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AN OVERALL EVALUATION OF THE USAID/
BANGLADESH FAMILY PLANNING SERVICES
PROJECT (388-0050), KEY ISSUES,
AND FUTURE ASSISTANCE

by

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ACRONYMS

| | |
|-------------|--|
| AID (AID/W) | U.S. Agency for International Development (Washington) |
| AVSC | Association for Voluntary Surgical Contraception |
| BACE | Bangladesh Association for Community Education |
| BAVS | Bangladesh Association for Voluntary Sterilization |
| BFPA | Bangladesh Family Planning Association |
| BFRP | Bangladesh Fertility Research Program |
| BPFH | Bangladesh Population and Family Health Project |
| CBD | Community-based distribution |
| CDC | Centers for Disease Control |
| CDR | Crude death rate |
| CIDA | Canadian International Development Agency |
| CPR | Contraceptive Prevalence Rate |
| CPS | Contraceptive Prevalence Survey |
| Cu-T | Copper-T (type of IUD) |
| CYP | Couple Years of Protection |
| FPCVO | Family Planning Council of Voluntary Organizations |
| FPHSP | Family Planning Health Service Project (Matlab) |
| FPIA | Family Planning International Assistance |
| FPSP | Family Planning Services Project |
| FPSTC | Family Planning Services and Training Center |
| FRG | Federal Republic of Germany |
| FWA | Family Welfare Assistant |
| FWVTI | Family Welfare Visitor Training Institute |
| GOB | Government of Bangladesh |

| | |
|---------|---|
| ICDDR,B | International Center for Diarrheal Disease Research, Bangladesh |
| IEC | Information, Education and Communication |
| IEM | Information, Education and Motivation |
| IMR | Infant Mortality Rate |
| IPPF | International Planned Parenthood Federation |
| IUD | Intrauterine Device |
| MCH | Maternal and Child Health |
| MIS | Management Information System |
| MOHFP* | Ministry of Health and Family Planning |
| NGO | Non-governmental organization |
| NIPORT | National Institute for Population Research and Training |
| ODA | Overseas Development Administration |
| PF | The Pathfinder Fund |
| PIACT | Program for the Introduction and Adaptation of Contraceptive Technology |
| PSI | Population Services International |
| PVO | Private Voluntary Agency |
| SIDA | Swedish International Development Authority |
| SMP | Social Marketing Project |

* As this evaluation came to an end, the Team was informed that the official title of the Ministry responsible for family planning had been changed from Ministry of Health and Population Control (MOHPC) to the Ministry of Health and Family Planning (MOHFP). Thus the new title is used throughout this report.

| | |
|-------|--|
| SRS | Sample Registration System |
| TAF | The Asia Foundation |
| TBA | Traditional Birth Attendant |
| TEMO | Training, Equipment and Maintenance Organization |
| TFR | Total Fertility Rate |
| UNFPA | United Nations Fund for Population Activities |
| USAID | United States Agency for International Development |
| VS | Voluntary Sterilization |
| VSST | Voluntary Sterilization Surveillance Team |
| WHO | World Health Organization |

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We were profoundly impressed with the cooperation, openness, and professional expertise we encountered in meeting with numerous population colleagues, both in Dhaka and the field. In the midst of their busy schedules, they provided us with data and insights without which our work could not have been done.

Writing at the time of the 15th anniversary of the liberation of Bangladesh, we are encouraged by the progress made in family planning, and are hopeful that the nation's number one problem will receive even greater priority in the coming years.

EXECUTIVE SUMMARY

1. The Evaluation

At the request of the U.S. Agency for International Development (USAID) mission in Bangladesh, the International Science and Technology Institute arranged for an overall evaluation of the Family Planning Services Project (FPSP) No. 388-0050, which has been providing support to the Government of Bangladesh (GOB) for its national population and family planning effort since 1981. The team selected for this undertaking included David A. Oot (team leader), Sallie Craig Huber, John Knodel, and Alan J. Margolis. The evaluation, carried out during the entire month of March 1986, was preceded by four other assessments of individual components of the FPSP--the non-governmental organization (NGO) programs, the Social Marketing Project (SMP), the Maternal and Child Health/Family Planning (MCH/FP) Extension Project of the International Center for Diarrheal Disease Research/Bangladesh (ICDDR,B), and the Female Secondary Education Project subprojects. The draft reports of these evaluations were used in the preparation of this overall evaluation.

The scope of work for the evaluation was divided into four parts as follows--an examination of project accomplishments, status of mid-term evaluation recommendations, key issues related to past and future assistance, and identification of future activities for USAID population assistance to Bangladesh. This scope of work was accomplished through a review of relevant documents, analysis of data, field visits, and interviews with selected individuals.

2. The Project

The original FPSP, funded in 1981 for a three-year period, provided support to three main components--the national program of the GOB; projects carried out by selected NGOs including the ICDDR,B; and the SMP. Amended in 1984, the project will now continue until 1987. The original purpose, to increase the contraceptive prevalence rate (CPR) from 13 to 25 percent, was revised with the amendment to reach a modern method CPR of 28 percent by the end of 1987. Elements supported by the FPSP include commodities, voluntary sterilization (VS) costs, contraceptive prevalence surveys (CPS), training, operations research, maternal and child health interventions, and the projects for service delivery carried out by NGOs.

3. Achievement of Demographic Goals

Despite an accelerated increase in the CPR over the past two years to approximately 19 percent (modern method) and 25 percent (all methods), it appears unlikely that the project goal of achieving a modern method CPR of 28 percent will be achieved. This conclusion is reached through a detailed analysis of 1983 and preliminary 1985 CPS data and a comprehensive review of GOB Management Information System (MIS) statistics. A rapid decline in VS procedures during the 18 months prior to the evaluation, without a concomitant significant increase in the acceptance of other methods, is identified as the primary reason for the potential shortfall in goal achievement. An analysis of the contribution of the three main components of the project reveals that the GOB continues to be the source of supply for most current contraceptive users. An accurate estimate of the relative contribution of SMP and the NGOs was not possible on the basis of available data.

4. Project Components

4.1 Ministry of Health and Family Planning (MOHFP)

USAID has provided major commodity support and has been generally successful in ensuring that adequate supplies of condoms, oral contraceptives, and surgical prerequisites needed for the VS program are in-country. While stock-outs of some items still occur, particularly at the periphery, major improvements in contraceptive planning, procurement, storage, and distribution have been made under the project. Storage and distribution at the upazila level and below remains a problem.

Access to and use of VS services has increased dramatically under the FPSP, with over 600 sites offering services in 1986. While 80 percent of the increase in contraceptive use between 1979 and 1983 was due to VS, preliminary data from the 1985 CPS suggest that between 1983 and 1985, only 40 percent of the increase in modern method use was due to sterilization. Demand is expected to stabilize at about the current level, and temporary method use is expected to increase. Unlike many other Muslim countries, the ratio of vasectomy to tubectomy cases in Bangladesh is currently about 1:1.

