bangladesh (FPAB)
(FY 89-91: $2.62 million)

The FPAB, established in 1953, is the oldest family planning NGO in Bangladesh, with programs implemented through branches in 20 districts. It is the national affiliate of the International Planned Parenthood Federation (IPPF). FPAB's primary objective is provision of family planning information, education, and services to supplement the national program, accomplished through reliance on volunteers, youth, and women as service providers. FPAB's strength is its status as the first FP organization in Bangladesh and the experience it has gained over the years.

Under the FPSP, FPAB developed and carried out two innovative CBD sub-projects; one with traditional rural healers, the other with village clubs. Each sub-project works within 20 district sites, primarily rural areas, scattered throughout Bangladesh. Contraceptive distributors (2000 in the two sub-projects) are volunteers who receive project travel allowances. As of September 1985, the two sub-projects reported contraceptive prevalence rates of 51 percent for areas served by traditional healers and 63 percent for areas served by village clubs or voluntary agencies. These activities will be expanded with support provided under the FPHSP.

FPAB will also expand activities in demand creation and, along with PF and the MOHFP's IEM Unit, organize training workshops for elected Upazila and Union leaders, opinion makers, and religious leaders. FPAB activities will emphasize the health benefits of child spacing. In addition, FPAB will produce documentary/motivational films for presentation in rural areas by Mobile Film Units, and will maintain a film lending library. To date, FPAB has produced 11 high quality films on family planning and related subjects for cinemas and mobile units.

Continuing an FPSP service, FPAB will requisition contraceptive supplies from MOHFP Warehouses and distribute them to other NGOs under the NGO Commodity Distribution Scheme, which reduces the logistical burden on the BDG and ensures that other NGOs and the two FPAB sub-projects receive a continuous supply of contraceptives. FPAB will improve storage and distribution capacities under the FPHSP.

B. Bangladesh Association for Voluntary Sterilization/ Association for Voluntary Surgical Contraception . (FY 88-91: $5.41 million).

Since 1974, BAVS, affiliated with AVSC, has been a leader in establishing voluntary sterilization as a routinely available health service in Bangladesh. BAVS has developed a network of 33 clinics that has served 16 percent of all Bangladeshi couples who have chosen voluntary sterilization. Moreover, BAVS has led the way in improving service quality by introducing counseling, improved medical supervision, safer anesthesia, effective asepsis, and basic and refresher training for BDG and NGO personnel.

Under the FPHSP, BAVS will continue to provide high quality voluntary sterilization services; will initiate IUD and non-clinical contraceptive services, and basic MCH services in selected clinics; and will introduce NORPLANT into the national clinical network. Once field trials are completed and the BDG approves NORPLANT for wider use, BAVS will assist in training practitioners and in delivering services. In addition:

- AVSC has designed a project to strengthen family planning education in medical colleges. Also, in collaboration with the MOHFP and the FPCST, BAVS will design and implement refresher training in clinical and non-clinical contraception for personnel at clinic sites. Consideration will be given to implementing this training program through Mobile Teams which will conduct training at MOHFP sterilization clinics, BAVS clinics, and medical colleges.

- AVSC will post a US-trained physician in Bangladesh to provide technical and medical assistance to BAVS and other NGOs on all aspects of the VS program.

USAID will also support a BAVS pilot project on safe birth delivery among women under 18 years of age in urban and selected rural areas emphasizing pre-natal and post-natal counselling, improved medical supervision, safer anesthesia, and more effective asepsis for high risk births. This effort will be combined with a new initiative promoting child spacing methods for high risk mothers.

C. Family Planning Services and Training Center (FPSTC)
(FY 87-91: $7.50 million).

FPSTC is a national organization formed in 1978 to serve as Secretariat for the Family Planning Council of Voluntary Organizations. Originally funded by the Ford Foundation and FPIA, FPSTC began receiving USAID support with initiation of the FPSP in 1981. These three donors still provide the bulk of support to FPSTC which, in turn, funds over 50 CBD sub-projects. Organizational objectives of FPSTC include encouragement of coordination among NGOs and provision of technical assistance to local NGOs providing FP services. FPSTC also directly develops, funds, and monitors service projects in family planning, some of which also incorporate MCH and income generation activities.

Under the FPHSP, USAID will continue to support the FP/MCH service delivery projects of FPSTC and new activities including development of streamlined management systems for better project monitoring and evaluation; efforts to strengthen involvement of local opinion leaders in project development and management; and a training program for project managers and supervisors. In addition, FPSTC will expand its role in providing a forum for exchange of information and ideas between the BDG and NGOs (and among NGOs) on innovative model projects, service delivery strategies, and program evaluation. FPSTC currently coordinates activities of NGOs by serving as the Secretariat of the Family Planning Council for Voluntary Organizations. In its position as "part-NGO, part-government" organization, FPSTC is in a unique position to coordinate BDG and NGO collaboration, particularly in rural areas.

D. Family Planning International Assistance (FPIA)
(FY 87-91: $8.25 million)

FPIA, the International Division of the Planned Parenthood Federation of America, has funded projects in Bangladesh through an AID/W Cooperative Agreement since 1972. FPIA began receiving bilateral funds under the FPSP in 1984 and, in keeping with USAID's current NGO strategy, has funded large consolidated sub-projects through indigenous organizations operating at multiple sites.

FPIA has supported sub-projects targeted on specific socio-economic groups rather than using the more traditional NGO approach which serves an entire geographic "catchment" area. Other FPIA innovations include use of part-time fieldworkers with reduced caseloads, and an innovative self-help scheme for family planning workers in which withheld salary payments are used for skill training and creation of a revolving fund for short-term personal needs of workers. FPIA's Rural Development and FP Project in Barisal provides an excellent example of collaboration between NGO, MOHFP and local government officials for the benefit of the national program.

Under the FPHSP, FPIA will continue to provide family planning services in large community-based distribution projects. Support for the International Union for Child Welfare, the Bangladesh Birth Control and Family Welfare Association, and Family Development Services and Research will continue. FPIA will also provide support to FPGTC to enable it to continue to support over 50 smaller Bangladeshi NGOs.

E. The Pathfinder Fund (PF)
(FY 87-91: $12.00 million)

The PF currently supports 24 CBD sub-projects and three clinic-based sub-projects (serving 10 sites). CPRs at sub-project locations range from 19 to 64 percent; most are in the 30 to 40 percent range. Ongoing CBD activities will be supported under the FPHSP, and, in many cases, local NGOs will be supported in expansion to adjacent areas. Emphasis will be given to incorporating new record keeping, reporting and work scheduling systems at all CBD sub-project sites.

The PF will initiate a major rural expansion effort by working with a large indigenous NGO, Swanirvar, which will provide family planning and immunization services (in collaboration with the BDG EPI in 12 Upazilas in the Dhaka and Chittagong Divisions). Swanirvar emphasizes self-reliance in various development efforts and currently works in 137 upazilas throughout the country. If successful in the first 12 upazilas, family planning and immunization services will be expanded to additional Swanirvar upazilas.

The FPHSP will provide continued support for PF to organize selected conferences, workshops and coordination meetings at the request of the BDG and other NGOs. The PF successfully assumed this role under the FPSP. Also under the FPSP, USAID provided a Population Data Specialist (a University of Michigan Intern) to be based at PF to work with all NGOs on standardizing service statistics, record-keeping, reporting systems, data collection and analysis. Although rationalizing disparate systems will be difficult, standardization of service statistics and record-keeping is essential as NGOs begin to work more closely with the MOHFP rural field system.

F. The Asia Foundation (TAF)
(FY 87-91: $18.00 million).

TAF's FP Project currently operates through 25 sub-grantees working at 73 project sites (12 urban areas and 44 Upazilas are covered). By 1990-91, The Asia Foundation expects to cover 2 million eligible couples and attain a prevalence rate of 43 percent.

Under the FPHSP, in cooperation with the MOHFP and local government, a new pilot program in joint NGO/BDG/local government delivery of family planning services will be implemented in four upazilas. TAF management, supervision, and reporting systems will be applied in support of both NGO and MOHFP workers. This pilot effort will be closely monitored and expanded as results warrant. Eventually, this effort may lead to 100 percent coverage in some 50 Upazilas.

Urban coverage will be expanded, especially in Chittagong and Dhaka. TAF plans to provide family planning coverage to all areas of Chittagong Municipality not covered by currently-funded NGOs and to improve administration, efficiency and performance through an umbrella organization called the Chittagong Unit. Coverage by TAF-funded NGOs in Dhaka will also expand using a similar support system.

TAF will operate a Technical Resources, Research, and Training Fund (TRRT) for the benefit of other NGOs to support technical assistance, local CPSs, small OR projects, training, and workshops and conferences.

TAF will also continue to assist the Female Secondary Education Scholarship Project. Established under the FPSP, this activity is an experiment in delaying age of marriage, and FP/MCH demand creation. Needy young women will be kept in school through grade 12 on the assumption that they will gain confidence in their ability to control their own lives; aspire to have fewer children; marry relatively late; readily adopt family planning; and have fewer children. A 1985 evaluation of pilot activities in three upazilas indicates that these are reasonable expectations.

USAID has chosen to keep this project component small while assessing its potential demographic impacts and evaluating the appropriateness of various selection methods and administrative strategies. If successful, USAID may decide to expand support at a later date (roughly FY 89). Since female education is likely to have a number of positive impacts in addition to fertility reduction (e.g. lowered infant and child mortality, increased female employment, improved family nutrition, etc.) consideration will be given to funding this activity from various USAID functional accounts. Other donors would also be invited to join USAID in funding this activity.

G. Strengthening NGO Training Capacity

The bulk of training for family planning workers is conducted by FPSTC and Concerned Women for Family Planning (CWFP). FPSTC is concerned with training of managers and, until recently, field supervisors. CWFP provides virtually all fieldworker training. CWFP will soon begin training field supervisors. PF has assisted training programs through provision of technical assistance and by convening the NGO Training Coordination Committee (TCC) which addresses common NGO concerns in the training field. A 1986 TCC NGO training needs assessment identified weaknesses in course content and methodologies, lack of appropriate teaching materials and aids, inadequate reference materials, the need for additional staff and physical facilities to accommodate the large increase in trainees anticipated in coming years, and the need for refresher training.

Through a US-based Cooperating Agency, USAID will finance one long-term Training Specialist to assist senior FPSTC and CWFP staff in planning, implementing, and evaluating training efforts. USAID will also provide salary support for trainers and funding for upgrading and expansion of existing training facilities.

Component IV
OTHER MCH ACTIVITIES

Under the FPHSP, USAID will draw on Population, Health, and Child Survival Accounts to expand assistance for MCH services in Bangladesh in order to reduce fertility, mortality, and related maternal and childhood morbidity. USAID will assist the Bangladesh National MCH Program with FPHSP funding for oral rehydration therapy, immunization of mothers and children, MCH training, and other innovative pilot interventions. Particular emphasis will be placed on IEC activities and increasing access to selected MCH interventions in addition to FP. Major indices of progress in MCH programs will include treatment rates for ORT, coverage rates for maternal and childhood immunizations, and adoption of improved nutritional practices. Quality of service indicators will be regularly reviewed and refined.

AID/W provides significant funding for MCH activities in Bangladesh. These resources are provided to UNICEF, ICCDR,B, Save the Children Federation, the Salvation Army World Service Organization, and Helen Keller International (HKI). Projects implemented by HKI seek to improve the BDG's efficiency in

Vitamin A capsule distribution and establish vitamin A's effects on diarrhoeal disease. ICDDR,B evaluates treatment methods for diarrhoeal and dysenteric disease (including cholera) and acute lower respiratory tract infections in Bangladesh.

USAID funded the Urban Volunteers Project (UVP) in FY 86 with $4.0 million in Child Survival funds. Assistance was provided via an AID/W project which already provides major support to the ICDDR,B. The purpose of the UVP is to deliver a package of MCH interventions to urban slum-dwelling female volunteers who identify, treat (and refer for treatment) children with diarrhea, scabies, vitamin A deficiency, and malnutrition. Volunteers also refer mothers and children for immunization and provide counseling and referrals for FP. The project will expand to cover 95 percent of the slum areas in Dhaka, Chittagong and Khulna by 1990. In FY 87, USAID provided UVP with an additional $500,000 to support extension of services through FY 91.

A. Oral Rehydration Therapy Through Social Marketing, Including Village Distributorships
(FY 87-91: $15.00 million)

UNICEF, the World Bank and BRAC are already assisting or planning to assist the BDG's National Oral Rehydration Program. When USAID began to plan a major child survival initiative in FY 85, a decision was made that the best strategy was to assist with commercial private sector distribution. Funds already committed to ORT-SMP will be supplemented to carry through FY 91. USAID provided $5.0 million in 1985 for promotion of oral rehydration therapy (both labon-gur and oral rehydration salts), procurement of ORS from Bangladeshi manufacturers, and sales of ORS through the Social Marketing Project.

Intended outcomes of ORT-SMP activities through 1991 are an increase in ORT treatment rates (from 20 percent in 1985 to 60 percent in 1991); improved case management of diarrhoeal episodes; and greater availability of subsidized ORS sachets in retail shops throughout Bangladesh. SMP sales of packaged ORS are expected to rise from 7.5 million sachets in FY 86 to 20.5 million in FY 90, representing an increase in SMP's share of total distribution of packaged ORS from 3 percent in FY 86 to 24 percent in 1990. By FY 90, the SMP will be distributing ORS through 65,000 pharmacies and other retailers. SMP has also successfully test marketed Safe Delivery Kits (SDK) for use by medical and lay people and will advertise and sell SDKs widely.

Funds are already available under the FPSP for establishment of a comprehensive monitoring and evaluation system for ORT-SMP, including an ORT-SMP Treatment Rate and Childhood Mortality Survey that will measure the effectiveness of ORT and assess national efforts in diarrhoeal disease control. This survey will be conducted in 1987 and repeated in 1991. (See Data Collection, Monitoring and Evaluation Plan in Annex L).

A major new ORT-SMP innovation during 1987-1991 will be development of a community-based sales distributorship system based on retail sales by rural women ("trunk ladies" and others) to rural women. Village saleswomen will sell special brands of SMP-ORS sachets emphasizing proper and effective use of ORS, including recommended nutritional practices. They will also distribute oral contraceptives, (and advise on contraindications and side effects) and refer village women to clinics for other FP methods. Women who stock these SMP products in their homes will be able to supply their neighbors even in the rainy season, thus substantially improving access. Design studies for this activity are currently under way and a pilot test will begin in FY 88.

B. Municipal Immunization Program
(FY 87-91: $10.00 million)

The BDG initiated the Expanded Program on Immunization (EPI) in 1979. An estimated 200,000 to 400,000 Bangladeshi children die each year due to six communicable diseases which can be prevented through immunization. Steps were taken in 1985 to accelerate EPI service delivery. Additional funds totaling $23.1 million were provided by the BDG, UNICEF, WHO, SIDA, World Bank, NORAD, and BRAC for the period 1985-1990. The present program supports rural expansion. No specific steps were taken to accelerate EPI in urban areas. However, the BDG and USAID have decided, with concurrence from UNICEF and WHO, that USAID will focus support from FY 87-91 on the large metropolitan areas of Dhaka, Chittagong, Khulna and Rajshahi (with an estimated 1987 total population of 8.8 million).

The Municipal Immunization sub-project of the FPHSP conforms to the BDG's National EPI Action Plan. Targeted age groups include children under two years of age and women of child bearing age (15-44 years). The sub-project goal is to reduce infant and childhood morbidity and mortality from tuberculosis, diphtheria, pertussis, tetanus, polio, typhoid and measles. Sub-project purposes are: 1) to raise coverage levels for EPI vaccines so that significant, sustainable reductions in morbidity and mortality can be achieved in Dhaka, Chittagong, Khulna, and Rajshahi, and 2) develop and strengthen Municipal Corporation management capabilities and delivery infrastructure to the point where they can sustain an effective immunization program.

Primary responsibility for immunization service delivery lies with the Municipal Corporations. To strengthen the capabilities of Municipal Corporation health personnel, and to increase the capacity of the present system to achieve and sustain necessary EPI coverage in targeted areas, the following approaches will be followed:

1. A management system will be developed to identify appropriate site locations, transport and logistics needs, and personnel requirements for EPI; develop a training plan for employees; prepare a communications strategy for beneficiary motivation and promotion; and design a monitoring and evaluation strategy.

2. Management capabilities will be strengthened through increased training and sustained counterpart relationships. Supervisors, vaccinators, and motivators will be trained in centers established in each of the municipalities.

3. Appropriate locations for Municipal Corporation EPI primary and out-reach centers will be identified, and equipped and upgraded as necessary.

4. An appropriate logistics system for management and delivery of vaccines will be established or expanded, including introduction of routines for regular equipment maintenance.

5. A simple recording and reporting system will be established to meet management, monitoring, and evaluation requirements.

Inputs during the six year sub-project will include: technical assistance; local salaries; training; commodities sufficient to meet program requirements; limited facility improvements for offices, operating centers and vaccine delivery posts.

C. Training and Innovative MCH Activities
(FY 88-91: $2.00 million)

USAID will set up a Training and Innovative MCH Activities Fund within the MCH component to allow for training in MCH subjects. In general, USAID will fund feasibility studies or small-scale trials and will join with other donors to cover costs of expansion if warranted.

Through funding to PF, the Bangladeshi self-help NGO Swanirvar (presently working in 137 of the country's 464 Upazilas) will expand FP/MCH education and services, including immunization referral services from 12 Upazilas in 1987 to 48 Upazilas in Chittagong and Dhaka Divisions by 1991. USAID is

considering additional support to cover further expansion to the remaining 89 Swanirvar Upazilas. FPHSP assistance may be combined with ODA funding under the World Bank's Third Population and Family Health Project.

USAID is also considering (a) assistance to a local organization that will coordinate design and funding of health activities implemented by local-level NGOs throughout Bangladesh and maintain liaison between the MOHFP and smaller NGOs; (b) support to BAVS to add selected MCH/Safe Birth Practice services at 33 BAVS clinics throughout Bangladesh; (c) support for ORS treatment and training centers in selected Upazila Health Complexes; and (d) investigating the feasibility of developing a national morbidity and mortality surveillance capability in Bangladesh.

IV. FINANCIAL ANALYSIS AND PLAN

BUDGET

Cost estimates provided in the Summary Budget are based on experience gained with previous USAID family planning projects in Bangladesh. The total USAID cost of the FPHSP is $178.75 million. Of the total, $151.0 million is drawn from the Population Account and $27.75 from the Health and Child Survival Accounts. Project costs are to be financed from an AID grant and obligated over 5 years.

Table 5

SUMMARY BUDGET--FPHSP*

	1987	1988	1989	1990	1991	TOTAL	% of Total
1) BDG/FP**	21.97	16.92	15.45	12.75	13.66	80.75	45%
2) FP/SMP	4.8[illegible]	3.37	3.39	3.49	3.40	16.47	9%
3) NGOs	5.21	9.71	11.66	13.76	13.44	53.78	30%
4) Other MCH	5.31	3.44	5.56	6.21	6.48	26.75	16%
TOTAL	35.31	33.4[illegible]	36.06	36.21	36.98	178.00	100%

A relatively large pipeline is required for most of the elements. NGOs experience long delay between obligation and actual expenditure for sub-projects because there are several steps involved. CA funds are normally obligated to NGOs mid-way through each fiscal year. (There will be an attempt during the FPHSP to make multiple year obligations whenever possible, to reduce management responsibilities). Cooperating Agencies then sub-obligate funds to indigenous PVOs, which then expend funds over the life of their projects. The government program also requires a fairly long pipeline as it is based on a system of payments and reimbursements at the local level. There is considerable accounting necessary before reimbursement for VS and IUD payments can be made to the government. Similar delays can be anticipated in making reimbursements for fieldworker travel costs.

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*Items 1-3 are Population Account and item 4 is from Health and Child Survival Accounts.

**Included in the Bangladesh Government FP program are contraceptive commodities totalling $37 million.

FINANCING POPULATION AND FP/MCH CARE IN BANGLADESH:

The FPHSP will contribute significantly to population and FP/MCH programs in Bangladesh. The TFYP states that the total cost of population and family planning activities for 1985-90 is $522 million. This includes all government expenditures and donor contributions. The FPHSP covers a 5 year period "lagged" one year behind the 5 year BDG planning cycle. Thus, approximately 80 percent ($400.0 million) of population/FP costs are being met by donors, including approximately 30 percent from USAID. Clearly, the financial needs of the program in Bangladesh are being met primarily by the donor community. This is likely to continue into the foreseeable future. This grant meets public and private sector needs not being covered by the BDG or other donors.

In 1986, USAID commissioned a consultant to examine the potential for FP/MCH program sustainability, specifically the question of recurrent costs (Stinson, 1986). The conclusion of the study was that, although sustainability is a worthy objective in the long run, it will not be achieved during the life of the FPHSP, nor for many years hence. In Bangladesh, people are generally reluctant to spend limited resources on preventive care, given the much greater unfulfilled demand for curative care and other requirements of daily life. In addition, communities must perceive that primary health care is of high quality before they will willingly support it. Strategies for cost containment and continued use of existing private sector providers and distribution channels are more viable responses to AID's financing guidelines than is a premature emphasis on cost recovery. Some finance-related innovations will be possible during the FPHSP period, but heavy BDG dependence on donor assistance will continue well beyond the end of the Project in 1991.

Beginning in late 1987, the World Bank (IDA) will support a major study of the financing of Bangladesh FP and health sectors which promises to provide useful insights into trends in family planning and health expenditures; the appropriateness of these expenditures in relation to BDG sector objectives; and the total resource gap in meeting BDG objectives over the next decade.