4.2 NGOs

Since 1981, there has been a major expansion of NGO activities, with more than 80 indigenous projects under way in nearly 300 sites. Through a combination of clinic and community-based service programs, NGOs now reach an estimated 15 percent of

the population. In some NGO-served community-based projects, contraceptive prevalence has risen to 45-50 percent.

In view of the need to coordinate closely with public sector programs to minimize duplication, it is recommended that the NGOs continue selectively to expand their coverage, focusing initially on underserved areas where relatively high levels of contraceptive prevalence have already been achieved.

4.3 SMP

Under the SMP, the number of outlets offering contraceptives has greatly increased. Sales of all methods have increased steadily since 1981, although a slight dip in condom sales was reported in 1985. Supporting the distribution system has been a major campaign to promote family planning, based on carefully prepared market research. SMP currently recovers about 30 percent of operating costs and 10 percent of overall costs.

Concern remains about an apparent leveling off of sales and about access by women to SMP retail outlets. A review of the current SMP strategy is recommended to determine how best to market SMP products, including strategies for more effectively reaching women. Efforts to document and enhance both use-effectiveness of SMP methods, and cost-effectiveness more generally, should be continued, especially in view of the apparent discrepancy between implied and reported use of pills and condoms. Finally, continued support of SMP is recommended, pending a thorough review and revision, as necessary, of the current strategy.

4.4 ICDDR,B

Under the MCH/FP project, ICDDR,B has been testing approaches to improving service delivery in large public programs. This high quality research is generating information which is feeding directly into the policy-making process in Bangladesh. A number of findings and recommendations have already been acted upon and others are under active consideration.

High priority is given to future support for this research activity, particularly with regard to increased emphasis on the transfer of lessons learned to other areas, in both the public and the private sectors.

5. Issues

A number of key programmatic issues were examined in some detail. Three specific areas deserve mention here: integration of government's health and family planning services; domiciliary service delivery; and the role of temporary services.

The 1980 decision to integrate health and family planning services has created unresolved problems that are having a generally negative impact on the program, primarily from the perspective of workers' morale, which in turn affects the delivery of services. This is especially the case at the upazila level and below.

Related to the integration issue, the importance of domiciliary service delivery cannot be overstated, given the difficulty Bangladeshi women have in seeking such services outside their homes. Thus, the need for a greatly increased field staff (especially females) is recommended.

Finally, the role, importance, and oftentimes preference for temporary methods is examined. There appears to be a large, and possibly growing, group of couples who say they want no more children but who wish to use non-permanent methods of contraception. Increased attention must be focused on reaching this group with quality information and services.

6. Status of Key Recommendations in the 1982 Evaluation

In regard to key recommendations made in the 1982 mid-term project evaluation, notable improvements have been made in commodity logistics and the quality and availability of VS services. Efforts to improve fieldworker training in the public sector have met with limited success, although a major commitment to upgrade this training is planned under the Third Five-Year Plan. Efforts to decentralize the administration of health and family planning service delivery have generally not materialized, and the Indonesia-based training in support of this was discontinued. Due in part to the decline in VS clients, there has been a marked shift in contraceptive method mix in favor of temporary methods since 1984.

7. Conclusions and Recommendations

In conclusion, it is recommended that primary attention should be given to supporting the efforts of the GOB to reduce the rate of population growth for the remainder of this project

period and into the future. USAID's primary focus should continue to be expansion and improvement in the delivery of family planning services, while continuing to encourage delivery of related MCH services, particularly through the NGOs. The various program elements and data examined in the course of the evaluation confirm that there is a significant receptivity to quality family planning services. This suggests that significant changes in demographic behavior are under way, and efforts to target specific subgroups in the population could result in substantially higher overall levels of contraceptive use.

USAID and the GOB are commended for the efforts and accomplishments to date in the FPSP. Enormous progress has been made in enhancing access to both clinical and non-clinical contraceptive services. That these accomplishments have taken place despite the changes in the structure and design of the program (e.g., integration) is remarkable. It is hoped that the program, with USAID support, will continue to build on the successes to date in making comprehensive family planning services widely available.

1. INTRODUCTION

1.1 Purpose of Assignment

This report was prepared at the request of the United States Agency for International Development (USAID) mission in Bangladesh. Its goal was to evaluate progress under the three-year amendment (1984-1987) to the Family Planning Services Project (FPSP) and to recommend follow-on activities to continue the Project's efforts to increase the contraceptive prevalence rate (CPR) in Bangladesh. A four-person team carried out the field work during March 1986.

1.2 Scope of Work

The original scope of work for the evaluation was divided into four parts: Project accomplishments, status of recommendations from the Mid-Term Evaluation (included as Appendix A), key issues related to past and future assistance, and identification of potential areas of future USAID population assistance to Bangladesh. Modifications in the original workscope were made based on suggestions provided by AID/W and the Evaluation Team. The modified workscope and methodology, as approved by the USAID Project Committee, is contained in Appendix B.

1.3 Evaluation Methodology

The evaluation methodology involved interviews, field observations (see Appendix C for list of Persons Interviewed and Sites Visited), analysis of selected data, and review of reports and other relevant Government of Bangladesh (GOB) and USAID documents. Assessment of purpose level accomplishment involved reviews of service statistics, Contraceptive Prevalence Surveys (CPS), and mini-surveys of prevalence conducted by selected non-governmental organizations (NGO). Analysis of project achievement at the output level was based on three recently completed evaluations of three major program components, supplemented by interviews of key project personnel and selected site visits. This accumulated research, together with discussions with some team members who had taken part in the evaluations, provided the basis for the discussion of key issues. The recommendations for future programming were developed after study of GOB's own plans and those of members of the donor community.

1.4 Country Profile

The following list of demographic and social characteristics provides a profile of the Bangladesh population (see Appendix F for further details).

Relevant Demographic and Social Data

| | |
|--|-----------------------|
| Population (mid-1985) | 100 million |
| Crude Birth Rate (USAID) | 41 per 1,000 |
| Crude Death Rate (USAID) | 17 per 1,000 |
| Rate of Natural Increase | 2.4 percent per year |
| Number of years to double population | 29 |
| Total Fertility Rate (USAID) | 5.6 |
| Infant Mortality | 140 per 1,000 |
| Maternal Mortality | 7 per 1,000 |
| Percent population 14 years and under | 46 percent |
| Average age of female at marriage | 16 |
| Life expectancy at birth | 50 |
| Per capita income (equivalent to US\$) (1983, World Bank) | 130 |
| Rural population (USAID) | 85 percent |
| Population Density | 1,800 per square mile |
| Number of married women 15-49 (1985) | 19 million |
| Religious identity | |
| Muslim | 86.6 percent |
| Hindu | 12.1 percent |
| Buddhist, Christian, Animist | 1.3 percent |

2. PROJECT OBJECTIVES

2.1 Project Components

The original FPSP, funded in 1981 for a three-year period, provided support to two major components of the national population effort in Bangladesh--the national program of the GOB and programs of the non-governmental sector. The purpose of this support was to increase the CPR from 13.6 to 25 percent (modern methods) during the life of this Project (see Section 3.1). The Project was amended in 1984 to cover the period 1984-87, and the target CPR was increased to 28 percent (modern methods) by the end of calendar year 1987.