A covenant under the World Bank's Third Population and Family Health Project proposes, consistent with AID recurrent cost policy, a time-phased schedule for the BDG to absorb "selected" costs of FP and MCH programs (e.g. salaries of family planning staff, operating costs of field clinics and training centers). Assuming a 5 percent real annual growth in MOHFP expenditures, IDA believes this cost assumption is possible. If the MOHFP's current 5.9% share of the annual budget remains constant, the recurrent cost portion of the MOHFP budget would be approximately the same at the beginning

and end of the Project. The IDA-sponsored study will also explore cost recovery measures to increase BDG financing capacity.

TA early in the IDA project will perform a financial analysis of the health sector. The study will analyze recurrent cost implications of the MOHFP investment plan, and review the potential for increased cost recovery through a number of measures, including user charges for services. AID is similarly concerned about the cost recovery issue and will closely monitor BDG efforts to implement recommendations emerging from the IDA study. If, as a result of the study and donor/BDG dialogue, changes are required in strategies or funding levels, the FPHSP will be modified accordingly.

V. PROJECT ANALYSIS

INSTITUTIONAL ANALYSIS

During the FPHSP, USAID will be directly concerned with administrative efficiency in the following institutional settings:

(1) Various levels and units of the BDG, including: (a) Presidential and Ministerial support for the FP program, and the ability of political figures to communicate a sense of commitment to lower-level officials, and to hold them accountable for their performance; (b) the efficiency of the Planning Commission and External Resources Division in clearing and approving project activities; (c) the need for improved management practices, full staffing, and better professional and technical training for MOHFP staff at national, district, upazila, and union levels; and (d) involvement of Upazila Parishads in the FP program, particularly through clearer definition of the responsibilities and authority of the elected Upazila Chairman for implementation of FP programs.

(2) Urban consolidation and rural expansion of six USAID-assisted NGOs and the SMP: (a) working productively with the BDG and among themselves; (b) pioneering cost-effective innovations in service delivery; and (c) generation of demand for birth spacing among younger couples with few children.

(3) Influence on national policy and program decisions by various research institutions, including BFRP, the universities, and professional associations in FP/MCH. (Private firms, working under contract to USAID on studies and evaluations, can also influence major administrative and policy decisions.)

Public/Private Sector Assistance

During the mid-1970s USAID has channeled population and FP assistance to the public and private sectors in Bangladesh in order to: (1) present individual FP clients with varied service options; (2) increase access to information and services country-wide through several different types of service outlets; and (3) influence the efficiency of the MOHFP by supplementing and complementing its work with efforts of NGOs, including the SMP, and encourage innovations in presentation of information and services by these more flexible private sector organizations. While the BDG has been tolerant and supportive of the growth of NGOs and SMP since the late 1970s, some bureaucrats resent the relatively high levels of USAID support received by NGOs since 1981 and have argued for tighter controls over NGOs and flow of funds to them. In response,

USAID and NGOs have emphasized services provided by the private sector to the public sector, and that these services can be further extended to the benefit of the national FP/MCH program. USAID has, in spite of occasional criticism, continued to administer its assistance to public and private institutions under separate obligating instruments. As a result, the NGOs have retained full control over their resources, still have substantial operating autonomy, and continue to offer unique strengths in service delivery. In discussions with the BDG, USAID will continue to emphasize U.S. policy which requires assistance to both public and private sectors in pursuit of cost-effective FP and MCH programs.

Functional Integration

Population and FP activities have been under the administrative control of the MOHFP establishment of Bangladesh. Since 1980, "functional integration" of all field activities at the upazila level and below has been mandated. Several administrative changes in 1883 and 1985 effectively placed the UFPO and lower-level FP workers under the authority of the health system. This step was designed to strengthen both FP and MCH activities by enabling all fieldworkers to serve a "dual purpose". However, functional integration in practice has had serious negative effects on FP worker morale and productivity and resulted in deliberate work slowdowns. Unfortunately, there have been no observable positive changes in attitudes and performance of health workers vis-a-vis their FP duties. Serious frictions between FP and health workers continue to cause problems in the field.

BDG decisions on UFPO encadrement (conversion from non-professional to professional career status, with salary reclassification) has implications for the status of employees in other ministries and is therefore being carefully studied by a BDG committee at the President's order. In a more positive development, UFPOs have recently been restored to membership on the Upazila Parishad -- another professional "demand". UFPOs will now serve as Union Parishad members <u>in addition</u> to the UHFPOs, with their physician-supervisors having overall responsibility for health and FP activities. Other status and management problems resulting from functional integration continue to disrupt MOHFP service delivery. UFPOs have lost signatory control over operational funds and they function at present under 3 "supervisors" whose roles in FP, and mutual relationships, are unclear. When USAID raises concerns about program performances, the MOHFP point to late 1986 improvements in contraceptive acceptance rates, and a recent World Bank review team acknowledgment of FP program recovery. USAID remains unconvinced by these data, and believes that the FP program is lagging badly.

A Task Force on Integration, including NGO as well as MOHFP representation, presented a report in late 1986 to the MOHFP with recommendations on functional integration issues. The Task Force, and the MOHFP, operate on the premise that functional integration must be made to work, that the MOHFP can take practical management actions to make it work, and that Upazila Parishads should assume greater responsibility for the success of the national program. The Task Force Report is still under review by the MOHFP. USAID will urge speedy and serious consideration of its recommendations. Some time will be required to observe the effect of implementation of Task Force recommendations on FP performance, but USAID will require a review of performance against expressed TFYP FP objectives in 1988 and an analysis of the overall effect of functional integration on the FP program. A 1988 external review will be a Covenant of the FPHSP. Among donors to Bangladesh FP activities, USAID believes most strongly that the program has lost impetus and must be accelerated considerably.

Female Fieldworkers

In 1986, without prior testing of consequences, the MOHFP decided that FWAs would be taken off their household rounds one day a week to participate in immunization activities at fixed clinic sites. (There is evidence that this has extended to 2 days in some areas.) USAID has pressed to have the effect of this action on FP service delivery carefully evaluated, since research by ICDDR,B and other NGO projects indicate that maintenance of frequent, regular household rounds is crucial for FP acceptance and effective follow-up and continuation, particularly of spacing methods. A prospective study of this issue was planned by the World Bank and UNICEF in collaboration with the BDG in 1985-86. However, the study has fallen victim to other priorities under the World Bank and UNFPA assistance programs. USAID and CIDA have now decided to pursue this study directly with the BDG and will collaborate closely in its design and implementation. The study and the issue are crucial because one female fieldworker is expected to cover (under adverse field conditions) a population of 7,500, an impossible task even when FWAs are not participating in EPI service delivery at clinics. The BDG decision is particularly distressing given that clinic-based workers in health and FP, male and female, have more time to participate in EPI than FWAs, the only females who provide outreach to women in their homes.

Under the FPHSP, USAID has responded to the BDG's expressed need for NGO female fieldworkers to supplement activities of FWAs by providing resources for NGOs to begin phased expansion into rural areas. TAF, FPIA, and PF will closely coordinate their plans for expansion with upazila-level MOHFP personnel and with Upazila Parishads. In addition,

under the SMP, USAID will support development of a system of contraceptive/ORS sales distributorships run by village women who stock commodities in their homes, sell them at nominal prices, and promote effective use of ORS and contraceptives in their neighborhoods. The ICDDR,B Extension Project is now working with MOHFP, CIDA, and USAID in establishing streamlined procedures for recruiting, training and deploying 10,000 additional FWAs, whose presence in the field will help establish a more favorable female worker-to-population ratio.

MOHFP Staff Vacancies

USAID has joined with other FP donors to press the BDG to fill the many staff vacancies among sanctioned health and FP posts. A number of Director and Deputy-Director positions in the Supervision, Logistics and MIS Directorates and in NIPORT, are vacant, and 1500 of 13,500 sanctioned FWA positions have fallen vacant even as the MOHFP moves to recruit, train and deploy 3,000 of 10,000 new FWA positions. The World Bank has set 1987 deadlines for the MOHFP to fill key positions; USAID will support that position with a Covenant in the FPHSP.

Professional Training

There is a disturbing lack of professional and technical skills in population and FP among high and mid-level planners and managers at the MOHFP and Planning Commission. USAID has budgeted funds for MA-level and short-term training so that when current program managers (recruited and trained in the mid-60) retire, their replacements are adequately prepared to take over program responsibilities. The BDG's reluctance to clear personnel for long-term training will be discussed with senior BDG officials as a formal USAID Population and Health Office training plan is developed in FY87. In addition to BDG personnel, USAID also plans to increase the pool of trained population professionals in universities and research organizations.

Improved Supervision of Clinical Program

In late 1986, USAID suspended reimbursements to the BDG for VS and IUD payments until improvements could be made in the FPCST monitoring system. An MOHFP Task Force has been formed to review USAID recommendations and to ensure adequate responses by the MOHFP. A full complement of WHO Advisers for the FPCST is expected to be in country by the end of April, and decisions have been made by the MOHFP and WHO which will improve logistical support for the FPCST by that time. When these tasks are completed, USAID will recommence reimbursements. The MOHFP has also accepted an offer of USAID

assistance for refresher training for District and Upazila-level MO/MCH-FP officials, which will extend the outreach of the FPCST in monitoring, supervision and training at service sites. If there is evidence in FY 87 that the FPCST cannot function adequately as part of the FP Directorate, the Secretary, MOHFP, has agreed to consider shifting responsibility for the FPCST to his direct control.

Setting Demographic and Health Goals and Measuring Performance

National goals and objectives developed by the MOHFP, Planning Commission, and BBS are not mutually consistent or grounded in solid analysis. USAID has budgeted funds to strengthen skills, particularly in the Planning Commission. Emphasis will be placed on establishing goals and then converting them to actionable objectives related to coverage, prevalence and quality-of-care. The MOHFP is keen to develop compensation systems in which worker performance is evaluated and compensated according to explicit quality-of-care or coverage indicators. USAID will assist with design of such a system and also help the MOHFP to make qualitative improvements in FP reporting systems and the MIS.

National Program Implementation Reviews

The National Council on Population is chaired by the President and meets irregularly. USAID will recommend formation of a high level Expert Group Committee on Population to advise the President and the National Council on Population regarding program implementation and progress against Development Plan goals. In 1987, USAID is also supporting the annual meeting of the Bangladesh Population Association, which will review TFYP progress in population and family planning.

Decentralization and Upazila Capacity

The Upazila FP Implementation Committee is convened irregularly by the Upazila Chairman, but is a potentially important element in monitoring and reviewing MOHFP activities. USAID will ensure that the Upazila team training program for elected and appointed officials, encourages active committees to review local FP policies, strategies, goals and resources, and to stimulate the interest and commitment of local leaders in relation to FP activities. At present, elected Upazila Chairmen and members are asked to work closely with and supervise appointed civil servants of Ministries working at the upazila level. However, in practice, authority relationships are not clear. Knowledge of technical subjects

by elected officials is limited, even though FP is designated as a "transfer subject" to be implemented by Parishads. Actual government funding (via block grants) for transfer subjects is small. Under the FPHSP, USAID will supplement BDG funds available to Parishads with FP Block Grants to accelerate local area MOHFP activities.

USAID Management of the FPHSP

A $150.0 million FP program and $26.75 million MCH program constitute about half of USAID/Dhaka's OYB. The Mission's population assistance program is the largest in the Agency. USAID will use a combination of grants/CAs, competitive contracts, and "buy ins" to S&T projects to implement FPHSP sub-components. In addition, USAID will strengthen the Office of Population and Health (OPH) with two full-time USDH employees, in order to manage this program. At present, OPH has 5 US Direct Hires and has made imaginative use of PSCs and university interns to extend technical assistance in clinical contraception quality assurance, logistics management, ORT program evaluation, demographic analysis and NGO service delivery. USAID will continue to utilize all of these mechanisms.

The FPHSP contemplates a substantial on-site TA component and heavy reliance on TA rendered by staff of AID/W projects. This reflects USAID's strongly-held view that the BDG and NGOs require substantial technical and management sub-support to implement a large, complex work program. Sub-components which particularly require such assistance include IEC, Upazila Team Training, Municipal Immunization, NGO training, Contraceptive Logistics Management, and various OR studies. The level of TA funding may be a contentious issue in negotiations with the BDG, which tends to underestimate its needs for technical and management assistance, and to cut back TA elements in development projects. In this case, USAID will insist on full funding of TA activities.

TECHNICAL ANALYSIS

The FPHSP anticipates that a 40 percent contraceptive prevalence rate will be achieved by 1991. An ORT treatment rate of 60 percent and municipal immunization coverage rates of 65 percent for children and 60 percent for mothers are foreseen by the end of the project period. If these objectives are met, Bangladesh should continue to experience declines in fertility and morality; namely, a reduction in the TFR from 5.6 to 4.8 and an increase in life expectancy from 52 to 53 years (which would entail a modest reduction in infant, child and maternal mortality). However, owing to the offsetting effect of declining birth and death rates, the population growth rate is projected to be 2.2 percent by 1991, a figure considerably

higher than the 1.8 percent projection of the BDG. Demographic trend analysis suggests that the total population of Bangladesh will be at least 150 million by 2001 unless a contraceptive prevalence rate of over 38 percent is achieved within the next fourteen years. (FPHSP technical analysis is given in Annex H).

SOCIAL ANALYSIS

If FPHSP objectives are achieved, the social welfare of children and mothers in Bangladesh will be enhanced. Reductions of high risk pregnancies (high parity and short-interval births) and improved MCH service delivery will not only lower maternal and childhood morbidity and mortality, but will reduce the fatalism many women currently attach to their own health prospects and overall social status. When effective FP/MCH programs are implemented in a culturally acceptable manner (as has been the case in the ICDDR,B program areas of Matlab, Sirajganj and Aboynagar Upazilas), Bangladeshi women have been shown to readily utilize program services. Even in regions of the country that are relatively underdeveloped, effective service delivery can stimulate measurable declines in fertility and mortality within a relatively short period. However, the extent to which fertility and mortality reduction can be sustained in the future is unclear, particularly given the uncertain long-term development prospects facing the country. One recent analysis maintains that the demand for contraceptive services (and the desire to limit family size) may actually increase over time if significant long-term development fails to occur. (FPHSP social analysis is given in Annex I).

ECONOMIC ANALYSIS

Cost-benefit analysis of the FPHSP indicates that family planning expenditures are highly cost-effective; namely, an overall cost-benefit ratio on the order of 8 to 1 is projected for the project period 1987-91. Analysis of the major sub-components of the FP program shows that NGO and SMP service delivery has been more cost-effective than the BDG program in recent years. This outcome may be partly due to the relatively high use effectiveness of NGO program methods (e.g. the provision of sterilization services) and the fact that NGO program services have been delivered primarily in urban areas. No cost-benefit or cost-effectiveness analysis was attempted for the MCH component of the FPHSP. (FPHSP economic analysis is given in Annex J).

INITIAL ENVIRONMENTAL EXAMINATION

Generally, population, health, and nutrition projects fall under Section 216.(c)(2)(viii) Categorical Exclusions of the Agency Environmental Procedures that do not require an Initial Environmental Examination. However, under this Project, AID funds are programmed for construction of a multi-storied office building to house the Family Planning Directorate of the MOHFP, thus requiring a complete IEE.

The MOHFP has been given a plot of land in the Kawran Bazar area of Dhaka to construct its office complex. All building construction within Dhaka city limits must conform to building requirements established by the Dhaka Improvement Trust (DIT); a building permit issued by DIT is mandatory. DIT has zoned various sections of the city for different functional uses and, through the building permit approval process, maintains control over adherence to established standards.

The plot on which the MOHFP will construct its office building is located in an area zoned for commercial use, including construction of multi-storied office buildings. Adjacent to the property, a government agency is constructing a 20 story office building, and the work is approximately 30 percent complete.

The area is serviced by the city sanitary sewer and water supply systems. Sewage is transported by a closed sewer system to a treatment plant where processing of waste occurs. The water and sewer requirements for the building can be met by the existing system; no additional provisions will be required. The power supply required to operate the building will be provided by the national grid that feeds Dhaka. The area is classified as commercial. Therefore, provisions are already made for the power and voltage requirements of office buildings.

It is not anticipated that design of the building will contain any special innovations requiring unusual environmental considerations. High-rise construction in Bangladesh is primarily masonry (reinforced cement concrete) with a minimal amount of wood used for finished work. The plot for the Family Planning Headquarters building is not located in a recent land fill area, and the proposed building will not alter existing drainage patterns. There are no trees on the proposed site, thus the construction will not reduce tree population in the area.

The final design for the building has not been completed. The firm that will eventually be engaged to finalize the designs will be instructed by USAID to be alert to any environmental considerations. USAID will retain approval authority for each phase of the design and construction process and will be able to intercede if environmental issues surface.

It is USAID's recommendation that, as a result of this Initial Environmental Examination, a negative determination be made for this Project.

VI. IMPLEMENTATION AND PROCUREMENT PLAN

The FPHSP will follow implementation procedures established in the current project, FPSP. The Family Planning Directorate of the MOHFP will administer components I and part of IV. PSI through SMP will administer social marketing of contraceptives and ORS and initiate the new Community Based Sales Project. Various NGOs will administer a large number of subproject activities. In addition, several non-governmental research organizations will undertake various studies, operations research and consultancies. A detailed implementation schedule is presented in Annex D.

In the Bangladesh Government (BDG) portion of the project, the primary method of implementation will be through AID direct contracts with payment being made by USAID. At present, the planned exceptions to this are the Management Information System (MIS) component and the Family Planning Services and Training Center (FPSTC). The method of implementation for these two components of the project agreement will be through PILs. Funds will be advanced to the BDG for these components. Prior to advances, USAID will assess the capacity of the implementing units to administer the funds.

The bulk of contraceptive commodities for the project are procured by S&T/POP and SER/OP directly on USAID-issued PIO/Cs. Other commodities (catgut, IEC and EPI materials and equipment, fieldworker supplies, etc) will be procured using competitive direct contracting procedures. USAID is considering utilizing on 8(a) PSA to handle all procurement for the Project not handled by AID/W or NGO grantees (CAs). USAID plans to continue relationships with the major Cooperating Agencies (CAs) mentioned in components I, II and III of the Project because of their established relationships with indigenous NGOs and with the MOHFP. The programs of these CAs (PSI/SMP, AVSC/BAVS, PF, TAF, FPIA, FPAB, FPSTC, ICDDR,B/Population Council, FHI/BFRP) are described in detail above. In order to renew cooperative agreements with these CAs, as shown in the implementation plan chart (Annex D), USAID requests AID/W approval to select these assistance recipients (HB 13, Ch 1). The Population Council and FHI are funded by buying-in to AID/W projects. The IEC component will be executed through buy-ins to two extremely well-suited AID/W projects; the Population Communication Services Project of S&T/POP and the HEALTHCOM Project of S&T/H.

PSC positions at USAID/Dhaka have always been competed, with excellent results. TA requirements for new components will be viewed as prime opportunities for involvement of Gray Amendment Organizations, in particular the possibility of

utilizing an HBCU paired with a major university's health department by the MOU arrangement recently announced by AID/W for the EPI subcomponent. 8(a) firms may be appropriate for TA in the Innovative MCH and Logistics & Commodities subcomponents and will be encouraged to apply for these TA contracts.

A&E and construction contracts for design and construction of the MOHFP headquarters building will be awarded competitively to firms of Code 941 or Bangladeshi nationality under FAR Part 36. By signing the facesheet, the USAID Director certifies that this project is appropriate for Gray Amendment contracting as stated above.

Provision has been made in the budget for non-federal audits of the BDG component to be coordinated by IG/Singapore. USAID will work with the IG to develop appropriate scopes of work to assure implementation of the planned audits. In addition each NGO will be required to provide USAID with annual audited financial statements.

VII. COVENANTS AND CONDITIONS

Covenants and conditions precedent listed in the draft Authorization (pp. iii-iv) are almost identical to those in the amended FPSP Authorization (388-0050), and contain prohibitions concerning abortion and sterilization required by FAA 104(f) and Policy Determination-3. The last covenant, that all funds shall be used in accordance with AID population policy, is intended to incorporate all proscriptions in the current year appropriations legislation, as well as any future changes in FAA 104 or AID population policy. Since language in the appropriation bills changes from year to year, USAID has not included additional proscriptions from the FY 87 Congressional Resolution in the draft Authorization.

USAID/Dhaka is well aware of AID population policy and applicable statutory and Congressional Resolution language, which have been followed scrupulously in drafting the FPHSP USAID therefore requests that AID/W authorize the FPHSP as written, and continue to inform us about other requirments of AID population policy. In addition to conditions and covenants in the Authorization, the Project Grant Agreement will contain several conditions precedent to disbursement and covenants reflecting specific implementation concerns of USAID/Dhaka.

ANNEX A
LOGICAL FRAMEWORK

Project Title & Number: Family Planning & Health Services (388-0071)

Life of Project: FY87-FY91.
Total US Funding: $ 177 million
Date Prepared: Feb. 25, 1987

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS		MEANS OF VERIFICATION*	IMPORTANT ASSUMPTIONS
Program Goal	Measures of Goal Achievement			
	Indicator	1991 Objective		
To reduce current high levels of fertility and mortality that restrain the attainment of sustained development in Bangladesh.	Total Fertility Rate	4.8	National Fertility and Mortality Survey, implemented in 1987 and 1991 in conjunction with the Contraceptive Prevalence Survey.	1. The national leadership remains committed to Family Planning as its number one concern.
	Crude Birth Rate	36.6		
	Crude Death Rate	13.5		
	Annual Growth Rate	1.8		
	Infant Mortality Rate	123.0		
	Child Mortality Rate	21.0		
	Maternal Mortality Rate	5.0		2. USAID's assessment that there is high unmet demand for FP services is correct.
	Life Expectancy	53.0		

*See Data Collection, Monitoring and Evaluation Plan for details of surveys and studies.

Project Purpose	End of Project Status			
	Indicator	1991 Objective		
To improve the coverage and quality of family planning and mother and child health services in Bangladesh.	Contraceptive Prevalence Rate	40%	1. Contraceptive Prevalence Surveys—1988, 1991.	1. Administrative problems associated with functional integration won't increase; in fact, they are likely to lessen over time.
	ORT Treatment Rate	60%	2. National Childhood Morbidity and Mortality Survey—1987, 1991. (For ORT Treatment rates.)	
	Coverage Rate—Urban Infant Immunization	65%		2. Hiring and placement of additional fieldworkers will proceed smoothly and on time.
	Coverage Rate—Urban Female Immunization			
	FWA Worker/Client Ratio	1:0000	3. MIS service statistics and BBS census data. (For coverage rates and client/worker ratios.)	3. The MHFP, MOLE, and local government will develop effective strategies for local collaboration in providing FP/MCH services.
				4. Effective OR will identify administrative problem, test solutions, and facilitate introduction of improved practices into the administrative system.

Outputs	Magnitude or Timing of Outputs to Achieve Purpose		
1. Increased knowledge of, and demand for, a full range of FP/MCH services, especially knowledge of, and demand for, birth spacing methods (Components I.A, II.A, IIIF, IV.A).	1. Number of "potential spacing couples" (wife's age under 30 and parity below 4) actually practicing temporary FP increases by 1,000,000 from 1987 to 1991.	1. Quarterly reports and meetings for each project sub-component.	1. Other donors will continue to provide complementary support to MOHFP activities
2. A more effective logistics system, capable of timely, efficient procurement and distribution of large quantities of contraceptives and related commodities. (Components I.D, III.A).	2. An 18 month supply of all essential contraceptives and other commodities incountry throughout Project life. By end of Project MOHFP is successfully procuring and importing 25% of related commodities internationally procured.	2. At least two external evaluations for each sub-component. Generally, an interim evaluation in 1988/89 and a final evaluation in 1990/91.	2. The BDG will continue efforts to strengthen local government and decentralize service delivery programs.
3. More cost effective utilization of retail outlets and private sector marketing techniques for delivery of contraceptives and ORS. (Components IIA, IVA.)	3. Operating costs associated with retail sale of each condom, pill, and ORS sachet decline by at least 25%.	3. USAID Project records. 4. MOHFP service statistics especially from MIS). 5. NGO service statistics. 6. Contractor reports and of records. 7. Upazila Parishad budgets and meeting minutes.	3. Six international and national NGOs (Cooperating Agencies) will continue to work in FP/MCH in Bangladesh.
4. Increased physical access to a full range of FP/MCH services in the villages and urban neighborhoods of Bangladesh. (Components I.B, II.A, III.A-3.F, IV.A.)	4. Verified household visits per FWA, per month increase by at least 20% between 1988 and 1991.		
5. Better trained, more effective fieldworkers and administrators in MOHFP and NGO programs in FP/MCH. (Components I.C, I.F, III.C.)	5. CPR increases to 40% by 1991.		
6. Substantial expansion NGO-provided FP services in urban and rural areas. (Components III.A, III.F.)	6. Number of eligible couples served by NGOs increases by at least 75% between 1987 and 1991.		

Outputs (Cont.)	Magnitude or Timing of Outputs to Achieve Purpose: Cont.)
7. Enhanced cooperation of MOHFP and NGO fieldworkers in delivery of FP/MCH services. (Components I.C, III.B, III.E, III.F.)	7. Explicit (formal or semi-formal) agreements for cooperation are established in at least 50 upazilas by 1991.
8. An enhanced role for elected leaders, concerned citizens, and local groups in establishing goals and policies for FP/MCH service delivery at the local level. (Components I.C, III.E, III.F)	8. FP/MCH programs which substantially supplement the ongoing efforts of MOHFP and major NGOs are present in at least 30 upazilas by 1991.
9. Improved coordination and management of the national FP program. (Components I.E, I.F.)	9. CPR reaches 40% by 1991.
10. Enhanced indigenous capacity to: monitor impact and quality of FM/MCH programs, carry out realistic demographic forecasting and population planning, and carry out Operations Research on innovations in FP/MCH administration. (Components I.F, II.A, III.C, III.E, III.F.)	10. At least 25 Bangladeshi research professionals are active in research on the national FP program each year during the life of Project.
11. Enhanced capacity in 4 municipal health departments to deliver immunization services to infants, children, and mothers. (Component IV.E.)	11. Immunization rate in 4 municipalities rises to 65% for infants and 60% for mothers by 1991.
12. Widespread, proper administration of ORS by Bangladeshi mothers (Components: I.A, IV.A.)	12. ORT treatment rate rises to 60% by 1991. Effectiveness ratio (proportion of treated episodes treated properly) rises to 75%.

Inputs:	Level of Expenditure: ($ million)		
AID Provided			
1. Commodities and equipment.	47.7	1. Internal monitoring documents.	1. Procurement, training, and delivery of TA are accomplished on a timely basis.
2. Funding for in-country and overseas training, study tours, conferences, and workshops.	4.1	2. External evaluation reviews.	2. AID funds are obligated and disbursed according to the Project Implementation Plan.
3. Long-term and short-term technical assistance.	7.0	3. Project disbursement and audit reports.	3. BDG and NGO resources (personnel, office space, equipment. etc.) are provided on a timely basis, and in adequate quantity.
4. Funds for activities (clinical reimbursements, travel costs, block grants) which enchance effectiveness of local administration & delivery of FP/MCH services.	24.4	4. Project Officer reports and records.	4. BDG processes PILs, training requests, and other documents in timely fashion.
5. Funding for Cooperative Agreements with FP NGOs.	53.8	5. Contractor reports and records.	
6. Funds for data collection, monitoring, and evaluation in order to assess program performance and improve project administration.	7.5	6. BDG reports and records.	
7. Funds for research on FP/MCH methods OR on improving administration and delivery of FP/MCH services in Bangladesh.	8.9	7. NGO reports and records.	
8. A National FP Headquarters Building and Facilities Improvement.	7.3		
9. Various expenditures for support BDG FP/MCH activities.	8.9		
TOTAL:	177.0*		

BDG Provided
Requisite field and headquarters staff, facilities and local costs.

NGO Provided
Necessary field and headquarters staff, facilities, and some local costs.

* excluding $1.0m for audit

ANNEX B

OTHER DONOR PROGRAMS

The following brief descriptions of major donor supported activities in population and health, by no means exhaustive, are nevertheless instructive regarding the manner in which USAID assistance relates to other on-going donor programs.

1. The World Bank

The World Bank is the largest multilateral donor in population and health in Bangladesh. Resources are drawn from the Bank's internal operating budget, the IDA fund and a consortium of six participating governments (Canada, Australia, West Germany, Netherlands, Norway, and the United Kingdom). The new World Bank Third Population and Family Health Project (1985-90) involves commitments of $213 million. The project will finance major family planning and MCH activities under the Third Five Year Development Plan. Recognizing the long time horizon for program and institutional development in the population and health sectors, and the continuing dependence of the BDG on external financial assistance, the project will continue selective support for field staff salaries, transport, medical equipment, clinic construction, training, women's programs, and evaluation and research.

Major components of the Third World Bank Project are as follows:

1. FP/MCH service delivery expansion through the MOHFP, including strengthened supervision and monitoring of field activities ($21.6 million), in service training for staff ($11.5 million), salaries for 14,500 Family Welfare Assistants ($25.2 million), supplies and MCH related drugs and surgical supplies ($16.2 million), construction of 1,000 new Upazila Health and Family Welfare Centres (UHFWC), upgrading of 73 rural dispensaries and maintenance of existing centres ($44.4 million);

2. Expansion of three MCH activities: immunization, dirrhoeal management and improved child birth practices, including support for training, vehicles and operating costs ($3.3 million);

3. Women's programs, including mothers clubs, cooperatives and vocational training in thirty Upazilas ($14.9 million);

4. Support to NGOs including experiments with innovative demand-creation, birth-spacing and MCH oriented programs ($9.0 million).

2. United Nations Fund for Population Activities

UNFPA has been providing family planning assistance to Bangladesh since 1974. The Third Country Program is scheduled for implementation over the period 1986-91 at a funding level of $21 million ($15 million in direct UNFPA funds and $6 million from other cooperating bilateral donors).

The UNFPA-funded components include (1) continued support for the MOHFP integrated FP/MCH program including equipment and logistics advisory services ($11.9 million); (2) strengthening of IEC activities within the MOHFP ($2.3 million); (3) creation of a Policy Operations Advisory Unit in the Planning Cell, Family Planning Wing, Ministry of Health and Family Planning ($.3 million); and (4) support for training and research at the Centre for Population Management and Research (CPMR), University of Dhaka ($.03 million). Projects funded through UNFPA by bilateral donors include (1) strengthened FP/MCH field activities including salary support for 1,500 female fieldworkers ($.3 million); and (2) three small projects supporting family planning education and training activities in the Agricultural Extension Service Rural Women's Cooperatives and support for various NGOs ($.9 million).

3. United Nations Children's Fund

UNICEF concentrates the majority of its program efforts in three areas; namely, environmental sanitation, education and health. Over the period 1985-88, UNICEF committed $55.2 million from its general resources and $36.5 million in supplementary funding for program activities in Bangladesh. Of this amount, $33.3 million is budgeted directly for health. UNICEF's child health care projects include (1) provision of drugs to the MOHFP and training of storekeepers; (2) support to the MOHFP's National Oral Rehydration Program for the production and distribution of ORS packets; (3) blindness prevention through the provision of Vitamin A capsules; (4) the accelerated EPI program and (5) nutrition supplementation.

UNICEF works closely with many donors. Some bilateral organizations (e.g. DANIDA, NORAD, and SIDA) contribute significant amounts to UNICEF projects. The Government of Sweden is presently contributing $10 million of the $14.7 million budget for UNICEF's EPI program. Although the UNICEF mandate is to design and implement projects with the BDG, it works with a variety of international and indigenous NGOs. For example, UNICEF collaborates with Helen Keller International on its blindness prevention program and with CARE on the EPI program. UNICEF distributes DDS (Drug and Dietary Supplementation) kits procured with funds from the World Bank.

In addition, UNICEF is working with the Bangladesh Rural Advancement Committee (BRAC) on a nationwide ORT program.

4. Other International Donors

The Asian Development Bank, a new multilateral contributor to the government program, is developing a $30 million Health and Population Project at the request of the BDG. The project is expected to strengthen health care and family planning service delivery in four districts; namely, Dinajpur, Mymensingh, Comilla and Jessore, improve the national system for procurement, storage and distribution of medical supplies, and upgrade the maintenance and repair of medical equipment.

The World Health Organization (WHO) is continuing to implement a small family planning clinical surveillance program. This activity was initially supported by SIDA, but has recently been transferred to NORAD funding. The Federal Republic of Germany has supported a $2.8 million MCH based Family Planning Project in Munshiganj. The objective of the project was to deliver family planning messages as an adjunct to primary health care activities. This was to be accomplished by generating community interest through a variety of IEC programs at mother's clubs, family welfare centers and rural dispensaries. The Netherlands has also provided bilateral assistance for family planning activities.

ANNEX C
DETAILED PROJECT BUDGET
FOR FAMILY PLANNING & HEALTH SERVICES PROJECT OBLIGATIONS

PROJECT COMPONENTS	FPSP PIPELINE (2/87)	Total
I. GOVERNMENT (BDG/FP)		
A. Information, Education & Communication	0.31	5.07
-Technical Assistance		1.04
-Local Personnel		0.28
-Equipment & Supplies		0.00
-Training: Incountry		0.29
US/Third country		0.00
-Program Support Services		2.83
-Evaluations/Research		0.63
B. Clinical & Community Based FP Services	8.30	15.23
-Local Personnel		
VS Reimbursements	7.21	4.65
IUD Reimbursements	1.09	0.97
NORPLANT Reimbursements		0.04
Other Field Worker Mobility		12.57
C. Upazila Initiatives		3.57
D. Contraceptive Commodities & Logistics	2.70	36.72
-Technical Assistance		0.80
-Contraceptive Commodities		35.92
E. National F.P. Headquarters		5.00
-Construction		5.00
F. Research, Monitoring & Training	4.09	14.08
1. Contraceptive Prevalence & Fertility Mortality Surveys (1989, 1991)	0.45	1.67
-Technical Assistance	0.45	0.90
-Local Personnel		0.35
-Equipment & Supplies		0.11
-Training: Incountry		0.04
US/Third Country		0.07
-Program Support Services		0.10
-Evaluation/Research		0.10
2. Clinical Services Monitoring		1.35
-Evaluation		1.35

PROJECT COMPONENTS	FPSP PIPELINE (2/87)	Total
3. Strengthening MIS		
-Local Personnel (Consultants)		0.75
-Equipment & Supplies		0.25
-Project Support Services		0.25
		0.25
4. Strengthening Population & Development Planning		0.58
-Technical Assistance		0.30
-Local Personnel		0.10
-Equipment & Supplies		0.08
-Training		0.08
-Audit/Evaluation		0.02
5. Research on New Contraceptive Methods and Improved Service Delivery	0.57	0.22
-Program Support Services	0.56	0.21
-Equipment & Supplies	0.01	0.01
6. a. ICDDR,B, MCH/FP Extension Project	0.90	4.62
-Technical Assistance		0.25
-Local Personnel		3.32
-Equipment & Supplies		0.25
-Program Support Services		0.80
b. Population Council Assistance to Ext. Proj	0.57	2.36
-Technical Assistance		1.75
-Equipment & Supplies		0.07
-Training· Incountry		0.21
US/Third Country		0.24
-Evaluation		0.09
7. Other Operations Research & Diagnostic Studies		1.63
-Technical Assistance		0.62
-Local Personnel		0.34
-Equipment & Supplies		0.08
-Training· Incountry		0.08
US/Third Country		0.21
-Program Support Services		0.30
8. Technical Resources, Research & Training	1.60	0.90
-Training· Incountry		0.00
US/Third Country		0.45
-Evaluation, TA & Research		0.45
9. Non Federal Audit-Financial & Compliance		1.00
TOTAL GOVERNMENT	15.40	80.75

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PROJECT COMPONENTS	FPSP PIPELINE (2/87)	Total
II. FAMILY PLANNING SOCIAL MARKETING PROJECT(FP/SMP)	4.75 (12/86)	16.47
-Technical Assistance		1.84
-Local Personnel		4.78
-Equipment & Supplies		2.79
-Training: Incountry		0.05
US/Third Country		0.02
-Program Support Services		4.93
-Evaluation/Research		2.06
III. NON-GOVERNMENT ORGANIZATIONS (NGOs)		
A. Family Planning Assoc. of Bangladesh (FPAB)	1.60	2.62
-Technical Assistance		0.00
-Local Personnel		0.25
-Training: Incountry		0.06
US/Third Country		0.09
-Program Support Services		2.10
-Evaluation/Research		0.12
B. BAVS/AVSC*	5.10	5.41
-Technical Assistance		0.35
-Local Personnel		0.12
-Equipment & Supplies		0.83
-Training: Incountry		0.62
US/Third Country		0.15
-Program Support Services		3.18
-Evaluation/Research		0.16
C. Family Planning Services & Training Center (FPSTC)	1.00	7.50
-Technical Assistance		0.00
-Local Personnel		1.37
-Equipment & Supplies		0.23
-Training: Incountry		0.25
US/Third Country		0.13
-Program Support Services		5.49
-Evaluation/Research		0.03
D. Family Planning International Assist. (FPIA)	1.80	8.25
-Technical Assistance		0.79
-Local Personnel		0.48
-Training: Incountry		0.26
US/Third Country		0.08
-Program Support Services		6.44
-Evaluation/Research		0.20

PROJECT COMPONENTS	FPSP PIPELINE (2/87)	Total
E. PATHFINDER FUND	3.20	12.00
-Technical Assistance		2.74
-Local Personnel		1.55
-Training· Incountry		0.12
US/Third Country		0.05
-Program Support Services		7.47
-Evaluation/Research		0.07
F. The Asia Foundation (TAF)	3.50	18.00
-Technical Assistance		5.08
-Local Personnel		0.10
-Equipment & Supplies		0.15
-Training· Incountry		0.28
US/Third Country		0.13
-Program Support Services· FP Services (subgrants)		10.40
Female Education*		1.82
-Evaluation/Research		0.04
Total NGOS	16.20	53.78
Total Population Account	30.00	151.00
IV. OTHER MCH ACTIVITIES (MCH)		
A. 1. Oral Rehydration Therapy Social Marketing (ORT/SMP)	4.40	5.00
-Technical Assistance		1.42
-Local Personnel		1.26
-Equipment & Supplies		0.12
-Training· Incountry		0.02
US/Third Country		0.00
-Program Support Services		1.80
-Evaluations/Research		0.38
2. ORT/SMP Community-Based Sales Distributorships		10.00
-Technical Assistance		0.00
-Local Personnel		1.62
-Contraceptive Commodities & Supplies*		6.43
-Training· Incountry		1.15
US/Third Country		0.00
-Program Support Services		0.30
-Evaluations/Research		0.25
B. Municipal immunization		10.00
-Technical Assistance		2.50
-Local Personnel		1.27
-Training· Incountry		1.10
US/Third Country		0.23
-Equipment & Supplies		2.42
-Facility Improvement		2.34
-Evaluation/NFA-Financial & Compliance		0.14
C. Training & Innovative MCH activities		2.00
Total Child Survival & Health Account		27.00
Total Pop, Child Survival, Health Accounts	34.40	178.00

ANNEX C
(CONTINUED)

Budgeting Assumptions, Definitions and Notes

1. The first time the budget was prepared for this project it totalled far more than would be realistically available. Budget cuts were made in several components, notably in later years of the IEC, contraceptive commodities, and field worker mobility elements. There is reason to believe that other donors will be able to increase their contributions in those years and that supplemental funding will be made available to these elements.

2. The pipeline of the Family Planning Services Project was taken into account in developing this budget. (It was calculated from February 1987 in all cases except FP/SMP, where it was calculated from December 1986.) Planned obligations from pipeline will reduce it as the FPHSP begins, but in cases where there will still be a balance of pipeline, obligations will be seen to be smaller in the early years of the FPHSP.

a. In the IEC component, the $.31 million pipeline is from "increasing demand" line item of the FPSP.

b. Clinical and Community Based FP Services

(1) Reimbursements (VS & IUD):

Pipeline $8.3 million as of the date USAID temporarily suspended reimbursements; the 1987 budgeted reimbursement obligation is 0 because it has been assumed that reimbursements will begin again as of 5/87 and the pipeline will be expended throughout FY 87 and part of FY 88.

(2) Other Field Worker Mobility:

The obligation budgets for FY 89, 90 and 91 are for half of the BDG's needs; USAID will work with the BDG and other donors to acquire other complementary donor support for this item in those years.

c. Contraceptive Commodities and Logistics:

As of early 2/87, the pipeline under FPSP for commodities and logistics was $6.7 million. PILs and PIO/Cs under processing reduced this amount to $2.7 million by late 2/87. P&H office expects to obligate $3.5 million by the end of FY 87 for a major TA contract ($2.75 million) and for oral contraceptives

for SMP ($.75 million). To do this, the FPSP commodities and logistics pipeline of $2.7 million will be fully utilized and the balance required of $.8 million will be drawn from new FPHSP FY 87 budgeted funding.

3. The primary line items used throughout this budget are defined below. Not all components have funds budgeted against every line item.

a. Technical Assistance (TA):

Long term or short term expatriate technical assistance and all associated costs, including overhead and administration for contractors, and internal travel. A long-term adviser is budgeted at $150,000/yr.

b. Local Personnel:

This line item includes all costs associated with local personnel wages, benefits, travel, overhead of local institutions, etc. Under "clinical & community-based family planning services", this line item includes reimbursements to the BDG for payments to health and family planning field workers, other service providers and clients for VS, IUD and NORPLANT procedures.

c. Commodities:

All contraceptive commodities are budgeted under I.C. except those required for the SMP Community Based Sales Program. Quantities of contraceptive commodities needed have been projected on the basis of expected method-specific contraceptive prevalence rates. However, contraceptive commodities have been budgeted at a lesser amount than indicated by the projected CPR due to budget constraint and in anticipation of finding another donor(s) to participate in costs. (33% reduction in 1989, 60% reduction in 1990 and 1991).

d. Equipment and Supplies:

Equipment and supplies are items other than contraceptive commodities associated with the projects. These funds will be used for in-country or out-of-country procurement.

e. Training:

Training is broken down into in-country and US/third country training. It includes all costs that might be associated, such as travel, tuition, insurance, per diem, etc. Overseas training for government and University personnel is included in the TRRT element.

f. Construction:

This includes A & E contracts as well as the construction itself.

g. Program Support Services:

In the case of NGOs, "Program Support Services" means actual delivery of services; the work that NGOs perform. For the BDG and SMP, it includes the support services required to carry out the function of the implementing institution or office such as printing, production of materials, conference costs, some transport, some office expenses, etc.

h. Evaluation & Research:

Although there is a project component entitled Research, Monitoring & Training there are also certain evaluation and research activities to be carried out in relation to specific project components.