The elements of the national program supported by the original FPSP included:

1. Contraceptive supplies and medical equipment
2. Training for various levels of GOB program staff
3. Voluntary sterilization costs
4. Operations research
5. Contraceptive prevalence surveys
6. Maternal and child health (MCH) activities
7. Community-level projects

The amendment includes support for items 1, 3, and 5 above. It combined items 2, 4, 6, and 7 into one component called Technical Resources, Research and Training (see Section 3.2.5) and added support for the reimbursement of expenses related to the insertion of intrauterine devices (IUD).

Both the original project and the amendment provided funds for the Government's family planning program, for the private sector contraceptive Social Marketing Program (SMP) and for family planning demonstration and service projects of selected NGOs.

Under the amendment, assistance was also provided to the International Center for Diarrheal Disease Research, Bangladesh (ICDDR,B) to continue research on the effects of integrated maternal and child health (MCH) and family planning services on contraceptive use, and to study the use of government fieldworkers in implementing the service delivery approach tested in proximity to the ICDDR,B, in two upazilas.

2.2 Project Funding

Cumulative 1981-85 USAID obligations for the major project components have amounted to U.S. \$118 million. Additional details on funding are provided in Table 1 and Appendix D.

2.3 Project Strategy

Collectively, it was anticipated that these activities and assistance would facilitate the achievement of the GOB's efforts to increase the effective use of contraception. Specifically, the USAID contribution was intended to enhance the availability and quality of family planning services. The strategy involved a combination of private and public sector initiatives, with each complementing the other. Clinical services would remain largely in the hands of the Ministry of Health and Family Planning (MOHFP), to capitalize on its extensive service delivery network, while non-clinical methods would be made widely available through a combination of Government clinics and fieldworkers, community-based NGO activities, and through retail outlets under the SMP. The NGOs, in particular, were encouraged to respond to a critical unmet need for services in the urban areas. Finally, USAID assistance was intended to support efforts to monitor and strengthen program performance through regular prevalence surveys and operations research.

It was envisioned that each of the three basic components of the Project (GOB, SMP and NGO) would contribute to the increase in CPR. While basic components and project strategy were retained, the emphasis was placed on expansion of family planning services through the SMP and other NGO activities rather than through the MOHFP. The former were believed to have a greater organizational capacity for non-clinical service delivery and were judged to be more cost-effective. The MOHFP continued to receive support for clinic-based contraceptive services and was provided with contraceptives for non-clinical services.

TABLE 1
Actual FY 81-85 Obligations
FPSP
by Major Project Component

Obligations (\$'000)

| <u>Component</u> | <u>FY 81</u> | <u>82</u> | <u>83</u> | <u>84</u> | <u>85</u> | <u>Total</u> |
|---|--------------|-----------|-----------|-----------|-----------|--------------|
| MOHFP* | 4.150 | 6.781 | 9.243 | 5.750 | 11.740 | 37.644 |
| SMP | 1.130 | 4.181 | 2.000 | 5.500 | 4.042 | 16.853 |
| NGOs** | 1.220 | 4.074 | 3.750 | 5.744 | 3.754 | 18.5422 |
| ICDDR.B | -- | 505 | 642 | 1.348 | 2.256 | 4.751 |
| Centrally Procured Commodities*** | 4.500 | 8.921 | 9.165 | 7.658 | 10.208 | 40.452 |
| Total | 11.000 | 24.462 | 24.800 | 26.000 | 32.000 | 118.262 |

* Excludes FPSTC which is added to NGO component.

** Excludes ICDDR.B which is a separate component; includes some small grants and contracts for evaluations, research, etc. which relate to NGO component.

*** Includes NGO and SMP commodities.

Note: 1986 obligations will be made at the end of the U.S. fiscal year, and are not reflected in this chart as yet; the total obligations will, at that time, amount to \$150 million.

3. PROJECT ACCOMPLISHMENTS

3.1 Overall Program Accomplishments

3.1.1 Contraceptive Prevalence

The goal under the original project had been to raise the CPR (modern methods) by 11.4 percentage points over a three-year period (from 13.6 - 25 percent between 1981 and 1984). At the end of 1983 (according to the final figures from the 1983 CPS), however, modern CPR had risen by only .2 percentage points, to 13.8¹ percent, although the overall CPR was found to be 19 percent.

The goal under the amended project was based on preliminary results of the 1983 CPS, which indicated a CPR of 15.1 percent. It called for an even greater increase in the CPR than had the earlier project--from the estimated 15 percent in 1984 to 28 percent by the end of 1987, or a total of 13 percentage points.

Preliminary results from the 1985 CPS based on the available sample spots² indicated that the national CPR at the

1 This figure is based on interviews with women only and may be an underestimate. Because of concerns about the possible undercount, the 1983 CPS included special samples of husbands as well as couples (in which both husband and wife were interviewed simultaneously and separately) and which revealed that condom use and perhaps also vasectomy were indeed underreported by women. Based on the results of all the samples, "working rates" of current use by method were estimated, which placed CPR for condoms at 2.7 instead of 1.5 and for vasectomy at 2.5 instead of 1.2, suggesting a modern method prevalence rate of 16.2 percent compared to the 13.8 percent rate based on the more conventional eligible woman sample (see Table A; this and other tables not in the text are in a special section at the end of the report). The 16.2 figure should probably be taken as a maximum prevalence rate. While the evidence from the different samples is consistent in indicating underreporting of condom use by women, the evidence is less clear with respect to vasectomy and thus the working rate for vasectomy may be too high.

2 At the time of the present evaluation mission, the 1985 CPS (which began in December 1985) was still in the field. Thus final results will not be available for some time. However, hand tabulated results for a substantial proportion of the sample spots (77 out of 120 rural spots and 37 out of 80 urban

end of 1985 was approximately 19 percent for modern methods and 25 percent for all methods (see Table 2). This represents approximately a five percentage point increase in modern method use and a six percentage point increase in total use during the two-year period between the 1983 and 1985 surveys. If these results are correct, the annual rate of increase was 2.5 percentage points, compared to an annual rate of increase of only 1.1 to 1.3 percentage points between 1975 and 1983 (see Table B). Urban CPR appeared to increase far more rapidly than rural CPR. CPR of modern methods in rural areas rose by only 4.4 percentage points compared to an urban CPR rise of 9.5 percentage points (Table 2).

3.1.2 Method Mix

3.1.2.1 Goals. The contribution that the four major modern methods (voluntary sterilization [VS], IUDs, pills and condoms) were expected to make to the total CPR between 1983 and 1987 is shown in Table 3. By 1987, when the overall modern methods CPR was projected to reach 28.2 percent, the aim was that VS represent 55 percent of that total, with the other three methods ranging from 12-17 percent. The CPR for IUDs was expected to triple between 1983 and 1987, for VS and condoms nearly to double, while the use of pills would only increase slightly.

3.1.2.2 Actual Performance. Data on actual contraceptive use comes from both the Management Information System (MIS) unit of the MOHFP and the CPSS. The MIS unit of MOHFP issues monthly reports of contraceptive performance statistics based on information reported to them through the GOB system and by the SMP and the NGOs. These statistics include the number of VSs performed, the number of IUDs inserted and the numbers of injectable doses, pill cycles, condom and foam tablet pieces, and emko vials dispensed or distributed each month. The primary purpose of these data is to monitor the family planning program. For some purposes they are converted into couple years of protection (CYP), although the precise conversion factors are a matter of debate, especially in the case of condoms.

spots) were made available to the team. Although these partial results must be taken only as a very rough indicator of the national CPR, we are using them given the critical importance of assessing progress to date. A reassessment should be made once final results are available.

TABLE 2

CONTRACEPTIVE PREVALENCE RATES (CPR) ACCORDING TO THE
1983 CPS AND PARTIAL RESULTS FROM THE 1985 CPS

| | <u>Partial sample spots only^a</u> | | <u>National Sample^b</u> | | |
|--------------------------------|--|---------------------|------------------------------------|---------------------|-------------------------|
| | 1983 | 1985 | 1983 | 1985 (projected) | 1983 - 85 (increase) |
| Modern method CPR ^c | | | | | |
| Rural | 12.9 | 17.5 | 12.2 | (16.6) | (4.4) |
| Urban | 29.6 | 39.3 | 28.9 | (38.4) | (9.5) |
| Total | (14.5) ^d | (19.6) ^d | 13.8 | (18.7) | (4.9) |
| All method CPR | | | | | |
| Rural | 18.8 | 24.8 | 17.3 | (22.8) | (5.5) |
| Urban | 37.3 | 48.8 | 35.8 | (46.8) | (11.0) |
| Total | (20.6) ^d | (27.1) ^d | 19.1 | (25.1) | (6.0) |

Source: Bangladesh Contraceptive Prevalence Survey 1983 Final Report and special tabulations provided by Mitra and Associates to the evaluation team.

Notes: CPR refers to the percent of currently married women under age 50 currently using a contraceptive method of the type specified. The year of the survey refers to the year the survey began. In each case field work actually extended into the subsequent calendar year. The CPR thus refers roughly to the end of year in which survey began. All figures in parentheses are derived and should be considered only as approximations.

^a For 88 out of a total 120 rural sample spots and for 37 out of total of the 80 urban sample spots. Results presented for 1983 and 1985 are based on the same sample spots.

^b Actual weighted total sample results for 1983; for 1985 the total sample results are projected by multiplying the partial results by the ratio of 1983 partial to 1983 total sample results to correct for the fact that the partial sample spots do not appear representative of the country as a whole.

^c Modern methods refer to pill, condom, IUD, vaginal methods, injection, and sterilization.

^d Derived by weighting the rural results by .902 and the urban results by .098 to approximate the national rural-urban distribution in the sampling frame of the 1983 survey; see Bangladesh Contraceptive Prevalence Survey 1983 Final Report, p. 26, footnote a.

TABLE 3
PROJECTED CONTRACEPTIVE PREVALENCE RATES
AIMED FOR IN THE PROJECT AMENDMENT
(CPRs to be measured through CPSs)

| Method | Year | | | | |
|--------|------|------|------|------|------|
| | 1983 | 1984 | 1985 | 1986 | 1987 |
| Modern | | | | | |
| Pill | 3.5 | 3.6 | 3.9 | 4.3 | 4.7 |
| Condom | 1.9 | 2.3 | 2.7 | 3.2 | 3.6 |
| IUD | 0.9 | 1.0 | 1.8 | 2.6 | 3.33 |
| VS | 8.2 | 9.9 | 11.7 | 13.6 | 15.6 |
| Other | 0.6 | 0.7 | 0.8 | 0.9 | 1.0 |
| Total | 15.1 | 17.5 | 20.0 | 24.6 | 28.2 |

Source: Amended project paper, Annex C, July 1984.

o Sterilization. The expectation that VS would be the major contributor to modern methods was based primarily on the important role it played during the 1979-83 period. During these four years, 80 percent of the increase in modern contraceptive use was due to increases in tubectomies and vasectomies (total CPR increased 5 percentage points while sterilizations increased 4 percentage points--see Table C).

Preliminary results on method-specific CPR from the 1985 CPS³ suggest that the increases in VS accounted for only about 40 percent of the increase in modern methods between 1983 and 1985--a considerably lower share than in previous years. Correspondingly, increases in temporary modern methods contributed considerably more to the rising CPR than in the past.

MIS figures substantiate these findings. The data indicate that the number of VSs more than doubled between 1980-81 and 1983-84, rising from approximately 259,000 to 552,000, but that they have since declined substantially (see Table 4). A month-by-month VS analysis for the calendar years 1984 and 1985 (see Table D) reveals a very sharp peak of almost 89,000 VS cases during the month of October 1984 followed by an immediate sharp decline. During the entire year of 1985, monthly sterilizations never again reached 40,000 cases. The monthly average during 1985 was about 26,000 cases compared to a monthly average of 54,000 cases during 1984. In short, VS performance declined by more than 50 percent between 1984 and 1985 and there is as yet no evidence in the monthly statistics that sterilization is again increasing.

o IUDs. IUD insertions also rose sharply from the 1980-81 levels but then appear to have peaked during the 1984-85 period when around 432,000 insertions took place. The annualized figure for the present year suggests that the number of insertions will be well below the 1984-85 figure, although the decrease is far less pronounced than in the case of sterilizations. Although there was some increase in the number of IUD insertions for some months following the sharp drop in sterilization after October 1984, the increase has not been sustained. The average number of monthly IUD insertions during the second

3 These are based on hand tabulations of 72 out of the 120 rural sample spots. The results are not comparable to those presented in Table 6 for the previous years, because they exclude urban areas completely and cover only part of the total rural sample.

TABLE 4

Yearwise Performance of Different Contraceptive Methods, 1980-86
Based on Distribution Statistics

| Period | Sterilization (in cases) | IUD (in cases) | Oral pill (in cases) | Condom (in pieces) | Injection (in doses) | EMKO (in vials) | Foam Tablets (in pieces) |
|---------------------------|-----------------------------|-------------------|-------------------------|-----------------------|-------------------------|--------------------|-----------------------------|
| 1980-81 | 258,793 | 41,601 | 8,237,774 | 87,111,780 | 112,010 | 59,804 | 5,001,943 |
| 1982-83 | 363,157 | 117,743 | 8,257,995 | 116,821,484 | 72,697 | 69,634 | 5,404,417 |
| 1983-84 | 552,051 | 303,338 | 9,725,834 | 131,096,735 | 122,503 | 64,249 | 4,384,707 |
| 1984-85 | 491,599 | 432,465 | 11,552,863 | 151,939,740 | 165,933 | 71,795 | 3,222,201 |
| 1985-86 July - January | 175,909 | 214,744 | 7,095,901 | 82,655,063 | 116,439 | 31,016 | 1,958,360 |
| (Annualized) ^a | (302,000) | (388,000) | (12,164,000) | (141,694,000) | (200,000) | (53,000) | (3,357,000) |

SOURCE: MIS Unit, Family Planning Directorate, except for 1980-81 and 1981-82 for Emko and Foam Tablets which are from the Mid-Term Evaluation Report of Family Planning Services Project (FPSP).