ANNEX D

SCHEDULE OF MAJOR OBLIGATIONS AND OTHER IMPLEMENTATION ACTIVITIES

Grants, Contracts, Buy-ins, Procurement Actions
Family Planning & Health Services Project 1 388-0071

I. GOVERNMENT	1987	1988	1989	1990	1991
A. Information, Education & Commun.	Pro Ag		Pro Ag		Pro Ag
-Technical Assistance -Local Personnel -Equipment & Supplies -Training: Incountry	Buy-in: PCS, JHG(S&T/P)		Buy-in: PCS, JHG(S&T/P)		Buy-in: PCS, JHG(S&T/P)
US/Third country Program Support Services -Evaluations/Research	Buy-in: AED/ HEALTHCOM(S&T/H)		Buy-in: AED/ HEALTHCOM(S&T)		Buy-in: AED/ HEALTHCOM S&T/P)
B. Clinical & Community FP Services -Local Personnel VS Reimbursements IUD Reimbursements NORPLANT Reimbursements Other Field Worker Mobility	Pro Ag PILs	PA Amend. PILs	PA Amend. PILs	PA Amend. PILs	PA Amend. PILs
C. Upazila Initiatives	Pro Ag Buy-in: FP Mgt.Tr(S&T)	PA Amend. Buy-in: FP Mgt.Tr(S&T)	PA Amend. Buy-in: FP Mgt.Tr(S&T)	PA Amend. Buy-in: FP Mgt.Tr(S&T)	PA Amend. Buy-in: FP Mgt.Tr(S&T)
D. Contraceptive Commod. & Logist. -Technical Assistance -Contraceptive Commodities	Pro Ag AID Cont. PIO/C(S&T/P)	PA Amend. PIO/C(S&T/P)	PA Amend. PIO/C(S&T/P)	PA Amend. PIO/C(S&T/P)	PA Amend. PIO/C(S&T/P)
E. National FP Headquarters -Construction			PA Amend. AID Cont.		

	1987	1988	1989	1990	1991
F. Research, Monitoring & Training					
1. CPS and Fertility/Mortality Surveys (1989, 1991)	Pro Ag	PA Amend	PA Amend	PA Amend	PA Amend
-Technical Assistance -Local Personnel -Equipment & Supplies -Training: Incountry US/Third Country -Program Support Services -Evaluation/Research	AID Cont. Res./Eval.Adv.	AID Cont. 1989 CPS	AID Cont. Res./Eval.Adv.	AID Cont. 1991 (CPS)	AID Cont. Res./Eval.Adv.
2. Clinical Services Monitoring -Evaluation	Pro Ag AID Cont.	PA Amend. AID Cont.	PA Amend. AID Cont.	PA Amend. AID Cont.	PA Amend. AID Cont.
3. Strengthening MIS -Local Personnel (Consultants) -Equipment & Supplies -Project Support Services	Pro Ag PILs	PA Amend. PILs	PA Amend. PILs	PA Amend. PILs	
4. Strengthening Population & Development Planning -Technical Assistance -Local Personnel -Equipment & Supplies -Training -Audit/Evaluation	Pro Ag Buy-in: INPLAN(S&T)	PA Amend. Buy-in: INPLAN(S&T)	PA Amend. Buy-in: INPLAN(S&T)	PA Amend. Buy-in: INPLAN(S&T)	PA Amend. Buy-in: INPLAN(S&T)
5. Research on New Cont. Methods and Improved Service Delivery -Program Support Services -Equipment & Supplies		PA Amend. Buy-in: FHI(S&T)	PA Amend. Buy-in: FHI(S&T)	PA Amend. Buy-in: FHI(S&T)	PA Amend. Buy-in: FHI(S&T)

	1987	1988	1989	1990	1991
6. a. ICCDR/B MCH/FP Ext. Proj.	CA Amendment	CA Amend.	CA Amend.	CA Amend.	CA Amend.
-Technical Assistance -Local Personnel -Equipment & Supplies -Program Support Services					
6. b. Population Council Assistance to Ext. Project	Buy-in Pop Counc.(S&T)	Buy-in Pop Counc.(S&T)	Buy-in Pop Counc.(S&T)	Buy-in Pop.Counc.(S&T)	Buy-in Pop Counc.(S&T)
-Technical Assistance -Equipment & Supplies -Training: Incountry US/Third Country -Evaluation					
7. Other OR & Diagnostic Studies	Pro Ag	PA Amend.	PA Amend.	PA Amend.	PA Amend.
-Technical Assistance -Local Personnel -Equipment & Supplies -Training: Incountry US/Third Country -Program Support Services	Buy-in: URC &/or Pop Counc.(S&T)	Buy-in: URC &/or Pop Counc.(S&T)	Buy-in: URC &/or Pop Counc.(S&T)	Buy-in: URC &/or Pop Counc.(S&T)	Buy-in: URC &/or Pop Counc(S&T)
8. Tech. Resources, Research & Trg			PA Amend. PIO/Ps AID Cont. or ISTI Buy-in(S&T)	PA Amend. PIO/Ps AID Cont. or ISTI Buy-in(S&T)	PA Amend. PIO/Ps AID Cont. or ISTI Buy-in(S&T)
-Training: Incountry US/Third Country -Evaluation, TA & Research					
II. FP SOCIAL MARKETING PROJ.	CA	CA	CA	CA Amend.	CA Amend.
-Technical Assistance -Local Personnel -Equipment & Supplies -Training: Incountry US/Third Country -Program Support Services -Evaluation/Research	PSI	PSI	PSI	PSI	PSI

	1987	1988	1989	1990	1991
III. NON-GOVERNMENT ORGANIZATIONS					
A. FP Assoc. of Bangladesh (FPAB)			CA	CA Amend.	CA Amend.
-Technical Assistance					
-Local Personnel					
-Training: Incountry					
US/Third Country					
-Program Support Services					
-Evaluation/Research					
B. BAVS/AVSC*					
-Technical Assistance			CA Amend.	CA Amend.	CA Amend.
-Local Personnel					
-Equipment & Supplies					
-Training: Incountry					
US/Third Country					
-Program Support Services					
-Evaluation/Research					
C. Family Planning Services & Training Center (FPSTC)	Pro Ag	PA Amend.	PA Amend.	PA Amend.	PA Amend.
-Technical Assistance	PILs	PILs	PILs	PILs	PILs
-Local Personnel					
-Equipment & Supplies					
-Training: Incountry					
US/Third Country					
-Program Support Services					
-Evaluation/Research					
D. Family Planning International Assist. (FPIA)	CA	CA Amend.	CA Amend.	CA Amend.	CA Amend.
-Technical Assistance					
-Local Personnel					
-Training: Incountry					
US/Third Country					
-Program Support Services					
-Evaluation/Research					

	1987	1988	1989	1990	1991
E. PATHFINDER FUND	CA	CA Amend.	CA Amend.	CA Amend.	CA Amend.
-Technical Assistance					
-Local Personnel					
-Training: Incountry					
US/Third Country					
-Program Support Services					
-Evaluation/Research					
F. The Asia Foundation (TAF)	CA	CA Amend.	CA Amend.	CA Amend.	CA Amend.
-Technical Assistance					
-Local Personnel					
-Equipment & Supplies					
-Training: Incountry					
US/Third Country					
Program Support Services:					
Female Education*					
-Evaluation/Research					
IV. OTHER MCH ACTIVITIES					
A. ORT Social Marketing (ORT/SMP)			CA Amend.	CA Amend.	CA Amend.
-Technical Assistance					
-Local Personnel					
-Equipment & Supplies					
-Training: Incountry					
US/Third Country					
-Program Support Services					
-Evaluations/Research					
ORT/SMP Community-Based Sales Distribution	CA	CA Amend.	CA Amend.	CA Amend.	CA Amend.
-Technical Assistance	PSI	PSI			
-Local Personnel					
Contraceptive Commodities & Equipment Supplies*					
-Training: Incountry					
US/Third Country					
-Program Support Services					
-Evaluations/Research					

	1987	1988	1989	1990	1991
B. Municipal immunization -Technical Assistance -Local Personnel -Training: Incountry US/Third Country -Equipment & Supplies -Facility Improvement -Evaluation/Audits	Pro Ag AID Cont.	PA Amend. AID Cont.	PA Amend. AID Cont.	PA Amend. AID Cont.	PA Amend. AID Cont.
C. Innovative MCH activities		PA Amend. PIO/Ps RFPs/CAs	PA Amend. PIO/Ps RFPs/CAs	PA Amend. PIO/Ps RFPs/CAs	PA Amend. PIO/Ps RFPs/CAs

ANNEX E

GOVERNMENT OF BANGLADESH REQUEST FOR FAMILY PLANNING AND MCH PROJECT SUPPORT

The BDG letter of request will be cabled to AID/W.

ANNEX F

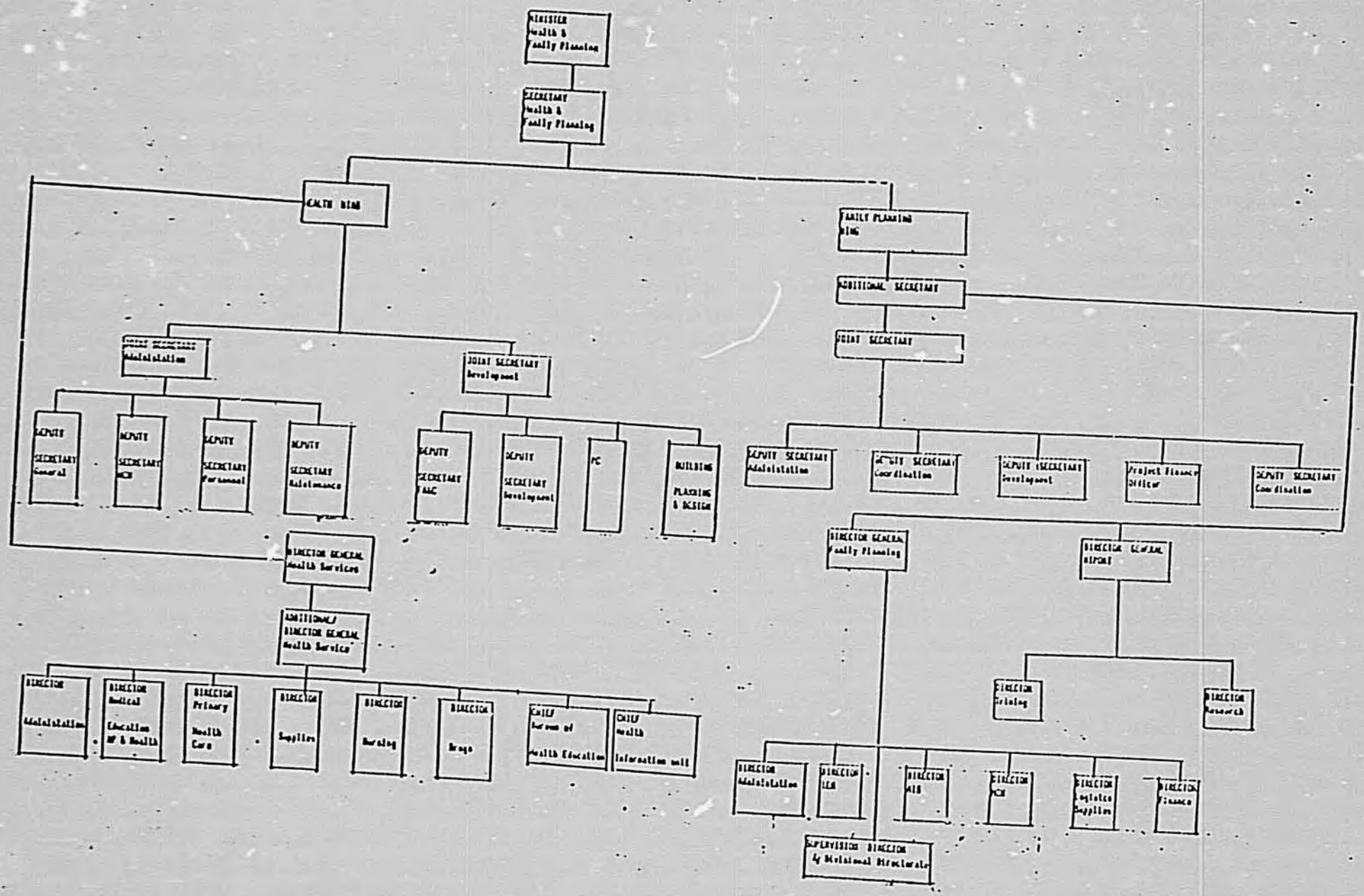
CONTRACEPTIVE PROCUREMENT TABLE FOR FAMILY PLANNING SERVICES PROJECT
PERIOD 1987-1991 (US $-1000)

ITEM	1987 QUANTITY	PRODUCT COST	SHIPPING COST	1988 QUANTITY	PRODUCT COST	SHIPPING COST	1989 QUANTITY	PRODUCT COST	SHIPPING COST
CONDOMS TAHITI	42,000	1,764	141	71,363	2,997	240	89,427	3,756	300
CONDOMS RAJA	75,000	3,150	252	103,744	4,357	349	114,119	4,793	383
CONDOMS MAJESTIC	0	0	0	0	0	0	8,091	340	27
ORAL PILLS OVACON	2,100	609	49	2,000	580	46	1,750	507	41
ORAL PILLS MAYA	2,600	754	60	1,867	541	43	1,510	438	35
IUDS TCU380A	500	475	38	1,000	950	76	775	736	59
NORPLANT	0	0	0	0	0	0	0	0	0
TOTALS	122,200	6,752	540	179,974	9,426	754	215,672	10,570	846

ITEM	1990 QUANTITY	PRODUCT COST	SHIPPING COST	1991 QUANTITY	PRODUCT COST	SHIPPING COST	PRODUCT TOTAL	VALUE W/O SHIPP	COST OF SHIPPING	TOTAL COST
CONDOMS TAHITI	102,842	4,319	346	111,027	4,663	373	416,659	17,500	1,400	18,900
CONDOMS RAJA	125,530	5,272	422	138,084	5,800	464	556,477	23,372	1,870	25,242
CONDOMS MAJESTIC	8,901	374	30	9,791	411	33	26,783	1,125	90	1,215
ORAL PILLS OVACON	1,981	574	46	2,179	632	51	10,010	2,903	232	3,135
ORAL PILLS MAYA	1,616	469	37	1,729	501	40	9,322	2,703	216	2,920
IUDS TCU380A	800	760	61	900	855	68	3,475	3,214	302	3,516
NORPLANT	100	500	40	150	750	60	250	1,250	100	1,350
TOTALS	241,770	12,269	981	263,860	13,612	1,089	1,022,976	52,067	4,210	56,278

ANNEX G : INSTITUTIONAL ORGANOGRAMS

Ministry of Health & Family Planning



ORGANIZATION OF UPAZILA ADMINISTRATION FOR HEALTH AND FAMILY PLANNING

UPAZILA PARISHAD

UPAZILA NIRBAHI OFFICER

UPAZILA HEALTH & FAMILY PLANNING OFFICER (60)

Personnel: 7

1 x U.H.F.P.O. (MMS: 1150-1800)
1 x Head Assistant-cum-Accountant (MMS: 370-745)
1 x Statistician (MMS: 370-745 if graduate otherwise MMS:300-540)
1 x Clerk-cum-Typist (MMS: 370-745 if graduate otherwise MMS: 300-540)
1 x Cashier (MMS: 370-745 if graduate otherwise MMS: 300-540)
1 x Store-Keeper (MMS: 300-540)
1 x Peon (MMS: 225-315)

HEALTH SERVICES (43)

FAMILY PLANNING (10)

HOSPITAL (INDOOR AND OUT DOOR) (39)

Personnel: 39

1 x R.M.O. (MMS: 900-1610/1150-1800)
1 x Surgical Specialist (MMS: 1150-1800)
1 x Gynaecologist (MMS: 1150-1800)
1 x Medical Specialist (MMS: 1150-1800)
1 x Dental Surgeon (MMS: 900-1610)
2 x Medical Officer (MMS: 900-1610)
2 x Medical Assistant (MMS: 425-1035)
2 x Compounder-cum-Dresser (MMS: 325-610)
5 x Staff Nurse (MMS: 300-540/425-1035)
2 x Lab Tech (MMS: 325-610)
1 x E.P.I Tech (MMS: 325-610)
1 x Driver (MMS: 325-610)
1 x X-Ray Tech (MMS: 300-540)
1 x Junior Mechanic (MMS: 300-540)
2 x L.D. Asstt (MMS: 300-540)
3 x Wardboy (MMS: 225-315)
2 x Aya (MMS: 225-315)
1 x Mali (MMS: 225-315)
2 x Darwan/Chowkidar (MMS: 225-215)
1 x Cook (MMS: 225-215)
1* x Mashalchi (MMS: 225-315)
5 x Sweeper (MMS: 225-315)

* where transport is available

DOMICILAL SERVICES* (4)

Personnel: 4

1 x Health Inspector (MMS: 325-610) (For 3 A.H.I)
1 x Sanitary Inspector (MMS: 325-610)
1 x Peon-cum-Medicine Carrier (MMS: 225-315)
1 x Peon-cum-Lab Specimen Carrier (MMS: 225-315)

Notes

1. No. of Health Inspectors will depend on the number of Asstt Health Inspectors.
2. One peon-cum-Lab Specimen carrier for one Health Inspector.

MEDICAL OFFICER (MCH-FP) (4)

Personnel: 4

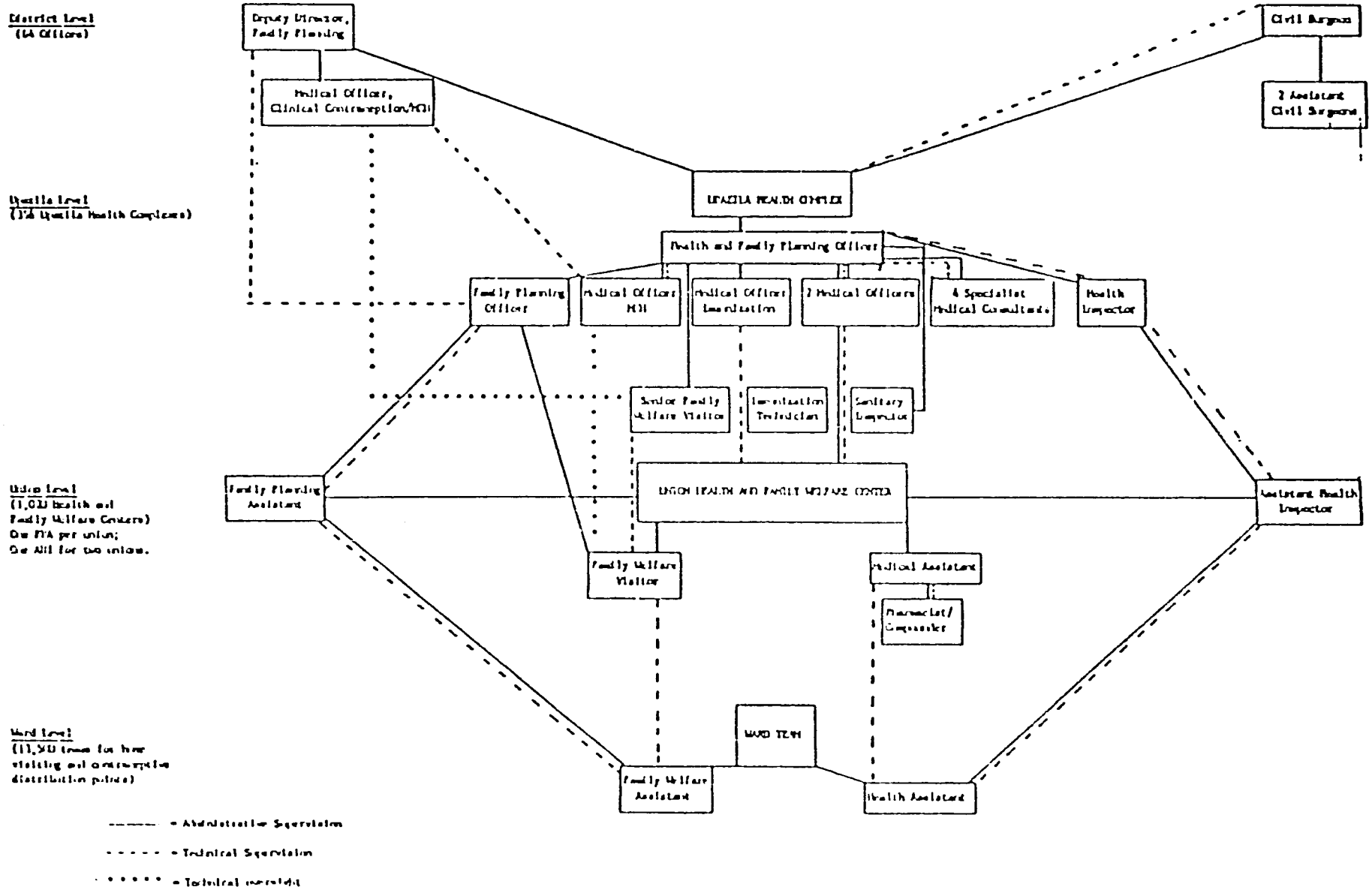
1 x Medical Officer (MMS: 900-1610/1150-1800)
1 x Family Welfare Visitor (MMS: 370-74'
1 x Aya (MMS: 225-315)
1 x MLSS/Peon (MMS: 225-315)

FAMILY PLANNING OFFICER (6)

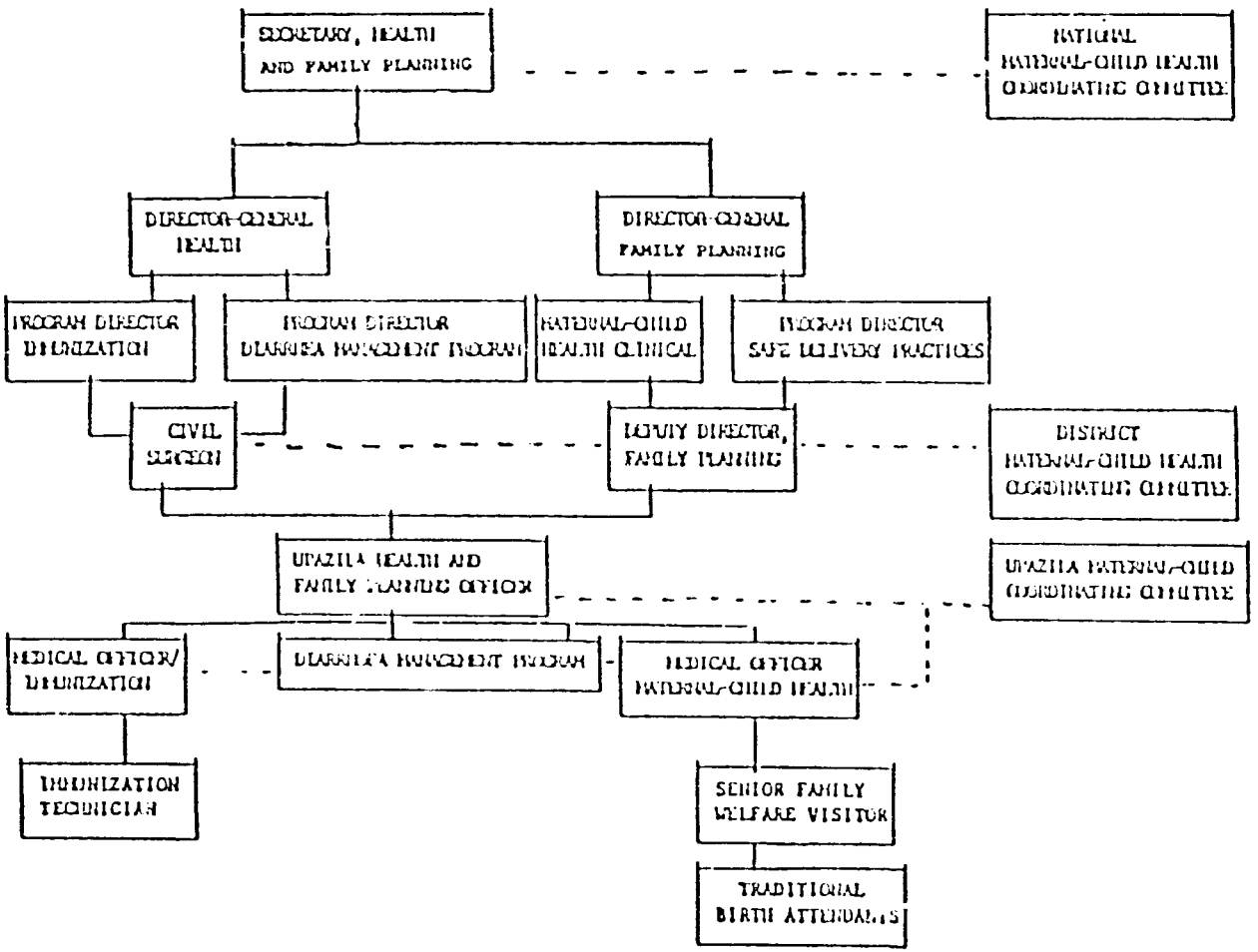
Personnel: 6

1 x FPO (MMS: 625-1315/750-1470)
1 x AFPO (MMS:625-1315)
3 x FPA (MMS: 300-540)
1 x MLSS/Peon (MMS: 225-315)

Organisation of Health and Family Planning Program at District level and Below



MCH Program Organisation Chart



ANNEX H

TECHNICAL ANALYSIS

1. Project Objectives in Family Planning

The original Family Planning Services Project (FPSP) (1981-84) and the Amendment to the FPSP (1984-86) planned to increase the level of contraceptive use in Bangladesh from 13.6 percent of all eligible women (using both modern and traditional methods) to 25 percent (using modern methods) in 1985. An additional goal specified in the Project Amendment was to increase the use of modern contraceptives among eligible women to 28 percent by December, 1987. An assumption was made that the use of traditional methods would continue at about 4 percent, implying an overall 1987 contraceptive use rate of 32 percent.

Owing to the problem of underreporting of male methods by females (i.e. vasectomy and condom use), the 1983 and 1985 CPS design included interviews with husbands and couples. A "working rate" for couples was developed which incorporated the reported use rates for male methods from the husband sample in 1983 and the couple sample in 1985(1). Table 1 presents national prevalence data for eligible women and couples (the "working rate") from the contraceptive prevalence surveys conducted to date, including the final estimates from the 1985 CPS.

The 1985 Contraceptive Prevalence Survey found that 18.4 percent of all eligible women and 22.9 percent of all couples were using a modern form of contraception by 1986. In 1983, modern method use was 13.8 percent among eligible women and 16.2 percent among couples. Using the prevalence estimates for couples, modern method prevalence grew by 41 percent (from 16.2 to 22.9 percent). If modern method contraceptive prevalence increases at the same rate between 1985 and 1987, the Project Amendment goal of 28 percent modern method prevalence by 1987 should be achieved. However, because of recent setbacks in program performance (discussed previously), this goal may prove difficult to attain.

1/ The 1983 CPS conducted eligible women, husband and couple samples in order to assess overall contraceptive prevalence in Bangladesh. Final "working rates" were estimated by incorporating male method prevalence from the husband sample and female method prevalence from the eligible women sample. Since male method use in the 1983 husband and couple samples was nearly identical, it was decided to conduct only an eligible women and couple sample as part of the 1985 CPS survey.

The increase in contraceptive prevalence between 1981 and 1986 has been an important factor responsible for the moderate decline in fertility between 1981 and 1986. Results shown in Table 2 utilizing the Bongaarts' "Target" model of contraceptive prevalence suggest that fertility may have declined from 6.3 in 1981 to 5.6 in 1986 (Bongaarts, 1986). It is assumed that this decline was accompanied by a gradual rise in the average age at marriage (a decline in the proportions of women currently married from 84 to 83.5 percent), a slight decline in the duration of breastfeeding and post-partum infecundability (from 28 to 27.5 months and 20 to 19.5 months respectively) and a constant induced abortion rate of .02 (i.e. roughly two abortions for every 10 women who have completed their reproductive years).

The family planning objective of the 1987-91 FPHSP is to increase the 1986 contraceptive prevalence rate from 29.8 percent (traditional and modern methods) to 40 percent by 1991. The project hopes to increase modern method use from 22.9 percent in 1986 to 33.6 percent in 1991. Table 3 shows that 9.2 million users will be required to reach an overall prevalence level of 40 percent by 1991. If this level is attained, and the proximate determinants of fertility conform to the levels and trends outlined in Table 4 over the period 1986-91, Bangladesh should have a total fertility rate of 4.8 by 1991.

The projected 1991 total fertility rate of 4.8 is sensitive to parameters that account for the "proximate determinants" of fertility. Unfortunately, obtaining reliable national estimates of the proximate determinants (i.e., the proportion of women currently married, the duration of breastfeeding, the length of post-partum infecundability and the level of induced abortion) is highly problematic in Bangladesh. For example, the only source of data on marital status is the 1981 Population Census. There are no reliable data currently available that provide evidence of trends in the average age at marriage between 1981-86. For the purposes of this exercise, a modest increase in the female average at age marriage was assumed.

The median duration of breastfeeding has recently been reported to be as high as 33 months in Matlab Upazila and as low as 18 months by the World Fertility Survey (WFS:1976). Given the uncertainty surrounding estimates of breastfeeding duration, there is also confusion regarding the length of post-partum infecundability. The present analysis has incorporated the Matlab breastfeeding duration figure (33 months), but has introduced a downward adjustment of five years to account for lower breastfeeding durations thought to prevail in other regions of the country, particularly in urban areas.

National estimates of 28 months (1981), 27.5 months (1986) and 27 months (1991) were adopted in this instance. The gradual decline in breastfeeding duration assumed over the 1981-91 period is consistent with recent experience in neighboring South and East Asian countries.

Few estimates of the number of induced abortions in Bangladesh are presently available. Data from the Demographic Surveillance System in Matlab indicate that the annual induced abortion rate in recent years has averaged between .08 and .10 abortions per women by the end of the reproductive age period 15-49 years. However, these figures are generally thought to underreport the actual number of abortions occurring in Matlab. Tietze (1981) reports an induced abortion rate of .06 for India, but this figure is also likely to be seriously underreported. Given the lack of reliable estimates, this analysis has adopted an induced abortion rate of .20. There is no evidence that the incidence of abortion is changing in Bangladesh. Therefore, a constant abortion rate has been assumed for the period 1981-91.

An additional factor that is crucial for attaining a 1991 total fertility rate of 4.8 is change in the method mix of contraception during the project period. USAID anticipates that BDG expectations in this respect will be realized; namely, a greater emphasis on reversible methods of contraception for women interested in birth spacing as well as fertility limitation and, among sterilization acceptors, an increasing prevalence of vasectomy in relation to tubectomy.

Reversible methods (primarily oral pills, injectables, NORPLANT and the IUD) will experience the most rapid rise in prevalence between 1986-91. Table 5 indicates that 8 percent of all eligible couples (aged 15-49) will be users of the oral pill, 3 percent injectables/NORPLANT and 3.2 percent the IUD by 1991. However, sterilization will continue to be the primary method of contraception by the end of the FPHSP. 15.2 percent of all eligible couples will be utilizing sterilization services by 1991.

Table 6, which gives the projected 1991 method mix as a percent of total prevalence, shows that 38 percent of all users will be sterilization clients in 1991 (a decline from 39.3 percent in 1986). 16 percent of total method use will be represented by vasectomy and 22 percent tubectomy. This pattern assumes a major decline in the relative prevalence of female sterilization, both in relation to male sterilization and total method use.

The number of users by method for the period 1981-91 is given in Table 7. An increase in the CPR from 29.8 percent in 1986 to 40.0 percent in 1991 entails an increase from 5.7 million to 9.2 million users over the project period. Most of this increase will result from the rapid adoption of modern contraceptive methods. By 1991, 84.0 percent of total method use will consist of modern contraception (an increase from 64.0 percent in 1981 and 76.9 percent in 1986). This expansion in modern as opposed to traditional method use may be due in part to a substitution effect; namely, couples that have been using traditional methods tend to switch to modern contraception as the coverage and quality of modern method service delivery improves. Despite the downward trend in the proportional use of traditional methods (a decline documented by the 1981 and 1985 CPS surveys), the absolute number of couples using traditional methods will nevertheless increase during the period 1986-91 (from 1.3 to 1.5 million users).

The annual number of acceptors and users required to reach a CPR of 40 percent by 1991 are given in Tables 8 and 9. Method specific estimates of use effectiveness and annual discontinuation (shown in Table 10) have been employed to estimate annual acceptors. Discontinuation rates for pills and condoms are based upon the 1986 Use-Effectiveness Survey of Oral Pills and Condoms (A.Y. Choudhury, et al., 1986) while other methods are assigned standard values that have been found to prevail in other developing countries (Bongaarts, 1986).

2. Project Objectives in Maternal and Child Health

The FPHSP will be supporting several MCH efforts in addition to family planning over the five year period of the project. Primary attention will be given to increasing the use of oral rehydration therapy to combat diarrhoeal disease among infants and children and raising coverage levels of urban immunization services for mothers and children. USAID may also support vitamin A and iron supplementation programs as part of the MCH component of the FPHSP.

Treatment rates for ORT and immunization objectives established by the BDG in the Third Five Year Plan are more ambitious than those adopted by the FPHSP. The BDG anticipates that 90 percent of all diarrhoeal episodes will be treated with ORT by 1990. In addition, the BDG hopes to immunize 85 percent of all children under 2 years of age against diphtheria, whooping cough, tetanus, measles and polio by 1990. USAID considers these objectives to be overly ambitious.

Table 11 provides treatment and coverage rates for ORT and urban immunization that will hopefully be attained by the end of the FPHSP. A major effort will be made to promote the effective use of ORT during the period 1987-91. It has been estimated that an increase in national ORT treatment rates from 20 to 60 percent could conceivably reduce the rate of diarrhoeal deaths per 1000 children aged 0-4 from 13.2 to 10.5. This decline would result in a 2.6 percent reduction in overall mortality among children under 5 years of age (Osinski, 1986).

An important factor determining the potential mortality impact of ORT is effective community utilization (e.g. are solutions mixed in the right proportions, are solutions ingested in sufficient quantity to compensate for fluid loss, are solutions taken at the onset of the first watery stool). As part of the planned SMP Treatment Rate and Childhood Mortality Survey, an effort will be made to assess the knowledge and effective use of ORT throughout Bangladesh. An additional element of this study will deal with the effectiveness of ORT in relation to different types of diarrhoeal and dysenteric disease, particularly schigella, in lowering infant and child mortality.

Since the rural immunization program is receiving support from other donors, primarily UNICEF, immunization activities to be supported by the FPHSP will be limited to the four urban municipalities of Dhaka, Khulna, Chittagong and Rajshahi. By 1991, USAID anticipates that 65 percent of all children in the four main urban areas of Bangladesh will be immunized against measles, whooping cough, diphtheria, polio and tetanus and that 60 percent of all women aged 15-44 will receive tetanus immunizations. The urban immunization program will continue through 1993, at which time 80 percent coverage levels for children and mothers will hopefully be achieved.

3. Demographic Indicators and Objectives, 1986-91

Table 12 provides estimates of demographic indicators and objectives over the period 1986-91 that have been adopted by the FPHSP and the BDG Third Five Year Plan (BDG:1985). The FPHSP expects that the contraceptive prevalence rate will reach 40 percent by 1991, one year later than anticipated by the BDG. The projected method mix for 1991 results in a prevalence rate of 33.6 percent for modern methods and 6.4 percent for traditional methods.

Using the "proximate determinant" parameters shown in Table 4 and an increase in prevalence from 29.8 percent in 1986 to 40.0 percent in 1991, USAID estimates that the total fertility rate will be 4.8 by 1991. The BDG TFR projection of 4.2 can only be attained with a contraceptive prevalence rate of 48 percent. The number of eligible couples required to reach a CPR of 40 percent by 1991 is projected to be 9.2 million, a figure considerably above the BDG expectation of 8.2 million.

The BDG projection of a four year increase in life expectancy (from 50 to 54 years) over the period 1985-90 may be too optimistic with regard to the short term mortality impact of the family planning program and selective MCH interventions. However, USAID believes that the BDG life expectancy estimate of 50 years for 1985 (which implies no improvement in mortality since 1981) may be overly pessimistic. Given recent gains in contraceptive prevalence, there may have been some modest mortality decline among infants, children and mothers in recent years.

USAID believes that there will be slow gradual improvement in mortality conditions between 1986 and 1991. Overall life expectancy is projected to increase by 1 year (from 52 to 53 years), with female life expectancy remaining slightly lower than male life expectancy by the end of the project period. This modest improvement in mortality is assumed on the grounds that nutritional levels as well as environmental sanitation conditions will not improve rapidly during the 1987-91 period. In addition, per-capita FP/MCH program coverage (including household rounds by FP/MCH fieldworkers) will likely remain inadequate and replacement mortality (mortality arising from multiple causes) may inhibit the effectiveness of FP/MCH interventions.

The fertility and mortality trends postulated by USAID result in a 1991 crude birth rate of 35.5, a crude death rate of 13.5 and an annual population growth rate of 2.2 percent. The infant mortality rate (IMR) is projected to be 123 deaths per 1000 live births, the child death rate (CMR) 21 deaths per 1000 children aged 1-4 and the maternal mortality rate (MMR) 5 maternal deaths per 1000 live births. The level of net out-migration from Bangladesh, estimated to be between 50,000-80,000 annually, does not significantly affect the annual population growth rate.

The BDG annual growth rate objective of 1.8 percent can only be attained if the total fertility rate declines to 4.2 (with a 1991 e(0) = 54) which, to be achieved, will require a contraceptive prevalence rate of 48 percent. Barring a sudden dramatic upturn in the fortunes of the family planning program, a CPR of 48 percent is not likely to be achieved by 1990.

4. Demographic Trend Analysis 1986-2001

During the remainder of this century, the population of Bangladesh will continue to grow rapidly. This outcome is largely pre-determined owing to the current high annual growth rate (at least 2.4 percent in 1986) and the relatively young age structure of the population. Table 13 outlines a future demographic scenerio for Bangladesh that USAID believes can be realistically attained by the year 2001. Fertility is projected to decline from 5.6 in 1986 to 3.6 in 2001, life expectancy to increase from 52 years in 1986 to 55 years in 2001, and the annual population growth rate to fall from 2.4 percent in 1986 to 1.8 percent by 2001.

Assumptions with regard to trends in the proximate determinants of fertility to the year 2001 are given in Table 4. It has been assumed that the pattern of change between 1981 and 1991 will continue until the year 2001; namely, a decline in the proportion of women currently married from .830 in 1991 to .820 in 2001, a reduction in the duration of breastfeeding (from 27 months in 1991 to 26 months in 2001) and post-partum infecundability (from 19 months in 1991 to 18 months in 2001) and a constant induced abortion rate .20 until the end of the century.

In order to attain a fertility rate of 3.6 by the end of the century, the contraceptive prevalence rate will need to rise from 29.8 percent in 1986 to 56.3 percent in 2001. The contraceptive method mix for the year 1991 has been assumed to remain constant until 2001, with modern methods continuing to account for 84 percent and traditional methods 16 percent of total use.

The infant mortality rate will likely remain above 100 for the remainder of this century. Utilizing a United Nations South Asian model life table, a life expectancy of 55 corresponds to an infant mortality rate of 113. USAID expects that projected improvements in mortality will closely follow the age and sex patterns established for different levels of life expectancy in the UN South Asian model life table. This model incorporates a more rapid decline in infant and child mortality than in adult mortality with an increase in life expectancy from 52 to 55 years. However, if the age pattern of mortality were to change more rapidly than anticipated by the UN South Asian model life table (e.g. if infant and child mortality were to decline even more quickly relative to adult mortality), it is possible that the infant mortality rate could fall below 100. However, within the relatively short projection period under consideration (15 years), it is not likely that a major shift in the age pattern of mortality (beyond that anticipated by the UN model) will occur.

A population projection based upon USAID program objectives through the year 2001 is shown in Tables 14 and 15. If fertility and mortality change occurs along the lines postulated, which will require consistently effective implementation of family planning and MCH services until the end of the century, the total population of Bangladesh will be 137.9 million.

Table 16 presents alternative population projections based upon different levels of family planning performance. Five future scenarios are presented, ranging from constant fertility to very rapid fertility decline (i.e. replacement level) between 1986 and 2001. (All projections assume an increase in life expectancy from 52 years in 1986 to 55 years in 2001). This analysis indicates that the population of Bangladesh will range between 125 and 155 million by 2001.

If the contraceptive prevalence rate does not rise above 38 percent by the end of the century, Bangladesh will likely have a population of at least 150 million by 2001. Even with a decline in fertility from 5.6 to 5.0, age structure effects (i.e. progressively larger female cohorts entering the child bearing years coupled with more women surviving through the reproductive ages as a result of falling mortality) will tend to bias the crude birth rate upward (from 38.9 in 1986 to 39.4 in 2001), thereby forcing the population growth rate higher. Only a rapid increase in contraceptive prevalence (e.g. to 56.3 percent by 2001) will reduce the population growth rate to less than 2 percent per annum by the end of the century. Replacement level fertility (TFR = 2.1) by 2001 will require a contraceptive prevalence rate of 75 percent, a figure that is almost certainly beyond the combined reach of BDG, NGO and SMP program efforts within the next fourteen years.