^a At the time of the evaluation mission, the most recent month for which data are available was January 1986. To annualize the results for the seven months from July 1985 to January 1986, in order to facilitate comparison with the other periods, the results were multiplied by 12/7 (to allow for 5 additional months' performance).

half of 1985 was approximately 31,000 compared to 37,000 during the first half of the year (see Tables 4, D, and E).

o Pills, Injectables and Condoms. The only methods that appear still to be increasing are injectables and pills, for which the annualized figures for the period from July 1985 to present are higher than for any other previous period. The pill increase for 1985-86, however, is relatively small. While since 1982, condom purchases by quarter have fluctuated radically, throughout 1985, condom distribution was about average. At present, only injectables appear to be still experiencing a sustained increase (see Tables 4, D, and E). The conclusion is that the substantial decline in VSSs has at best been only partially compensated for by other methods.

Conclusions

At this point, MIS statistics suggest that the downward trend in sterilizations is unlikely to be reversed and that the performance of other methods, while more favorable, will not compensate for this decline. The inevitable result will be a slowing in the rate of increase of users.

The implications for reaching the projected 28 percent CPR are evident. To achieve this goal would require an increase of an additional 10 percentage points during the two years between the end of 1985 and 1987 or an annual rate of increase of almost 5 percentage points. This is twice even the accelerated rate of increase of 2.5 per annum observed during the last two years (see Section 3.1.1). The conclusion then must be that the Project goal will not be reached.⁴ (See Appendix G for implications of this analysis vis-a-vis the Government's own Five-Year Plan Goals.)

4 It is not clear whether the possibility of attaining the final stated goal of 28 percent should be judged in terms of the conventional eligible woman sample or an adjusted working rate (see footnote 1). Since the intention of the amended Project was to increase prevalence by 13 percentage points, it seems reasonable to use this figure as the basis for judging the likelihood of achieving the Project purpose and to leave aside the issue of whether year-end prevalence in 1987 is to be measured by the conventional eligible women sample or an adjusted working rate.

3.1.3 Contributions of Specific Project Components

While results of the national CPSs provide adequate information for judging the extent to which the Project is meeting its CPR goals, the CPSs do not permit a precise assessment of the separate contributions of the various project components to prevalence.

The USAID Mission makes estimates of "active users" that are based on MIS figures. These are provided in a format that permits determination of the contribution of each component to changes in overall prevalence (see Table 5). According to these calculations, of a total 11.2 percent increase between 1981-1985, 54 percent can be credited to the GOB (an increase of 6.1 percentage points), 39 percent to NGOs (an increase of 4.4 percentage points), and only 6 percent to the SMP (an increase of 0.7 percentage points--see Table 6).

The validity of these estimates, however, is open to question. Specifically, the contribution of the SMP may have been underestimated and that of the NGOs overestimated. The question arises because figures for condoms and pills, when converted into active user statistics, do not indicate the same level of use as do the findings of the CPS. Specifically, distribution figures for pills, translated into "active user prevalence" for 1983, suggest a far higher rate of use than does the CPS (3.8 compared to 2.0--see Table 5). This is the so-called "pill gap." There is an even greater "condom gap," particularly regarding SMP's performance. SMP's distribution figures imply a prevalence rate of 3.35 percent compared with the 1.73 percent rate based on the 1983 CPS (see Table Q).

In calculating the contribution of the SMP, USAID chose to ignore the actual distribution figures for condoms and instead assumed that prevalence for condoms remained constant at the 1983 CPS estimate of 2.7 percent of the total prevalence during the entire 1981-85 period, although distribution figures rose during that period (see Table 6). Since condoms represent the vast majority of contraceptives distributed by SMP, the failure to reflect the increase in distribution may well have resulted in an underestimate of SMP's contribution to any rise in contraceptive use. By contrast, because USAID used the perhaps inflated distribution figures for pills instead of the CPS figures, the NGOs' contribution to contraceptive use may be inflated, since pills represent a substantial proportion of the contraceptives distributed by the NGOs.

TABLE 5

COMPARISON OF USAID "ACTIVE USER" PREVALENCE RATES
WITH CPS PREVALENCE RATES BY METHOD, 1983

| | <u>"Active User"</u> <u>Prevalence 1983</u> | <u>Comparable</u> <u>1983 CPR</u> |
|------------|--|--------------------------------------|
| | (USAID) ^a | From CPS ^d |
| Vasectomy | 2.2 ^b | 2.5 |
| Tubectomy | 6.1 ^b | 6.2 |
| Condom | 2.7 ^c | 2.7 |
| Oral Pill | 3.8 | 2.0 ^e |
| IUD | 1.4 ^b | 1.0 |
| Injectable | 0.1 | 0.2 |
| Vaginal | 0.4 | 0.3 |
| TOTAL | 16.8 | 14.9 |

Source: Active User Prevalence from USAID Mission, Dhaka; CPS prevalence derived from Bangladesh Contraceptive Prevalence Survey 1983 Final Report as described in Text.

Notes: ^aNumber of active users is estimated using CYP assumptions for non-clinical methods and decrement tables for clinical methods.

^bEnd of year active users.

^cThe conversion factor used to derive condom prevalence from the service statistics on number of pieces distributed was determined by assuming a 2.7 prevalence rate based on the 1983 CPS results. This is not an independent estimate from the CPS.

^dRates refer to the "working rates" except for oral pill use.

^eAdjusted to remove 40 percent of prevalence due to non-SMP commercial sales.

TABLE 6

ESTIMATED "ACTIVE USER" RATES FOR PROGRAM METHODS
AT END OF YEAR BY MAJOR PROVIDERS OF CONTRACEPTION BASED ON MIS
SERVICE STATISTICS AND USAID DECREMENT TABLES

| | <u>"Active Users" as % of of Eligible Couples</u> | | | | <u>% of Active Users Attributable to Provider</u> | | | |
|------|---|-----|------|-------|---|-----|------|-------|
| | GOB | SMP | NGO* | TOTAL | GOB | SMP | NGO* | TOTAL |
| 1981 | 8.6 | 2.2 | 1.4 | 12.2 | 71 | 18 | 11 | 100 |
| 1982 | 9.8 | 2.4 | 1.9 | 14.2 | 70 | 17 | 13 | 100 |
| 1983 | 10.9 | 2.7 | 3.1 | 16.7 | 65 | 16 | 19 | 100 |
| 1984 | 13.9 | 2.9 | 4.7 | 21.5 | 65 | 14 | 22 | 100 |
| 1985 | 14.7 | 2.9 | 5.8 | 23.4 | 65 | 13 | 25 | 100 |

Source: USAID Mission, Dhaka, Bangladesh.