TECHNICAL ANALYSIS TABLES

TABLE 1
CONTRACEPTIVE PREVALENCE RATES (1979-85)

	Eligible Women Sample				Couple Sample	
Methods	1979	1981	1983	1985	1983	1985
Modern Methods (Total)	8.9	10.9	13.8	18.4	16.2	22.9
Oral Pill	3.6	3.5	3.3	5.1	3.3	5.1
Condom	1.5	1.6	1.5	1.8	2.7	4.0
Vaginal Method	.1	.3	.3	.2	.3	.2
Injection	.2	.4	.2	.5	.2	.5
IUD	.2	.4	1.0	1.4	1.0	1.4
Tubectomy	2.4	4.0	6.2	7.9	6.2	7.9
Vasectomy	.9	.8	1.2	1.5	2.5	3.8
Traditional Methods (Total)	3.8	7.7	5.4	6.9	5.5	6.9
Safe Period	2.2	3.9	2.4	3.8	2.4	3.8
Withdrawal	.2	1.8	1.3	.9	1.3	.9
Abstinence	.8	1.2	.4	.5	.4	.5
Other	.6	.7	1.4	1.7	1.4	1.7
Any Method	12.7	18.6	19.1	25.3	21.7	29.8
No Method	87.3	81.4	80.9	74.7	78.3	70.2

1. Columns do not always add exactly owing to rounding.
Source: Mitra and Associates (1985, 1987).

TABLE 2
FERTILITY AND CONTRACEPTIVE PREVALENCE
IN BANGLADESH (1981-86)

	TFR	CPR	Married Women of Reproductive Age (1000)	Total Users (1000)
1981	6.3	20.9	15895.3	3322.1
1982	6.2	22.8	16475.8	3750.3
1983	6.0	24.6	17077.4	4198.0
1984	5.9	26.4	17700.9	4666.2
1985	5.7	28.1	18347.3	5155.6
1986	5.6	29.8	19017.1	5667.1

1. Computed Using the Bongaarts Proximate Determinants "Target Model", (Bongaarts, 1986).
2. The CPR of 20.9 for 1981 was derived by correcting for underreporting of male methods (vasectomy and condom use) by female respondents. Since no husband or couple sample was conducted in 1981, the rate of female underreporting of male methods found in the 1983 CPS was applied to the 1981 eligible couple sample to obtain "working rates" that provide a valid comparison with the 1985 couple sample prevalence estimate of 29.8%

TABLE 3
PROJECTED FERTILITY AND CONTRACEPTIVE PREVALENCE
IN BANGLADESH (1986-91)

	TFR	CPR	Married Women of Reproductive Age (1000)	Total Users (1000)
1986	5.6	29.8	19017.1	5667.1
1987	5.4	31.9	19740.2	6292.9
1988	5.3	33.9	20490.8	6954.2
1989	5.1	36.0	21269.9	7652.5
1990	5.0	38.0	22078.6	8389.6
1991	4.8	40.0	22918.0	9167.4

1. Computed Using the Bongaarts Proximate Determinants "Target Model", (Bongaarts, 1986).

TABLE 4
ESTIMATION PARAMETERS USED IN BONGAARTS TARGET MODEL OF FERTILITY AND CONTRACEPTIVE PREVALENCE (1986-2001)

	1981	1986	1991	1996	2001
Proportions of Women Currently Married (15-49)	.840	.835	.830	.825	.820
Duration of Breastfeedsing (In Months)	28.0	27.5	27.0	26.5	26.0
Duration of Postpartum Infecundability (In Months)	20.0	19.5	19.0	18.5	18.0
Total Induced Abortion Rate	.20	.20	.20	.20	.20

1. The proportion of women aged 15-49 in 1981 was computed from the 1981 Bangladesh Population Census (BBS, 1984:25). Estimates for 1986 and 1991 allow for a gradual increase in the average age at marriage over the 1981-91 decade.

TABLE 5
METHOD MIX OF CONTRACEPTIVE USE (1981, 1986, AND 1991)

	1981	1986	1991
Vasectomy	7.9	12.8	16.0
Tubectomy	18.7	26.5	22.0
Injectables/Norplant	1.9	1.7	3.0
IUD	1.9	4.7	8.0
Oral Pill	16.3	17.1	20.0
Foam/Jellies	1.4	.7	1.0
Condom	15.9	13.4	14.0
Traditional Methods	36.0	23.1	16.0
Total	100.0	100.0	100.0
Modern	64.0	76.9	84.0
Traditional	36.0	23.1	16.0

1. 1981 and 1986 estimates are from the 1981 and 1985 Contraceptive Prevalence Surveys (Mitra and Associates, 1985, 1987). 1991 figures constitute FPHSP objectives adopted by USAID.

TABLE 6
CONTRACEPTIVE PREVALENCE BY METHOD (1981, 1986, AND 1991)

	1981	1986	1991
Vasectomy	1.6	3.8	6.4
Tubectomy	3.9	7.9	8.8
Injectables/Norplant	.4	.5	1.2
IUD	.4	1.4	3.2
Oral Pill	3.4	5.1	8.0
Foam/Jellies	.3	.2	.4
Condom	3.4	4.0	5.6
Traditional Methods	7.5	6.9	6.4
Total	20.9	29.8	40.0
Modern	13.4	22.9	33.6
Traditional	7.5	6.9	6.4

1. 1981 and 1986 estimates are from the 1981 and 1985 Contraceptive Prevalence Surveys (Mitra and Associates, 1985, 1987). 1991 figures constitute FPHSP objectives adopted by USAID.

TABLE 7
USERS OF CONTRACEPTION BY METHOD (1981, 1986 AND 1991)

	1981 (1000)	1986 (1000)	1991 (1000)
Vasectomy	262.3	725.4	1466.8
Tubectomy	621.5	1501.8	2016.8
Injectables/Norplant	63.6	96.3	275.0
IUD	63.6	266.4	733.4
Oral Pill	542.0	969.1	1833.5
Foam/Jellies	46.1	39.8	91.7
Condom	527.7	759.4	1283.4
Traditional Methods	1195.3	1309.1	1466.8
Total	3322.1	5667.1	9167.4
Modern	2126.8	4358.0	7700.6
Traditional	1195.3	1309.1	1466.8

1. 1981 and 1986 estimates are from the 1981 and 1985 Contraceptive Prevalence Surveys (Mitra and Associates, 1985, 1987). 1991 figures constitute FPHSP objectives adopted by USAID.

TABLE 8
ANNUAL NUMBER OF USERS BY METHOD REQUIRED
TO REACH CPR = 40% BY 1991 (1000)

	1987	1988	1989	1990	1991
Vasectomy	845.0	978.5	1126.0	1288.4	1466.8
Tubectomy	1611.5	1718.1	1821.6	1921.4	2016.8
Injectables/Norplant	123.9	154.9	190.1	230.1	275.0
IUD	337.2	418.6	511.1	615.8	733.4
Oral Pill	1113.3	1270.4	1442.2	1629.5	1833.5
Foam/Jellies	48.1	57.2	67.5	78.9	91.7
Condom	850.3	948.1	1052.7	1164.3	1283.4
Traditional Methods	1363.7	1408.4	1441.3	1461.3	1466.8
Total	6292.9	6954.2	7652.5	8389.6	9167.4

TABLE 9
ANNUAL NUMBER OF ACCEPTORS BY METHOD REQUIRED
TO REACH CPR = 40% BY 1991 (1000)

	1987	1988	1989	1990	1991
Vasectomy	152.7	170.3	189.3	209.8	225.0
Tubectomy	145.8	145.5	144.6	143.0	131.8
Injectables/Norplant	71.0	85.7	102.1	120.5	139.7
IUD	193.6	232.8	276.7	325.8	376.7
Oral Pill	558.2	630.0	708.0	792.6	876.2
Jellies/Foam	25.1	29.3	34.0	39.2	44.4
Condom	430.9	476.1	524.4	575.9	624.8
Traditional Methods	518.8	523.1	522.1	515.3	496.1
Total	2096.1	2292.8	2501.2	2722.3	2914.7

TABLE 10
USE EFFECTIVENESS AND ANNUAL DISCONTINUATION RATES
BY METHOD (1986-1991)

	Use Effectiveness Rate	Annual Discontinuation Rate
Vasectomy	1.000	.010
Tubectomy	1.000	.010
Injectables/Norplant	.980	.333
IUD	.950	.333
Oral Pill	.900	.358
Foam/Jellies	.800	.333
Condom	.800	.385
Traditional Methods	.700	.333

1. The annual discontinuation rate for pills and condoms is from the 1986 Pill and Condom Use Effectiveness Survey, (A.Y. Chowdhury, et. al., 1986).

TABLE 11
TREATMENT AND COVERAGE RATES FOR ORAL REHYDRATION THERAPY
AND URBAN IMMUNIZATION PROGRAM (1986-1991)

Oral Rehydration Therapy (ORT)

Treatment Rate
(% of All Diarrheal Episodes in Children Aged 0-4 Treated With ORT)

1986	20%
1991	60%

Immunization

Immunization of Children Aged 0-1 in the Four Urban Municipalities of Dhaka, Khulna, Chittagong and Rajshahi

1986	5%
1991	65%

Immunization of Women Aged 15-45 in the Four Urban Municipalities of Dhaka, Khulna, Chittagong and Rajshahi

1986	3%
1991	60%

TABLE 12
PROJECTED DEMOGRAPHIC OUTCOMES OF THE 1987-91
FAMILY PLANNING AND HEALTH SERVICES PROJECT (FPHSP)
AND THE BDG THIRD FIVE YEAR PLAN (1985-1990)

	USAID Estimates 1986	USAID Projection 1991	BDG Projection 1990
Total Population (Million)	101.6	113.4	111.5
CBR	38.9	35.6	31.0
CDR	14.9	13.5	13.0
Annual Growth Rate	2.4	2.2	1.8
TFR	5.6	4.8	4.2
Life Expectancy	52	53	54
IMR	128	123	100
CMR	24	21	12
MMR	6	5	4
CPR	29.8	40.0	40.0
Modern	22.9	33.6	-
Traditional	6.9	6.4	-
Eligible Couples Using Contraception (Million)	5.7	9.2	8.2

1. The Third Five Year Plan, (Dhaka: Planning Commission, Ministry of Planning, 1985:372-33, 378).
2. Infant mortality and child mortality rates estimated by USAID have been computed from South Asian pattern model life tables corresponding to e(0) values of 52 and 53 years (United Nations, 1983).

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TABLE 13
PROJECTED PROGRAM OBJECTIVES AND DEMOGRAPHIC OUTCOMES
1981-2001

	TFR	CBR	CDR	r	CPR	e(0)	IMR
1981	6.3	42.8	15.8*	2.7	20.9	51	133
1986	5.6	38.9	14.6	2.4	29.8	52	128
1991	4.8	35.5	13.5	2.2	40.0	53	123
1996	4.2	33.6	12.8	2.0	48.3	54	118
2001	3.6	30.3	11.9	1.8	56.3	55	113

* The 1981 CDR of 15.8 was computed from the UN South Asian Model Life Table using the central age death rate (Mx) for male e(0) = 51.5 and female e(0) = 50.5 applied to the 1981 census age distribution.

TABLE 14
POPULATION PROJECTION CORRESPONDING TO USAID PROGRAM
OBJECTIVES FOR THE PERIOD 1986-2001 (1000)

	Total	Male	Female
1981	89915	46361	43554
1986	101553	52320	49233
1991	113359	58370	54989
1996	125805	64763	61042
2001	137904	70982	66922

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TABLE 15
POPULATION PROJECTION BY AGE AND SEX
CORRESPONDING TO USAID PROGRAM OBJECTIVES 1986-2001 (1000)

	1986 Population			1991 Population		
	Male	Female	Total	Male	Female	Total
0-4	8039	7572	15610	8308	7819	16127
5-9	7234	7057	14290	7593	7079	14673
10-14	7314	7086	14400	7143	6953	14096
15-19	6371	5536	11907	7255	7012	14267
20-24	4217	4085	8302	6309	5459	11768
25-29	3306	3586	6893	4168	4021	8188
30-34	3294	3218	6512	3259	3522	6781
35-39	2521	2492	5014	3233	3149	6382
40-44	2367	2090	4456	2455	2428	4883
45-49	1903	1768	3670	2276	2021	4296
50-54	1538	1253	2791	1792	1684	3476
55-59	1333	1215	2547	1405	1161	2567
60-64	830	635	1465	1163	1076	2239
65-69	875	770	1645	675	527	1202
70-74	395	293	689	646	580	1225
75-79	784*	578*	1362*	256	190	446
80+	-	-	-	434	309	743
* = 75+						
Total	52320	49233	101553	58370	54989	113359

	1996 Population			2001 Population		
	Male	Female	Total	Male	Female	Total
0-4	8820	8293	17112	8837	8303	17140
5-9	7877	7339	15217	8392	7814	16206
10-14	7504	6982	14486	7790	7245	15035
15-19	7089	6886	13975	7450	6918	14369
20-24	7188	6921	14110	7027	6802	13830
25-29	6240	5378	11618	7114	6825	13939
30-34	4111	3953	8064	6160	5293	11452
35-39	3201	3451	6652	4042	3877	7920
40-44	3151	3072	6223	3125	3370	6495
45-49	2364	2351	4715	3040	2979	6019
50-54	2148	1928	4077	2237	2247	4484
55-59	1643	1564	3207	1975	1795	3770
60-64	1231	1033	2264	1444	1396	2840
65-69	951	897	1848	1011	865	1876
70-74	501	399	901	711	684	1395
75-79	421	379	800	329	263	593
80-84	143	103	246	237	207	444
85+	177	114	291	60	38	98
Total	64762	61042	125804	70982	66922	137904

TABLE 16
ALTERNATIVE POPULATION PROJECTIONS ASSUMING DIFFERENT FERTILITY TRENDS BETWEEN 1981-2001

	TFR	CPR	CBR	CDR	r	Total Population (1000)
1. Constant Fertility						
1986	5.6	29.8	38.9	14.6	2.4	101553
1991	5.6	29.8	40.9	14.2	2.7	116037
1996	5.6	30.3	42.9	14.1	2.9	134035
2001	5.6	30.8	43.0	13.5	3.0	155344
2. Low Fertility Decline						
1986	5.6	29.8	38.9	14.6	2.4	101553
1991	5.4	32.4	39.6	14.1	2.6	115362
1996	5.2	35.4	40.3	13.7	2.7	131761
2001	5.0	38.5	39.4	13.1	2.6	150293
3. Moderate Fertility Decline						
1986	5.6	29.8	38.9	14.6	2.4	101553
1991	5.0	37.5	36.9	13.8	2.3	114013
1996	4.6	43.2	36.4	13.2	2.3	128058
2001	4.2	48.7	34.4	12.4	2.2	142935
4. Rapid Fertility Decline (USAID Program Objective)						
1986	5.6	29.8	38.9	14.6	2.4	101553
1991	4.8	40.0	35.5	13.5	2.2	113359
1996	4.2	48.3	33.6	12.8	2.1	125804
2001	3.6	56.3	30.3	11.9	1.8	137904
5. Replacement Level Fertility by 2001						
1986	5.6	29.8	38.9	14.6	2.4	101553
1991	4.4	45.3	32.8	13.2	2.0	112010
1996	3.2	61.1	26.4	11.8	1.5	120464
2001	2.1	75.4	18.9	10.5	0.8	125646

1. All projections estimated with the following pattern of mortality change between 1986 and 2001: e(o) = 52 in 1986, 53 in 1991, 54 in 1996 and 55 in 2001. A one year differential in favor of males is assumed throughout the projection period.

ANNEX I

SOCIAL ANALYSIS

The impact of a successful family planning and MCH program should be considerable in Bangladesh. Women still typically marry early (between 16 and 17 years on average), begin child-bearing immediately upon marrying and lack full access to education, gainful employment, knowledge of legal and social rights, and economic independence. Having many children and caring for them (particularly sons) is the role-model into which women are socialized from birth. Providing the means for women to limit fertility will be an important step in transforming traditional role models. This effort will complement parallel efforts to increase female educational attainment and labor force participation and to further strengthen women's institutions (e.g. social and economic cooperatives and women's clubs).

Family planning and MCH programs are important in providing women with a changed view of their own prospects and that of their children. By providing basic immunizations and giving women necessary training and skills in ORT and personal hygiene, infant mortality and morbidity should be reduced. Enhancing a women's ability to control her reproduction will also have a major impact on infant and maternal mortality by reducing health risks associated with pregnancy (especially high parity births to older women and births occurring at short intervals). Such change should have a powerful modernizing impact on the village women of Bangladesh.

The "fertility transition" in most western and an increasing number of Asian and Latin American populations has been accompanied by other transformations, including changes in the structure and function of the family. During the process of modernization, the family tends to evolve from a male-dominated institution aimed primarily at guaranteeing the survival of the family lineage to a more equalitarian center for market and home production designed to benefit all members of the household. The family planning and MCH interventions outlined in USAID's FPHSP (1987-91) will be an important step in encouraging such social change in Bangladesh.

In order for family planning and other MCH programs to be effectively implemented, adequate demand must exist for program services. Preliminary results from the 1985 CPS indicate that 31 percent of all currently married women (32 percent rural and 24 percent urban) were not using contraception and did not want any more children. These figures provide a rough indication of the level of unmet demand for family planning services in Bangladesh. It is likely that some women in this group are not

using contraception owing to cultural constraints (e.g. opposition from husbands, family members or religious leaders) rather than lack of access to services. However, if the expressed desire for greater use of spacing methods is taken into account, the overall level of unmet demand among eligible women would probably exceed 31 percent. If male contraceptive demand is also considered, the level of unmet demand among couples would also likely exceed current CPS estimates.

The level of existing demand for family planning and MCH services in Bangladesh, while not insubstantial, is nevertheless modest. A program strategy oriented to improving the coverage and quality of services (a "supply side" approach) would seem appropriate in Bangladesh since the delivery of services is still inadequate in many areas of the country, especially in rural areas. However, in order to stimulate greater demand for services, there is an ongoing need to strengthen Information, Education and Communication (IEC) programs and "beyond family planning" activities (such as expanded educational and employment opportunities for women).

The nature of demand is also of fundamental importance in determining resource allocations and implementing strategies. For example, greater demand may exist for contraceptive methods that limit family size rather than increase the spacing of births since birth intervals are already long in Bangladesh owing to the extended duration of breastfeeding and post-partum infecundability. However, as the average age of users declines (which is commonly encountered when the level of prevalence increases), it is not unrealistic to expect that the demand for reversible methods will increase more rapidly than permanent method demand.

While family planning performance has not attained the goals initially established for the program, there does appear to have been a significant increase in prevalence (from 20.9 percent in 1981 to 29.8 percent in 1985) and a moderate decline in fertility (from 6.3 in 1981 to 5.6 in 1986). This change has occurred despite the lack of substantial social and economic development in Bangladesh in recent years. Deborah and Ronald Freedman (1986) have argued that gains in contraceptive prevalence (and a higher level of demand for family planning services) may be the result of a widening gap between expectations and living standards. In other words, in environments typified by extreme poverty, the consumption costs attributable to children may constitute a growing proportion of family income, with the result that children may no longer be perceived as net productive assets. The Freedmans comment as follows:

> Among many of the desperately poor, more than a modest number of children may not be economically useful either in the family's own economic activity or in in a non-familial labor market. This becomes more probable with increased landlessness and the growing pressure on small fragmented land holdings where the non-agricultural sector offers limited opportunities for the rural poor (Freedman and Freedman, 1986:9).

Other factors that may account for the increasing cost of children, particularly in agrarian settings, are the growing monetization and commercialization of the economy (including the substitution of contractual labor relations for traditional payment-in-kind distributive mechanisms), diminished access to agrarian technical innovations and extension services (including financial credit), increasingly restrictive educational and employment opportunities beyond the immediate village setting and a shifting pattern of consumption that entails new aspirations for goods that cannot be obtained directly through the mobilization of household child labor. Improved communication and transportation systems may also be defusing alternative aspirations affecting the pattern of consumption and the perceived value of children.

Clues regarding demand for contraception and the future course of demographic change in Bangladesh can possibly be identified from the experience of Matlab Upazila, a program service area of the ICDDR,B(1). In the mid-1970's, an initial attempt to test demand through an intensive contraceptive supply effort in Matlab met with only short-lived success. Initial high rates of acceptance were followed by a rapid decline in levels of contraceptive use related to extensive unattended side effects associated with the use of oral contraceptives. Women were ready to limit child-bearing, but not at the expense of perceived costs to their health. Beginning in 1977, when quality issues were addressed and delivery mechanisms became more culturally appropriate (e.g. door-to-door delivery of FP/MCH services by women to women), higher rates of family planning acceptance were sustained over many years (Degraff, et al., 1986).

1/ Substantial increases in contraceptive prevalence have also been achieved by other NGO family planning efforts in Bangladesh, but their success is less well documented (e.g., see Alauddin and Khan, 1983; Alauddin and Muhri, 1984).

The Matlab experience suggests that survey results indicating latent demand for family planning had some validity, but that high quality, culturally appropriate services were required to meet the demand and make it manifest in contraceptive prevalence. It would be difficult to argue that increased contraceptive prevalence in Matlab was a result of rising demand produced by socio-economic development. If anything, conditions in Matlab have deteriorated, and given the existence of appropriate services, demand for family planning may have risen as circumstances made it increasingly difficult for parents to support their children. Despite persistently high mortality, survey findings between 1977 and 1984 report an increase in demand for fertility limitation in the Matlab treatment and comparison areas.

In addition to demonstrating the existence of latent demand in rural Bangladesh and the importance of quality family planning services in meeting this demand, operations research in Matlab has generated potentially important findings regarding the effect of improved services on the composition of contraceptive demand. After several years of improved service delivery, demand in the Matlab treatment area appears to be changing from an almost exclusive focus on permanent contraceptive methods that limit births to demand for reversible methods that both limit and space births. Similarly, in the FP-MCH Extension Project areas of Aboynagar and Sirajganj, where important elements of the Matlab service system are being adapted and transferred to the government program, much of the increase in contraceptive prevalence is due to greater use of reversible contraception. In addition, increased contact with female family planning workers (in both the Matlab and BDG programs) has been found to result in increased levels of contraceptive use and a broader method mix.

Despite the gains in contraceptive prevalence and reductions in fertility obtained in Matlab, Aboynagar and Sirajgang, there is still considerable uncertainty regarding the extent to which fertility will decline in the future given persistent high mortality and slowly improving (if not stagnant) living standards. Clearly, the future coverage and quality of family planning and other MCH services will be a major factor influencing demographic trends in Bangladesh. However, change in social and economic perceptions of the value of children and the utility ascribed to large families (particularly in traditional agrarian communities typified by low agricultural productivity and high land fragmentation) will also likely play a critical role in determining the demand for contraception and the course of future demographic change.

ANNEX J

ECONOMIC ANALYSIS

Family Planning

The following analysis is based upon a study commissioned by USAID in 1984 entitled An Economic Analysis of Family Planning in Bangladesh by George Simmons, Ubaidur Rob, and Stan Bernstein. Certain coefficients employed in this study have been questioned by a subsequent investigation completed by John Laing and David Walker (1986). However, the major findings of the Simmons analysis are not significantly affected by the use of the revised Laing-Walker coefficients.

(1) Measuring Benefits

The benefits of the family planning program arise from specific outputs, measured variously as clients, continuous users, units of supplies distributed, and procedures performed. Couple years of protection (CYP) is the conventional statistical denominator that allows for the aggregation of various program inputs and outputs into a single total. A CYP is one year's protection afforded a couple (male or female partner) from the risk of pregnancy by the use of contraception. Table 1 shows the coefficients, based on Bangladesh experience, used in this analysis to convert various program inputs and outputs into standard CYPs.

CYPs can be converted into births prevented (BPs) by dividing total CYPs by the average birth interval for all eligible non-contracepting women. In Bangladesh, it has been determined that the mean birth interval is approximately 42 months. Therefore, 3.5 CYPs prevent one birth. Using this calculation, total CYPs yield an estimate of births prevented (BPs), the ultimate "output" of the program. Actual program performance data are shown in Table 2 in terms of specific methods distributed or performed. Using these figures in conjunction with the CYP-conversion coefficients presented in Table 1, it is possible to estimate total CYPs and births prevented (BPs) in Table 3(1).

1/ Table 3 is in terms of "Adjusted Births Prevented", with adjustments allowing for the greater value to planners of assessing immediate rather than delayed demographic impact. A discount rate of 15 percent was used for all future BPs in order to adjust these figures to present BPs. Table 1 shows the adjustment factors as well as other coefficients used in calculating CYPs and BPs. This adjustment reduces the relative impact of sterilization and raises the effect of temporary methods.

Table 1
Coefficients used for Calculating Demographic Impact of Contraceptive Use

Temporary Methods

Method	Units per CYP	CYPs per BP	Units per BP	Adjustment Factor
Oral Pill	14	3.5	49.00	0.870
Condom**	250	3.5	875.00	0.870
Emko	5.33	3.5	18.66	0.870
Foam Tab	123	3.5	437.50	0.870
Injection	4	3.5	14.00	0.870

Long-term methods

Method	CYPs per	CYPs per	BPs per	Discount	Adjustment
IUD/CU T	2.45	3.5	0.70	0.15	0.756
Tubectomy	7.75	3.5	2.21	-	0.572
Vasectomy	7.75	3.5	2.21	-	0.572

*Average expected lifetime effects of methods used in calculating adjustment factors:

Temporary methods	1.0 year
IUD/Copper T	1.0 years
Sterilizations =	4.0 years

** Laing and Walker (1986) conclude that 180 rather than 250 condoms provide one couple year of protection. The conversion factor employed by Simmons et al. may over-estimate the utilization of condoms by as much as 28 percent. However, the final CBA estimates obtained by Simmons et al. with regard to the overall benefits of the family planning program are not significantly affected by this disagreement.

Source : George, Simmons, V. Rob and S. Bernstein, An Economic Analysis of Family Planning in Bangladesh, (Ann Arbor, Michigan Dept. of Population Planning and International Health, 1986)

Table 2
Contraceptives Distributed by Year and Method

Method	Unit Year	1982	1983	1984	1985
Oral Pill	Cycles (1000)	8121	8839	10935	11828
Condom	Pieces (million)	107	127	157	127
Emko	Vials (1000)	67	72	64	64
Foam Tablet	Pieces (million)	4	6	4	3
Injection	Units (1000)	64	108	141	193
IUD/CU T	Units (1000)	108	182	400	402
Tubectomy	Operations (1000)	297	290	336	144
Vasectomy	Operations (1000)	97	113	306	169
Total (thousand units)		8865	9737	12343	12930

Source: Dhaka: Management Information System (MIS), 1985.

Table 3
Adjusted Births Prevented by Year of Contraceptive Adoption and Method (thousands)

Method	1982	1983	1984	1985
Oral Pill	144.117	156.859	194.055	210.0
Condom	106.335	126.211	156.025	126.3
Emko	3.123	3.356	2.983	3.1
Foam Tab	7.950	11.925	7.950	8.0
Injection	3.975	6.708	8.758	12.0
IUD/CU T	57.164	96.333	211.720	212.74
Tubectomy	376.009	367.147	425.384	182.03
Vasectomy	122.804	143.061	387.404	213.50
Total	821.479	911.601	1394.279	967.12

Simmons, et al., p. 58.

Estimates of the social gain (or economic benefit to society) of preventing a birth involves constructing a model of the interaction between demographic and economic variables. Simmons et al. (1986) discuss two approaches for deriving such a model. One can initially assume that the future marginal productivity of additional members of the labor force will be zero and that future births will have the effect of reducing per capita consumption. Any birth prevented raises future per capita consumption for other members of the population. Therefore total benefits are the discounted present values of future gains in consumption.

A second assumption allows for a slightly more complex interaction, including the possibility that the future marginal productivity of added labor force members may be positive. Thus, future GNP may be slightly lower if fewer births occur. This must be offset against consumption benefits in calculating net benefits of births prevented. Two additional interactions can also be allowed for: (a) a reduction in the savings rate due to lowered per capita income accompanying rapid population growth and (b) the possible effect of increased population leading to greater technical change and hence more rapid economic growth. Other assumptions could be added but this exercise is already highly conjectural since no data for Bangladesh are available on these linkages.

Table 4 summarizes the resulting values per birth prevented for these various assumptions. The range is from 10,000 Taka to 20,000 Taka. Thus, under the least pessimistic assumptions (and using the relatively high discount rate of 15 percent to convert future to present BPs) the economic benefit of preventing a birth is over 10,000 Taka, or roughly 3 times current per capita income.

(3) Measuring Costs

Simmons, et al., (1986) reviewed the difficulties of arriving at definitive totals for the actual expenditures on family planning in Bangladesh. The majority of family planning program expenditures are donor-funded. However, some establishment costs are covered from the Government Revenue Budget. There are also non-Annual Development Plan inputs from donors directly to NGO's for projects and centrally allocated supplies that are not reflected in BDG accounts. The total BDG and NGO budget allocations for family planning was $52.7 million in 1983 and $56.8 million in 1984.

(4) The Benefit-Cost Ratio

From estimates of total births prevented and the value of each birth prevented it is possible to estimate total program benefits. Table 5 presents these results. The ratios for the three years considered are highly favorable, averaging 8 to 1.

Table 4

Alternative Estimates of the Value of a Birth Prevented
Discount Rate = 15%, Values in Taka

ASSUMPTION	VALUE OF A BIRTH PREVENTED
A. Effects on Per Capita Income:	
1. Pure Denominator Effect (INDEP)	15,570
2. Mixed Numerator and Denominator Effects:	
a) Population growth increases labor force and thus GNP (LAB FORCE).	12,309
b) Population growth discourages saving and thus decreases GNP (SAVING).	19,062
c) Population growth stimulates technological change	10,432
d) Combined 2a, 2b, and 2c effects.	10,664

Source: Simmons, et al., p. 63.

Table 5

Benefit-Cost Calculation for the Bangladesh
Family Planning Program, 1982 - 1985

	Adjusted BP (thousand)	Value of BP (Tk.)	Total Benefits (million Tk.)	Total Expenditure	Benefit /Cost
1982	8226	10,000	8,226	869	9.46
1983	9111	10,000	9,111	1,261	7.23
1984	1,3943	10,000	13,943	1,492	9.14
1985	967.2	10,000	9,672	1,512	6.40

The cost-benefit situation of the 1987-91 FPHSP is expected to be similar to that of previous years. A rough cost-benefit calculation yields the following:

(a) In 1991, 40 percent of an estimated 23 million couples will be contracepting (or roughly 9.2 million couples).

(b) Assuming 3.5 CYPs equals one BP, then 2.6 million BPs will result.

(c) Assuming one BP equals 10,000 Taka, then total annual 1991 benefits are 26 billion Taka.

(d) The official BDG estimate in the Third Five Year Plan is that 9.4 billion Taka (US $293 million) will be spent during the Third Five Year Plan period 1985-90 on FP, or roughly 1.9 billion Taka (US$58.5 million) per year on average.

(e) Even allowing for another 1 billion per year for the non-budgeted inputs from USAID (direct commodities, SMP, NGO's, etc) and other donors, the resulting overall cost-benefit ratio is still on the order of 8 to 1, an estimate similar to the 1982-1985 calculations.

(5) Cost-Effectiveness Analysis

The Simmons Report also undertook an extensive cost-effectiveness analysis (CEA) of the major sub-components of the overall program. The three sub components compared were: (1) NGOs; (2) SMP; and (3) the BDG program (the residual effect). The cost and performance (or output) in terms of CYPs and BP's were estimated for each of the three sub-components and a cost per unit measure derived for 1982 and 1983.

In deriving separate measures of output and costs, certain issues should be taken into account. The most important are as follows :

a. The SMP has no independent estimate of the actual number of persons buying and using its products. The CYPs (and BPs) attributed to SMP are, therefore, derived by assuming a per client use rate for products and dividing this figure into total products distributed to obtain total clients per year (as CYPs). In this analysis the assumed use-rate is 250 condoms and 14 pill cycles per year per client. (As noted previously, Laing and Walker have recommended a lower estimate of 180 condoms per CYP). The 250 condoms per client estimate might appear high since coital frequency has been estimated at 150 per couple per year. The 250 figure is intended to allow for

other factors arising from the difference between the number of condom users obtained by the 1983 Contraceptive Prevalence Survey (2.7 percent of eligible couples or 400,000 users in 1983) and estimates derived from SMP distribution figures(1). Laing and Walker suggest that several factors explain most of this so-called "gap": condom use under-reporting by couples; wastage and loss; non-marital use (chiefly prostitutes); and minor non-contraceptive use. Allowing for these factors approximately doubles the number of condoms which must be distributed to achieve one CYP;

b. Some NGO's frequently refer clients to government clinics and hence get no credit for the output, although they bear some of the field costs leading to the adoption of family planning;

c. NGO's have worked chiefly in urban areas where travel costs are lower, density higher and hence unit costs on average lower;

d. NGO's also receive some administrative support and assistance from the government;

e. The SMP expends considerable resources on media advertising of family planning which creates demand for program components other than SMP products.

These problems might require adjustments in the costs and/or outputs attributed to the three sub-components. It is not unreasonable to assume that items (b) through (d) are largely off-setting and that no adjustment is needed. Item (e) remains an imponderable. SMP probably has generated greater NGO and BDG program performance, but there is no reliable estimate of this input.

Under the assumptions made by the CEA exercise, the principal USAID-funded elements - NGOs and SMP - appear to be cost-efficient compared to the BDG (residual component). For 1983, cost efficiency estimates of three program components were as follows: $67.67 per BP for the BDG Program, $ 51.25 per BP for SMP, and only $ 31.86 per VP for NGO programs. The

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1/ Laing and Walker (1986) have questioned the 1983 estimate of the number of eligible couples estimated by Simmons et al. employed to estimate the number of condom users. The 1983 CPS derived an estimate of 18.3 million eligible women (recommended by Laing and Walker) while Simmons et al. employed a BDG Planning Commission estimate of 15.4 million. Using the lower BDG estimate places the SMP program at some disadvantage since SMP is the major distributor of condoms in Bangladesh.

relative cost efficiency of NGO programs can be partly attributed to the high use effectiveness of vasectomy and tubectomy. These methods constitute a significant proportion of NGO service delivery. The SMP program, which has been primarily oriented to the sale of condoms (a method of relatively low use effectiveness) can therefore be expected to be less efficient than the NGO sector. In addition, the BDG and SMP programs are concentrated in rural areas (as opposed to most NGO services that are urban based). Given the higher logistical costs of delivering FP/MCH services in rural areas, it is not surprising that BDG and SMP cost efficiency estimates are somewhat unfavorable relative to NGO estimates.

2. Maternal and Child Health

Official BDG estimates indicate that the infant mortality rate has fallen from 150 to 125 in the last 6 to 8 years and that the incidence of numerous infant and childhood diseases has been reduced. The crude death rate has reportedly declined from 15.0 to 13.0 per thousand, implying 200,000 fewer deaths annually. However, there is considerable uncertainty regarding the quality of BDG mortality estimates. The national level and trend in mortality in recent years is essentially unknown. Therefore, no calculation of the cost and benefit of past MCH activities in terms of deaths prevented is advisable.

It is also impossible to divide any overall mortality decline into a USAID program component (as is possible for family planning outputs). The same situation applies to future MCH achievements under the FPHSP. Problems of joint cost and multiple causation will make measuring individual agency outputs impossible.

The ultimate benefit of MCH activities (i.e. reduction in infant, child and maternal morbidity and mortality) defies easy economic quantification. The purely economic value of a human life is sometimes taken to be the discounted present value of lifetime productivity minus lifetime consumption requirements. This measure of the value of a human life is probably low in Bangladesh. Such a calculation, which would suggest that it is uneconomic to save lives, is at best irrelevant.

The USAID MCH Strategy guidelines state that cost benefit analysis is not required to justify MCH activities. Cost effectiveness analysis is possibly useful for maximizing the impact of a given USAID expenditure on MCH activities, but research is only now attempting to identify relevant variables (performance measures and key inputs) in the Bangladesh program. One important future activity will be to construct a better statistical baseline and develop monitoring and evaluation procedures for assessing the impact of MCH activities.

ANNEX K

DATA COLLECTION, MONITORING, AND EVALUATION PLAN

The Family Planning and Health Services Project (FPHSP) will undertake a wide array of monitoring and evaluation activities during the period 1987-1991. A major element of the FPHSP Evaluation Plan will consist of quarterly and annual reviews of BDG, NGO and SMP program performance. BDG and NGO performance reports (provided monthly by the MIS Unit at the MOHFP) and various survey instruments will be utilized in preparing these reviews. Periodic monitoring activities will include (1) qualitative review of progress in attaining program objectives, (2) analysis of administrative and managerial efficiency, (3) assessment of cost effectiveness in program implementation and (4) appraisal of technical capabilities.

More comprehensive external evaluations of the FPHSP will be conducted at the "mid-term" of the project (during 1989) and at least six months prior to the conclusion of the project (early 1991). These in-depth evaluations will assess performance in relation to the original stated purpose of the project, provide recommendations for the successful completion of the project and determine long-term "follow-on" needs for population and health assistance in Bangladesh.

The principal evaluation mechanism for the FPHSP will be the measurement of levels and trends in fertility, morbidity, mortality, and contraceptive prevalence over the 1987-91 project period. During 1987, USAID plans to sponsor a contraceptive prevalence survey, a national fertility and mortality survey (to be conducted as part of the 1987 CPS) and an ORT treatment rate and childhood mortality survey focusing on the use of oral rehydration therapy (1). Survey results should be available by mid-1988, with findings serving as baseline measures to assess program performance.

In 1989, another contraceptive prevalence survey will be undertaken to measure family planning performance at the mid-point of the FPHSP implementation period. 1989 CPS estimates are scheduled to be available by mid-1990. This survey should provide clear guidance as to whether FPHSP prevalence objectives can be attained by the end of 1991.

1/ The 1987 CPS has been funded under the 1981-86 Family Planning Services Project (FPSP)

The final evaluation of the FPHSP will be conducted utilizing results from the 1991 contraceptive prevalence survey which, as in 1987, will be coupled with a national fertility and mortality survey measuring change in basic demographic parameters between 1987 and 1991. The ORT treatment rate and childhood mortality survey undertaken in 1987 will also be repeated in 1991 in order to assess progress in promoting effective knowledge and use of ORT, increasing ORT treatment rates and lowering morbidity and mortality levels in the under five population.

1. Users of the Information: The major users of information generated by the FPHSP Evaluation Plan will be the Family Planning and Health Wings of the MOHFP, the MIS Unit at the MOHFP, the Population Development and Evaluation Unit of the Planning Commission, NGO and SMP project managers, and relevant program officers at USAID and other donor organizations (e.g. the World Bank, UNFPA and UNICEF) that support segments of the family planning and MCH program in Bangladesh.

2. Institutional Locus: An important goal of the FPHSP will be to strengthen data collection, analysis and policy formulation capabilities in Bangladesh. While the major evaluation studies for the FPHSP will be contracted to private survey research organizations following competitive bidding, USAID is concerned that public sector institutions engaged in basic data collection and research on population and health issues be encouraged and further strengthened. USAID will follow a pluralistic strategy with regard to supporting research studies in Bangladesh; namely, by providing assistance to BDG institutions such as the MOHFP, the Planning Commission, and the Bangladesh Bureau of Statistics while, at the same time, creating opportunities for private sector organizations (including professional university personnel) to become more active in the collection, analysis and dissemination of information central to the future development of Bangladesh.

3. Project Goal, Purpose, Output Questions, Indicators and Data Collection Methodologies?

A. Project Goal: The goal of this project is to reduce current high levels of fertility and mortality that inhibit rapid and sustained development in Bangladesh.

1. Goal-Level Questions: (1) What level of fertility will be attained by 1991? (2) To what extent will infant, child and maternal mortality decline between 1987 and 1991? (3) What will be the average life expectancy in Bangladesh by 1991? (4) Will Bangladesh succeed in significantly reducing its rate of population growth by the end of the project period?

2. Indicators: The following demographic indicators will be employed to measure success in achieving the overall goal of the FPHSP.

Indicator	1986 Status	1991 Objective
Total Fertility Rate	5.6	4.8
Crude Birth Rate	38.9	35.6
Crude Death Rate	14.9	13.5
Annual Growth Rate	2.4	2.2
Infant Mortality Rate	128	123
Child Mortality Rate	24	21
Maternal Mortality Rate	6	5
Life Expectancy	52	53

3. Data Collection Methodology: Demographic and health measures of program performance will be obtained primarily from the 1987 and 1991 fertility and mortality surveys that will be implemented in conjunction with the 1987 and 1991 CPS surveys. These surveys will contain complete maternity histories (the first full maternity histories to be collected in Bangladesh since the 1976 World Fertility Survey) and questions that will allow for the direct and indirect measurement of infant, child and adult mortality (e.g. questions on widowhood and orphanhood). Additional health status information relating to children and mothers (e.g., on breastfeeding patterns, nutritional status, post-partum infecundability, and secondary sterility) will also be considered for possible inclusion in these inquiries. The ORT treatment rate and childhood mortality surveys will also be utilized in measuring trends in health conditions in the under five population. Demographic levels and trends may also be assessed through MIS service statistics, BBS census records, NGO and SMP performance data and internal and external USAID sub-project monitoring reports.

B. Project Purpose: The purpose of this project is to improve the coverage and quality of family planning and other MCH services in Bangladesh. The FPHSP aims to increase the contraceptive prevalence rate to 40 percent of all eligible couples by 1991 (from 29.8 percent in 1986). Emphasis will be placed on promoting prolonged duration of modern method use and increasing the number of ever-users in the program. This achievement will be largely dependent upon improvements in client/worker ratios and the expansion of domiciliary FP/MCH service delivery through the fielding of additional Family Welfare Assistants (FWAs). However, consideration will also be given to mechanisms that may stimulate greater awareness and demand for FP/MCH services (e.g., female secondary school scholarships and programs that promote greater labor force participation for women). The FPHSP will also strive to achieve significant gains in treatment rates for oral rehydration therapy and coverage rates for infant and maternal immunization services in the four major urban municipalities of Bangladesh.

1. Purpose-Level Questions: (1) To what extent will contraceptive prevalence among eligible women and couples increase between 1987 and 1991? (2) Will national treatment rates for ORT reach 60 percent by 1991? (3) Will coverage rates for infant and maternal immunization services in urban areas reach 65 and 60 percent respectively by the end of the project period? (4) What client/worker ratios for FP/MCH service delivery will be achieved with the addition of 10,000 FWAs and the extension of female NGO workers in the rural areas? (5) Based upon evaluation research findings, what new policy and program initiatives could be recommended for implementation that might stimulate greater demand for FP/MCH services and enhance the status of women in Bangladesh?

2. Indicators: The following indicators (and quantified objectives) will be used in evaluating the purpose of the FPHSP. (TBE = to be established).

Indicator	1986 Status	1991 Objective
Contraceptive Prevalence Rate (Percent of Eligible Couples Using Modern and Traditional Methods of Contraception)	29.8%	40%
ORT Treatment Rate (Percent of Diarrhoeal Cases Treated with ORT)	20%	60%

Effective Use of ORT (Percent of Diarrhoeal Cases in which ORT Appropriately Administered)	TBE	75%
Coverage Rate of Infant Urban Immunization Services (Percent of Infants Aged 0-1 Immunized Against Major Childhood Diseases in Dhaka, Khulna, Chittagong and Rajshahi)	5%	65%
Coverage Rate of Maternal Urban Immunization Services (Percent of Women Aged 15-45 Immunized Against Tetanus in Dhaka, Khulna, Chittagong and Rajshahi)	3%	60%

3. Data Collection Methodology: Trends in contraceptive prevalence over the 1987-91 project period will be measured by biennial CPS surveys consisting of 200 sample areas (120 rural and 80 urban) in which a total of approximately 10,000 households will be interviewed. As in past years, the CPS will collect information on knowledge of family planning methods, ever use and current use of contraception, source of supply for services, unmet demand for contraception, duration of use and reasons for non-use. Data on current and retrospective fertility and infant and child mortality will continue to be collected by the CPS, although in 1987 and 1991 the main source for such information will be the planned national fertility and mortality surveys to be implemented in conjunction with the CPS.