NOTES: The number of active users is estimated using couple year of protection assumptions for non-clinical methods and decrement tables for clinical methods. For condom use, a constant prevalence of 2.7 percent is assumed based on the 1983 CPS. To achieve 2.7 percent prevalence, 200 condoms are required in 1981, 225 for 1982, 260 for 1983, 315 for 1984 and 240 for 1985 for one CYP.

* The NGO category includes all NGOs, not just those funded by USAID.

Data collected on brand names of pills and condoms distributed, which indicate SMP as an important source particularly of condoms, suggest a more important role for the SMP than do USAID's figures (see Table F). On the other hand, data collected on the source of supply of contraceptive methods suggest a very small role for the NGOs (see Table G). Finally, mini-CPSSs done in several subproject areas suggest that prevalence rates based on active user statistics can either over- or understate prevalence by a large margin (Table H). These discrepancies undermine the credibility of reported successes of NGOs (see Appendix G for further details).

Thus, while there is an impression by many observers that the NGOs are performing very well and are contributing to relatively high levels of contraceptive prevalence in the areas they serve, further research is needed to determine the actual contribution both of NGOs and of the SMP.

3.1.4 Family Planning Impact on Maternal and Child Health

Although the original statement of Project purpose did not include any reference to the health impact of family planning, it is useful to consider this when evaluating the Project accomplishments. Despite frequent references to health benefits in general discussions of family planning programs in developing countries, few empirical studies have been done to document the nature and extent of these effects directly. One of the major contributions of the FPSP is the high quality research that it has facilitated on this topic through support of the research component of the ICDDR,B Extension Project. The past and current research on family planning and fertility impact on maternal and child health that is being done as part of this project is not only of great importance for the Bangladesh program; it is also among the most important research on this topic being done anywhere.

There is good reason to suppose that increased family planning practice and associated fertility reduction will lead to lower levels in maternal mortality. At the most obvious level, fewer confinements per woman will mean less exposure to the risk of death associated with childbirth. In addition, there is widespread evidence that in Bangladesh as elsewhere the risk of maternal mortality is particularly high at older ages and for women above parity four. For example, two recent studies of maternal mortality in rural Bangladesh found above average maternal mortality rates for mothers in age groups over 30

(Alaudin, 1986; Khan et al., 1986). These same studies showed that maternal mortality risks were several times higher than average for women giving birth to fifth or higher order births. In addition, septic abortion was found to be one of the major causes of maternal death. Since family planning is used primarily for limitation of family size in Bangladesh, its main effect is to prevent higher order births and births at older ages. Thus an additional impact on reducing maternal mortality can be expected from this prevention of these high risk confinements. Moreover, to the extent that effective family planning is obviating the need for a woman to resort to improperly performed abortions, an additional contribution toward lower maternal mortality is occurring.

Although there are many studies showing the association between maternal mortality and higher parity, little research has been done to document the effect of increased family planning on reducing maternal mortality. Such research is currently under way through the Matlab Family Planning Health Services Project (FPHSP). More specifically, data from Matlab are being collected and analyzed to determine the relative impact on maternal mortality of reduced fertility associated with increased family planning practice and that associated with the introduction of MCH services.

While the benefits of family planning for lowering maternal mortality are important, the contribution that this would make towards lowering overall mortality will be quite modest, given that maternal death is a relatively infrequent event. (The two studies referred to above indicate overall levels of around 60 maternal deaths per 10,000 births.) The potential for affecting overall mortality is considerably higher in connection with impacts on infant and child mortality. There are several ways in which effective practice of contraception leading to a reduction in fertility could contribute to an improvement in infant and child mortality, which together claim the lives of perhaps one out of every five children born. One way is through alteration in the factors associated with the pattern and composition of births, such as maternal age and parity and birth spacing. Another way is less direct and could operate through increased availability of limited family resources including parental attention divided among fewer family members or improved quality of child care because of a healthier and less exhausted mother (Chen et al., 1983).

Very few studies have actually attempted to examine empirically the impact of different fertility levels and ferti-

ity decline on infant and child mortality. Again, ICDDR,B research is surely among the most important research being done anywhere on this topic. Results of research to date are summarized in a recent report issued by ICDDR,B (Phillips, Koenig and Chakraborty et al., 1986). Although the findings are only preliminary at present, they suggest a substantial effect of family planning practice on lowering mortality of children aged 1-4, virtually no effect on post-neonatal infant mortality, and a possible modest effect in lowering neonatal mortality, although the evidence on the latter seems ambiguous. The cumulating data and continuing analysis are likely to clarify these issues further.

3.1.5 Project Outputs

Under the original Project, outputs were specified for each major component and were summarized in the logical framework. The status of these outputs, as of the end of FY 83, is briefly summarized in Appendix E. Under the FY 84 Project Amendment, quantification of project outputs was expressed only in terms of their intended contribution to increased prevalence of contraceptive use.

Given the changes that have occurred in the Bangladesh program more broadly, and the issues that have arisen since the original Project was designed, this evaluation is focused on the activities covered under the Amendment, rather than under the original Project. To summarize briefly, however, the objectives of the original Project were largely met, particularly with reference to the expansion of voluntary sterilization service facilities, provision of commodities, social marketing, and the involvement of NGOs in family planning service delivery. Information, education and communication (IEC) activities, implemented largely under the SMP project, also proceeded generally as planned. Feasibility and operations research studies progressed more slowly than planned, as did selected training activities. In sum, however, project outputs during the FY 1981-83 were generally met.

The remainder of this section provides a narrative review and assessment of the major activities funded under the FY 84 Amendment.

3.2 Ministry of Health and Family Planning

3.2.1 Commodities and Logistics Support

USAID has been a major supplier of commodities needed by the Bangladesh Family Planning Program. Since 1981, a total of nearly \$20 million has been expended on commodity support. Other major suppliers of commodities include the World Bank (DDS kits and medical/surgical supplies), the United Nations Fund for Population Activities (UNFPA) (injectables and drugs/equipment for the sterilization program), Canadian International Development Agency (CIDA) (oral contraceptives and technical assistance), and the Federal Republic of Germany (FRG) (oral contraceptives). It is anticipated that the Asian Development Bank (ADB) will finance 20 District Warehouses, although construction has not yet begun.

USAID has also provided long-term technical assistance to help address problems related to procurement, storage, distribution, and monitoring of commodities needed by the program. As part of this effort, USAID has financed annual commodity inventories, revised the supply manual, computerized commodity distribution data, developed procedures for projecting future need, and organized training for logistics personnel. Up-to-date Contraceptive Procurement Tables have been completed and submitted to AID/W.

As a result of the national inventory, reliable data upon which to base projections of future contraceptive needs are now available. Adequate quantities of all USAID-supplied commodities are in-country, although stock-outs of some items (e.g., IUDs) are still a problem at lower levels of the distribution system (particularly at family welfare centers and among field personnel). Inadequate warehouse space at the district and upazila level is also a problem.