Estimates of national ORT treatment rates will be derived from the 1987 and 1991 ORT treatment rate and childhood mortality surveys to be conducted under the auspices of the Social Marketing Project. 8,400 women will initially be interviewed (in both rural and urban areas) to establish the incidence of recent diarrhoeal episodes (within 2 weeks preceding the survey) and ORT treatment patterns. Coverage rates for the urban immunization program and client/worker ratios for FP/MCH fieldworkers will be established through MOHFP and NGO service statistics and Bangladesh Bureau of Statistics census records (including results from the recently completed 1986 Economic Census).

C. Project Outputs: The major outputs of the project will consist of (1) increased demand for a full range of FP/MCH services (especially birth spacing methods), (2) improved access to quality FP/MCH services in rural and urban areas of Bangladesh (including more cost effective utilization of retail outlets and private sector social marketing techniques for delivery of contraceptives and ORS), (3) better trained and more effective fieldworkers and administrators in BDG and NGO program implementation, (4) greater cooperation of BDG and NGO fieldworkers in the delivery of FP/MCH services, (5) a more effective logistics system for procuring and distributing contraceptives and related commodities, (6) an expanded role for elected leaders, concerned citizens and local groups in establishing goals and policies for FP/MCH service delivery at the local level, and (7) enhanced capacity to undertake data collection, monitoring and evaluation research on population and health issues in Bangladesh.

1. Output Level Questions: Major output level questions include the following: (1) How has the level of unmet demand for contraceptive services changed over time in Bangladesh? (2) Have family planning and MCH services become more readily available throughout Bangladesh (either through BDG, NGO or SMP program sources)? (3) Has the quality of FP/MCH service delivery improved over the project period (in terms of the frequency and quality of client/worker contacts, the availability of a broad contraceptive method mix at household and clinic levels and the enhanced quality of clinical procedures)? (4) Have essential contraceptives and other commodities been supplied on time and in sufficient quantity during the project period? (5) Have indigenous demographic and health research capabilities been strengthened over the project period? (6) To what extent have population policy and planning capabilities in Bangladesh been strengthened over the project period?

2. Output Indicators: The following output indicators will be employed to measure achievement of FPHSP objectives: (TBE = to be established)

Indicator	1986 Status	1991 Objective
Contraceptive Prevalence Rate	29.8%	40%
Municipal Immunization Coverage	5% Infants 3% Mothers	65% Infants 60% Mothers

ORT Treatment Rate (Percent of all Diarrhoeal Cases Treated)	20%	60%
Unmet Demand (the Proportion of Women who say they do not want any more Children and are not using any form of Contraception)?	31%	20%
Verified Household Visits Per FWA Per Month	TBE	20% Increase
Operating Costs associated with Retail Sales of Condoms, Pills and ORS Packets	TBE	20% Decline
Number of Upazilas with Formal or Semi-Formal Agreements for Cooperation between BDG and NGO Organizations	TBE	30
Supply Time Horizon (Months) for Essential Contraceptives and Other Commodities	12	18
Data Collection, Monitoring and Research Activity Supported by FPHSP (1987-91):		
Local Senior Professionals	5	25
Mid-Junior Level Personnel	20	50

3. Data Collection Methodologies: Project outputs will be evaluated primarily through the same instruments used to assess the project goal and purpose; namely, biennial CPS surveys, fertility/mortality surveys, ORT treatment rate and childhood mortality surveys, MIS service statistics, BBS census records, and NGO/SMP program performance data and USAID sub-project monitoring reports.

IV. Special Studies: USAID will be assisting the MIS Unit at the MOHPP in improving the quality of FP/MCH service statistics, including the installation of a simplified FP/MCH reporting system that will increase the quality and timeliness of data and reduce the administrative work load of fieldworkers. Support will also be provided to the Population Development and Evaluation Unit (PDEU) of the Planning Commission in order to strengthen BDG capabilities in population and development planning (including the

establishment of national program objectives in family planning and MCH for the Fourth Five Year Development Plan). A central focus of the research studies to be implemented by the PDEU will relate to the issue of demand for FP/MCH services within various social and economic settings in Bangladesh. The FPHSP may also provide modest technical assistance to the Bangladesh Bureau of Statistics in order to assess the reliability of demographic statistics generated by the Vital Registration System (VRS) and field test the feasibility of incorporating innovations utilized in the ICDDR,B Sample Registration System (SRS) as permanent elements of the VRS program.

The FPHSP will also assist private sector evaluation and research efforts over the period 1987-91. Continued support will be given to the ICDDR,B FP/MCH Extension Project which, among other activities, will study fertility and mortality trends in Aboynagar and Sirajgang Upazilas resulting from the introduction of new FP/MCH service delivery strategies in the MOHFP system. The University Research Corporation (URC) will be undertaking operations research to assess means of improving the efficiency of BDG and NGO FP/MCH service delivery strategies. Issues to be addressed by URC include establishment of family planning worker quality-of-care performance measures, the effectiveness of management innovations (involving NGO work planning, record-keeping and client-worker relations) and time-use analysis of FWA work routines. The FPHSP will also provide support to NGOs in order to measure contraceptive prevalence levels and trends in NGO sub-project areas.

The Social Marketing Project (SMP), as host institution for the two national childhood ORT treatment rate and childhood mortality surveys mentioned previously, will generate 1987 (baseline) and 1991 estimates of the incidence of diarrhoeal and dysenteric disease, the knowledge and use of oral rehydration therapy, and the effectiveness of ORT in reducing infant and child mortality. This information will provide a partial assessment of the success of SMP efforts to distribute ORT packets commercially and promote greater awareness and effective use of ORT. SMP will also undertake several research studies on the sale and distribution of contraceptives in Bangladesh. A contraceptive product market segmentation study will be undertaken to provide information on the demographic and behavioral characteristics of SMP customers and an analysis of retail store audits and "consumer intercept interviews" to provide information about consumer purchasing habits. Additional studies will determine whether to include a progesterone only pill in the SMP product line and how to more effectively target consumer groups in mass media motivational campaigns.

During the 1987-91 project period, quarterly audits of the voluntary sterilization and IUD payment programs will be continued (assuming that currently suspended VS payments are reinstated in the future). These quarterly audits serve to monitor levels of compensation payments in relation to VS prevalence and the socio-economic characteristics of sterilization clients.

Additional data collection, monitoring, and evaluation activities may be developed and recommended for implementation as part of the 1987-91 FPHSP. For example, USAID may study the feasibility of implementing an "early warning" national morbidity and mortality surveillance system similar to those currently being established in several sub-Saharan African countries. Such a system could conceivably monitor short-term regional fluctuations in the prevalence of disease (including the outbreak of major diarrhoeal and dysenteric epidemics), nutritional levels, and treatment rates for various health interventions.

V. Feedback: Evaluation research reports supplied by local contractors will be carefully reviewed by USAID to ensure that data is reliably collected, responsibly analyzed and effectively disseminated to the users identified in Section I. Efforts will be made to see that research findings are presented in a timely and concise manner that allows for their ready incorporation in program evaluation activities (including internal USAID quarterly, annual, mid-term and final impact evaluations) and policy analysis oriented to the design of future family planning and MCH programs. In order to facilitate more effective dissemination of evaluation research findings, in-country seminars and workshops will be sponsored during the project period and opportunities will be provided for local researchers to present their study results in appropriate international forums.

VI. Budget: The total budget for data collection, monitoring and evaluation activities is $14.710 million (or 8.3 percent of the total 1987-91 FPHSP budget). Individual budget components are shown below:

	Activity	Budget (US$ million)
1.	Contraceptive Prevalence and Fertility/Mortality Surveys	1.67
2.	Clinical Services Monitoring	1.35
3.	Strengthening MIS	.75
4.	Population and Development Planning	.58
5.	Research on New Contraceptive Methods and Improved Service Delivery	.22
6.	ICDDR,B MCH/FP Extension Project	4.62
7.	Population Council Assistance to the Extension Project	2.36
8.	Operations Research and Diagnostic Studies	1.63
9.	IEC Evaluation Research	.63
9.	Technical Resources, Research and Training (TRRT)	.90
	Total	14.71

VII. Evaluation Schedule: The schedule for major survey research activities under the FPHSP is as follows:

	Activity	Implementation Date	Completion Date
1.	1987 Contraceptive Prevalence Survey	12/87	9/88
2.	1989 Contraceptive Prevalence Survey	12/89	9/90
3.	1991 Contraceptive Prevalence Survey	12/91	9/92
4.	1988 Fertility and Mortality Survey	2/88	12/88

5.	1992 Fertility and Mortality Survey	2/92	12/92
6.	1987 ORT Treatment Rate and childhood Mortality Survey	3/87	12/87
7.	1991 ORT Treatment Rate and childhood Mortality Survey	3/91	12/91
8.	FWA Time-Use Study	6/87	12/87
9.	Family Planning Quality of Care Performance Measure Study	2/87	10/87
10.	Voluntary Sterilization and IUD Quarterly Surveillance Surveys*	On-Going By Quarter	On-Going

* The current IUD annual survey will be converted to a quarterly survey and linked with the voluntary sterilization surveillance exercise.

ANNEX L

BANGLADESH
FAMILY PLANNING & HEALTH SERVICE PROJECT

CERTIFICATION PURSUANT TO SECTION 611 (E) OF THE FOREIGN ASSISTANCE ACT OF 1961, AS AMENDED

I, John R. Westley, Mission Director, the principal officer of the Agency for International Development in Bangladesh, having taken into account, among other things, the maintenance and utilization by the Bangladesh Government and its agencies of similar projects previously financed by the United States, do hereby certify that in my judgment Bangladesh has the financial and human resources capability to utilize effectively the project to be financed by this grant.

The judgment is based upon considerations discussed in the Project Paper to which this certification is attached.

John R. Westley
Mission Director

3/30/87
Date

PROJECT NO. 388-0071

5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable generally to FAA Funds, and criteria applicable to individual fund sources: Development Assistance and Economic Support Fund.

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FAA Sec. 481(1); FY 1987 Continuing Resolution Sec. 526. Has it been determined or certified to the Congress by the President that the government of the recipient country has failed to take adequate measures or steps to prevent narcotic and psychotropic drugs or other controlled substances (as listed in the schedules in section 202 of the Comprehensive Drug Abuse and Prevention Control Act of 1971) which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States Government personnel or their dependents or from entering the United States unlawfully? No.

2. FAA Sec. 481(h)(4). Has the President determined that the recipient country has not taken adequate steps to prevent (a) the processing, in whole or in part, in such country of narcotic and psychotropic drugs or other controlled substances, (b) the transportation through such country of narcotic and psychotropic drugs or other controlled substances, and (c) the use of such country as a refuge for illegal drug traffickers? No. No. No.

3. FAA Section. 620(c). If assistance is to a government, is the government liable as debtor or unconditional guarantor on any debt to a U.S citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) the debt is not denied or contested by such government? No.

4. FAA Sec.620(e)(1). If assistance is to a government, has it (including government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities? No.

5.	FAA Sec. 620(a), 620(f), 620D; FY 1987 Continuing Resolution Sec. 512. Is recipient country a Communist country? If so, has the President determined that assistance to the country is important to the national interests of the United States? Will assistance be provided to Angola, Cambodia, Cuba, Iraq, Syria, Vietnam, Libya, or South Yemen? Will assistance be provided to Afghanistan without a certification?	No. N/A No. No.
6.	FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction by mob action of U.S. property?	No.
7.	FAA Sec. 620(l). Has the country failed to enter into an agreement with OPIC?	No, OPIC Agreement signed January 15, 1975.
8.	FAA Sec. 620(o): Fishermen's Protective Act of 1967, as amended, Sec. 5. (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made?	a) No. b) N/A
9.	FAA Sec. 620(q); FY 1987 Continuing Resolution Sec. 518. (a) Has the government of the recipient country been in default for more than six months on interest or principal of any AID loan to the country? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the appropriation bill (or continuing resolution) appropriates funds?	a) No. b) No.
10.	FAA Sec. 620(s). If contemplated assistance is development loan or from Economic Support Fund, has the Administrator taken into account the amount of foreign exchange or other resources which the country has spent on military equipment? (Reference may be made to the annual "Taking Into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)	N/A

11. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have they been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption? — No. N/A

12. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears were such arrearages taken into account by the AID Administrator in determining the current AID Operational Year Budget? (Reference may be made to the Taking Into Consideration memo.) — Not in arrears.

13. FAA Sec. 620A. Has the government of the recipient country aided or abetted, by granting sanctuary from prosecution to, any individual or group which has committed an act of international terrorism? — No.

14. ISDCA of 1985 Sec. 552(b). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures? — No.

15. FAA Sec. 666. Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA? — No.

16. FAA Secs. 669, 670. Has the country, after August 3, 1977, delivered or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.) — No. No.

17. FAA Sec. 670. If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported illegally (or attempted to export illegally) from the United States any material, equipment, or technology which would contribute significantly to the ability of such country to manufacture a nuclear explosive device? — No.

18. ISDCA of 1981 Sec. 720. Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. of Sept.25 and 28, 1981, and failed to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the Taking into Consideration memo.) No.

19. FY 1987 Continuing Resolution Sec. 540.

Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? No.

Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilization? No.

Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? No.

20. FY 1987 Continuing Resolution, Title II, Population.

If the assistance being made available to any organization or program which has been determined as supporting or participating in the management of a program of coercive abortion on involuntary sterilization? No.

If assistance is from the population functional account, are any of the funds to be made available to family planning projects which do not offer, either directly or through referral to or information about access to, a broad range of family planning methods and services? No.

21. FY 1987 Continuing Resolution Sec. 528. Has the recipient country been determined by the President to have engaged in a consistent pattern of opposition to the foreign policy of the United States? No.

22. FY 1987 Continuing Resolution Sec. 513. Has the duly elected Head of the Government of the country been deposed by military coup or decree? No.

B. FUNDING SOURCE CRITERIA FOR COUNTRY ELIGIBILITY:

1. Development Assistance Country Criteria.

FAA Sec. 116. Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights?	No.
If so, can it be demonstrated that contemplated assistance will directly benefit the needy?	N/A

2. Economic Support Fund Country Criteria:

FAA Sec. 502B. Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the country made such significant improvements in its human rights record that furnishing such assistance is in the national interest?	N/A

PROJECT NO. 388-0071

5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A. includes criteria applicable to all projects. Part B. applies to projects funded from specific sources only: B.1. applies to all projects funded with Development Assistance loans, and B.3. applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? a) Yes.
HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT? b) Yes.

A. GENERAL CRITERIA FOR PROJECT

1. FY 1987 Continuing Resolution Sec. 523, FAA Sec. 634A.

   Describe how authorizing and appropriations committees of Senate and House have been or will be notified concerning the project.

   Congressional Notification will be made before obligation.

2. FAA Sec. 611(a)(1). Prior to obligation in excess of $500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

   (a) Yes.
   (b) Yes.

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

   Not required.

4. FAA Sec. 611(b); FY 1987 Continuing Resolution Sec. 501. If for water or water-related land resource construction, has project met the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See AID Handbook 3 for new guidelines.)

   N/A

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?

   Yes, 611(e) certification is attached to PP.

6.	FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.	No.
7.	FAA Sec. 601(a). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; and (c) encourage development and use of cooperatives, and credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.	(a) N/A (b) Approximately one-half of the project operates in the private or nongovernment sectors. (c) N/A (d) Contracts will be competitively let. (e) The Social Marketing Project promotes village-level commerce in contraceptives, ORS, and Safe Birth Kits, which will have positive effects on other forms of local commerce. (f) N/A
8.	FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).	N/A
9.	FAA Secs. 612(b), 636(h); FY 1987 Continuing Resolution Sec. 507. Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.	The host country will contribute salaries, facilities and operating expenses during project implementation. The BDG uses its own resources to support the MOHFP.
10.	FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?	No.
11.	FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?	Yes.
12.	FY 1987 Continuing Resolution. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?	N/A

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13. FAA Sec. 118(c) and (d). Does the project comply with the environmental procedures set forth in AID Regulation 16? Does the project or program take into consideration the problem of the destruction of tropical forests?

a) Yes.

b) N/A

14. FAA Sec. 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated therefrom)?

N/A

15. FY 1987 Continuing Resolution Sec. 532. Is disbursement of the assistance conditioned solely on the basis of the policies of any multilateral institution?

No.

16. ISDCA of 1985 Sec. 310. For development assistance projects, how much of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

USAID/Bangladesh will make efforts to provide that a substantial proportion of technical assistance contracts are let to minority (Gray Amendment) firms through the 8(a) and IQC processes.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria:

a. FAA Secs. 102(a), 111, 113, 281(a). Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; (e) utilize and encourage regional cooperation by developing countries?

(a) Beneficiaries of the project are primarily the rural poor and women. The Social Marketing Program is extending its commercial influence opportunities to the village level. Also the Upazila initiative will involve local officials in population program development and management.
(b) N/A
(c) Self-help plays a major role in subprojects and in the new Upazila In .iative.
(d) As this is intended to increase family planning and material/child health, the participation of women at all levels will be critical.
(e) The training of Bangladeshi Upazila officials in Indonesia will foster regional cooperation.

b. FAA Sec. 103, 103A, 104, 105, 106. Does the project fit the criteria for the type of funds (functional account) being used?	Yes, Sec. 104
c. FAA Sec. 107. Is emphasis on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?	Yes.
d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?	Yes.
e. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?	Yes.
f. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?	Yes.
g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.	(a) Family Planning-MCH services are critically needed in Bangladesh and desired by both the govt. and the rural & urban poor. (b) Institutional development will take place at the MOHFP, the Social Marketing Program and at indigenous non-governmental organizations. (c) N/A.
2. Development Assistance Project Criteria (Loans Only):	
a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan, at a reasonable rate of interest.	N/A

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan? N/A

3. Economic Support Fund Project Criteria:

a. FAA Sec. 531(a). Will this assistance promote economic or political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of part I of the FAA? N/A

b. FAA Sec. 531(c). Will assistance under this chapter be used for military, or paramilitary activities? N/A

c. ISDCA of 1985 Sec. 207. Will ESF funds be used to finance the construction of, or the operation or maintenance of, or the supplying of fuel for, a nuclear facility? If so, has the President certified that such country is a party to the Treaty on the Non-nonproliferation of Nuclear Weapons or the Treaty for the prohibition of Nuclear Weapons in Latin America (the "Treaty of Tlatelolco"), cooperates fully with the IAEA, and pursues nonproliferation policies consistent with those of the United States? N/A

d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? N/A

PROJECT NO. 388-0071

5C(3) - STANDARD ITEM CHECKLIST

Listed below are the statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. PROCUREMENT

1. FAA Sec. [illegible]: Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? Yes.

2. FAA Sec. 604(a) Will all procurement be from the U.S. except as otherwise determined by the President or under delegation from him? Yes.

3. FAA Sec. 604(d). If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company? Yes.

4. FAA Sec. 604(e); ISDCA OF 1980 Sec. 705(a). If offshore procurement of agricultural commodity or product is to be financed, is there provisions against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.) N/A

5. FAA Sec. 604(g). Will construction or engineering services be procured from firms of countries which receive direct economic assistance under the FAA and which are otherwise eligible under Code 941, but which have attained a competitive capability in international markets in one of these areas? No.
   Do these countries permit United States firms to compete for construction or engineering services financed from assistance programs of these countries? N/A

6. FAA Sec. 603. Is the shipping excluded from compliance with requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and

tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? — No.

7. FAA Sec. 621. If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? If the facilities of other Federal agencies will be utilized, are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? — a) Yes. b) N/A

8. International Air Transport. Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available? — Yes.

9. FY 1987 Continuing Resolution Sec.504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? — Yes, such clauses are routinely inserted in all A.I.D.-direct contracts under the FAR.

B. CONSTRUCTION

1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services be used? — Yes.

2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? — Yes.

3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed $100 million (except for productive enterprises in Egypt that were described in the CP)? — N/A

C. OTHER RESTRICTIONS

1. FAA Sec. 122(b). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter? — N/A

2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? N/A

3. FAA Sec. 620 (h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? Yes.

4. Will arrangements preclude use of financing:

a. FAA Sec.104(f); FY 1987 Continuing Resolution Sec. 525: (1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization? (3) to pay for any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; (4) to lobby for abortion?

(1) Yes.
(2) Yes.
(3) Yes.
(4) Yes.

b. FAA Sec. 488. To reimburse persons, in the form of cash payments, whose illicit drug crops are eradicated? Yes.

c. FAA Sec. 620(g). To compensate owners for expropriated nationalized property? Yes.

d. FAA Sec. 660. To provide training or advice or provide any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? Yes.

e. FAA Sec. 662. For CIA activities? Yes.

f. FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? Yes.

g. FY 1987 Continuing Resolution, Sec.503. To pay pensions, annuities, retirement pay, or adjusted service compensation for military personnel? Yes.

h. FY 1987 Continuing Resolution, Sec.505. To pay U.N. assessments, arrearages or dues? Yes.

i. FY 1987 Continuing Resolution, Sec.506. To carry out provisions of FAA section 209(d) (Transfer of FAA funds to multilateral organizations for lending)? Yes.

j. FY 1987 Continuing Resolution, Sec.510. To finance the export of nuclear equipment, fuel, or technology? Yes.

k. FY 1987 Continuing Resolution, Sec. 511. For the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights? Yes.

l. FY 1987 Continuing Resolution, Sec.516. To be used for publicity or propaganda purposes within U.S. not authorized by Congress? Yes.

ANNEX N

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