Recommendations

Management of inventories

Policies governing the management of inventories need revision, and persons currently responsible for managing the central and regional warehouses need additional training in commodity management. Specific steps might include

- The post of senior logistics advisor should be filled without delay and the Director of the Central Warehouse

should be encouraged to use the newly developed MIS for logistics management and planning.

- MOHFP's Family Planning Directorate should develop procedures as soon as possible to minimize possible losses due to shelf-life limitations.

Contraceptive storage space

Central warehouse capacity needs to be increased, or policy changed to permit more commodities to be stored in the regional warehouses where space exists, and perhaps at the upazila level as well.

- If new regional ("greater district") warehouses are put in place, it will be necessary to recruit and train the required supply officers as well as warehouse managers. Although under the Third Five-Year Plan, supply officers are to be recruited, thus far no plan has been developed for warehouse managers.
- USAID, in collaboration with the GOB, should assess the need for storage space at the upazila level. To the extent that such space is not available, USAID should consider financing the construction or renovation of such storage space, perhaps on a fixed amount reimbursement (FAR) basis.

3.2.2 The Voluntary Sterilization Program

3.2.2.1 History of Program. In 1977 a short-term (nine-week) intensive VS campaign utilizing temporary facilities was successful in performing 65,000 male and female procedures. An unmet need for VS was clearly identified, but VS acceptance levels remained relatively low (83,000 in 1978-1979). A highly visible expanded program was incorporated into the Second Five-Year Plan (1981-1985). Meanwhile a high level of mortality (14/100,000 cases) associated with VS provoked a study by consultants from the U.S. Centers for Disease Control (CDC), which defined "excess" deaths to be those related to infection in men and women and analgesia dosage in the women tubectomy clients. A revised anesthesia protocol was accepted and special training for Medical Officers and Family Welfare Visitors (FWV) was put in place, using Bangladesh Association for Voluntary Sterilization (BAVS) and model clinics at the eight medical colleges as a technical base. Anticipating the success of the

expanded program, the GOB requested and received USAID support to help finance provider costs and reimbursements to clients and to "helpers" who accompanied clients to the clinic as well as for medicines and technical assistance. A condition precedent for FPSP funding was the establishment of a voluntary sterilization surveillance team (VSST) for each of the country's four divisions (see Section 3.2.2.2 for more on the VSST).

The stage was set and in the following four years (1982-1985) a remarkable success story unfolded (see Table I):

- o Male sterilization increased from 20,000 (1980) to 306,000 (1984). In 1985 for the first time, the number of vasectomy clients exceeded tubectomy clients (ratio 1.1/1).
- o Female sterilization (minilaparotomy/tubectomy) rose from 105,000 (1980) to 336,000 (1984).
- o The mortality rate decreased from 13.7/100,000 cases (1980) to 2.1/100,000 (1984)--a rate similar to comparable surgery in the U.S. This low mortality continued in 1985.
- o The failure rate for tubectomy was approximately one percent and for vasectomy four percent. The former is acceptable, but the latter suggests lack of adequate post-operative instruction to the male and/or failure of condom provision or use during the post-operative period.

Currently VS services are offered by NGOs, which provide approximately 15 percent of the services (see Sections 3.3.4.1 and 3.3.4.3), and at 500 static government facilities (40 district and subdistrict hospitals, 340 Upazila Health and Family Welfare Centers, and 63 Maternal and Child Welfare Centers with 1,200 union-level Health and Family Welfare Centers available as settings for mobile teams.

The keys to success of the program are:

- o Access: most people are within five miles of service.
- o Affordability: client reimbursements helped to offset the financial barriers to acceptance, especially among those who are landless day laborers without savings.

- o Client Centered Support: financing was provided to enable all clients to be escorted to and from the clinic site by officially recognized helpers who provided informal nursing, infant care, food fetching and reassurance in a strange setting.
- o Acceptability: low mortality and, inferentially, low morbidity and relatively brief post-operative disability.

In an article prepared in 1982, A. R. Measham and co-authors (International Family Planning Perspectives 8:18-21) correctly described the average female recipient as 29 years of age and the mother of four. Average age for men was 40 with four children also. They correctly forecast that the GOB goal of three million sterilizations was too high and that two million would be done in the First Five-Year Plan period. Using their approximation, they said that the crude birth rate (CBR) would fall one percent per year--a significant effect for a single program. Because of the births averted, approximately 40,000 maternal lives would be saved, thus preserving family structure and welfare of children already born.

The recent decline in the level of VSs (see Section 3.1.2.1) is probably a result of a large part of the latent demand having been met. Assuming that age and parity characteristics of acceptors remain relatively stable, the number of procedures will probably not exceed the current numbers of approximately 250,000-300,000 per year.

Quality and quantity of services are related. For example, in Bangladesh 12 procedures per surgeon per day has been set as a maximum. There are, however, no local data on how many procedures are the lower limit needed to keep a unit or team at satisfactory proficiency.

The reported low mortality rates are judged to be reliable. Sterilization is a high profile activity: there is a well-publicized death compensation of Tk. 5,000. VSST investigations are thorough and there is an active and inquisitive press. Infection, particularly tetanus, and cardio-respiratory deaths at the time of surgery, are the major causes of the deaths that do occur. In their joint visits with VSST teams, USAID consultants noted the emphasis placed on these areas by all the VSST members. Continued emphasis is required.

3.2.2.2 The Voluntary Sterilization Surveillance Team (VSST). The four VSSTs were funded by the Swedish International Development Authority (SIDA), executed by the World Health Organization (WHO), and coordinated by the World Bank. Each team was composed of an expatriate advisor and a Bangladeshi counterpart. The four teams have been functional since 1983, but all posts have been filled for only seven months in the past three years--the principal vacancies being on the expatriate side. At present only the Dhaka division has two team members. WHO is actively seeking expatriate consultants to fill the empty slots. A nursing component is being added to the team (one expatriate stationed in Dhaka and four Bangladeshi nationals--one for each division). Continuing sponsorship (1986-1991) is being financed by Norway.

Each team visits 12 to 16 sites weekly. There is a monthly review meeting in Dhaka with the team members and the Family Planning Directorate plus a representative of USAID. Deficiencies are reviewed and plans are made for correction. Quarterly meetings with the Health Wing were begun in 1985; to date three have been held. It has been estimated that approximately 30 percent of the correctable deficiencies identified by the VSST are the Family Planning Directorate's actions and 70 percent are the responsibility of the Health Directorate.

Forty percent of a normal site visit is spent in surveillance and 60 percent in teaching. Usually on one day, a single sterilization site is visited extensively (2 1/2- 3 hours) and shorter visits are made to Union Health and Family Welfare Centers en route. Records are reviewed with particular attention to evidence of signed consent, operating theaters inspected for general hygiene and availability of emergency equipment, laboratory technicians interviewed, anesthesia discussed, medical officers quizzed on emergency procedures, and the family welfare visitor activity evaluated.

Overall, the deficiencies in VS facilities appear to be fewer than five years ago and all units seemed capable of performing VS procedures. The equipment and linen sterilization routines performed by workers at the menial levels, however, present glaring lapses and can be the entry point for infectious organisms by direct tissue inoculation. Any weak link in the chain of aseptic events breaks the required continuity. A disruption of sterilization protocol can be lethal, regardless of the training and effectiveness of the rest of the staff.

A review of the minutes of monthly meetings, however, suggests that the correction of deficiencies noted by the VSST is incomplete. There is no clear line of communication and responsibility from the VSST to the Health and Family Planning Wings and back to the units at the operating level.

3.2.2.3 Informed Consent and Voluntarism. Under AID Policy Determination 3 on Voluntary Sterilization, VS programs that receive AID assistance must use an AID-approved signed consent form. Moreover, any payments made to defray the costs associated with this sterilization should not cause VS to be favored over other methods of contraception.

The Bangladesh government has established clear directives that all sterilization (like all family planning) must be voluntary to ensure that clients meet eligibility requirements. Consequently each person goes through a screening process on arrival at the clinic. Some clinics (notably BAVS) have full-time counselors trained to assist in this process. Only a miniscule percentage (six people out of 853,557) of men and women who underwent sterilization between January 1, 1984 and September 30, 1985 apparently were not sufficiently informed about the operation. On the other hand, special studies reflect a high level of satisfaction among those who have had the procedure, a strong indication that it has been undertaken voluntarily.

USAID has made a concerted effort to monitor the implementation of the Bangladesh voluntary sterilization program (see Table J for a summary of the actions/studies completed, planned, and on-going). Although occasional incidents of abuse have been publicized, these have not been sanctioned by Government nor have they been widespread. Both USAID and the GOB have taken quick action in each of these cases to resolve the problem. In addition to the clinical quality of care monitored by the VSSTs, USAID finances quarterly independent evaluations (carried out by M.A. Quasem and Co.) of the VS program. These evaluations consistently find that more than 98 percent of clients have signed the approved consent form.

3.2.2.4 Cost Reimbursements in the Voluntary Sterilization Program. Since the 1977 sterilization campaign, monetary reimbursement has been provided to VS clients. This activity has been supported to date by USAID through the GOB. In 1980 the reimbursement was Tk. 106 for males and TK. 123 for females. In

1983 there was an increase and equalization so that all clients now receive Tk. 175. Meanwhile inflation has decreased the taka value (Tk. 15/US\$ in 1980; Tk. 33/US\$ in 1986). In addition there are helper compensation costs and provider reimbursements of lesser amounts (see Table M).

Men receive a lungi (Value--Tk. 50) and women a sari (Value--Tk. 90) as a perisurgical garment to wear as a protection from infection for three days after surgery while the wound heals. The garments act to minimize the exogenous bacteria access to the wound--a serious risk in an environment where wound healing is marginal because of anemia and undernutrition and serious infection a significant risk to life. Although there is some degree of continued use, it is minimal because the color and pattern of the garments easily identify the wearer as a sterilization acceptor when worn in public. Funding of this element of the VS program will be shifted from USAID to the World Bank in its third project, the Bangladesh Population and Family Health Project, to begin in 1986.

Helper compensation, particularly for the women, is marginal because the procedure involves at least one night away from home in many circumstances. Medical provider payments are intended to compensate for the income forgone from private practice in order to provide this service. The reimbursement level is equal to the Government approved level for the least expensive surgical procedure (Tk. 20 or \$.67 at the current exchange rate).

A recently published external review (Pillsbury and Knowles) found no evidence that these reimbursements resulted in coercion. Follow-up studies showed high levels of post-operative satisfaction and a general inclination to recommend the procedures to others. The reimbursement functions to enable couples to act upon a decision they have already made, but would have to postpone, perhaps indefinitely, because of the cost involved.

In short, cost reimbursements act to overcome real obstacles to access and provision of care. On the basis of actual costs the reimbursements are currently appropriate (see Table K) but will change with time.

3.2.2.5 Recommendations

Adjustment to overcapacity

Both the NGOs and the government should seek ways to adjust to the excess service capacity brought on by the leveling

off of sterilizations (see Recommendations in Section 3.3.4.1 for NGOs).

- The GOB may need to consolidate service facilities or to use alternative methods of service delivery (e.g. mobile surgical teams). Possible criteria for retaining GOB facilities might include the number of procedures per year, the availability of running water and of windows in operating theaters, surveillance reports, morbidity/mortality levels, etc.
- To ensure that upazila and union-level medical staff maintain their technical skills, the MOHFP should consider initiating a system, perhaps as part of the VSST system, for monitoring the frequency of surgical contraceptive procedures. Technical assistance should be provided for this effort.

Continuation of VSSTs

Efforts should be made to ensure and expand the effective functioning of the VSSTs. Specifically:

- USAID should urge the GOB to move quickly to fill the existing VSST vacancies.
- VSSTs should supervise clinical contraceptive services at all levels, including the union.

Greater efforts should be made to ensure that reported deficiencies are corrected. Steps might include:

Training

- o USAID should support family welfare visitor refresher and on-site training in basic sterilization maintenance and procedures (e.g., using BAVS mobile teaching teams).
- o FWV refresher courses should include instruction on sterilizing techniques and equipment maintenance, as well as the demonstrated capability to teach the method to unskilled employees.

Communication

- o The establishment of lines of communication between the VSST, the Health and Family Planning Wings and the operating level should be encouraged.

Continuation of Monitoring

Intensive monitoring of the VS program should be continued and strengthened. It could be further improved by the following:

- USAID should employ a full-time person to fill the role of Clinical Services Quality Assurance Advisor.
- Procedures for screening VS clients should be given increased attention.
- Questions regarding client satisfaction should be built into the quarterly independent evaluation reports.

Continuation of Reimbursements

USAID should continue, in real terms and in principle, to support monetary reimbursement to providers, clients, and staff. An annual review of reimbursement levels is suggested.

3.2.3 The IUD Program and Cost Reimbursements

Background

The (Copper T) Cu-T 200 IUD has been available in Bangladesh since 1982. Its use has tripled in the last three years (1983--256,000; 1984--517,000; 1985--767,000), and it is the only clinical contraceptive method to have exceeded targets. Although the program is clinic-based and requires transport and time away from work, these potential disincentives are overcome in part by USAID-funded cost reimbursement for transportation of the client (Tk. 15) and to paramedics and physicians (Tk.5) for the insertion procedure. Actual reimbursements are based on service statistics collected by the MIS unit. Client escorts also receive Tk. 45.

Increasing numbers of Cu-Ts will require follow-up for removal and re-insertion during the next three years. (It is

recommended that Cu-T 200s be removed during the fourth year of use because of slightly decreasing effectiveness and the beginning of copper wire fragmentation.)

There are no data from Bangladesh sources on problems associated with Cu-T 200 removal (lost strings, Cu-Ts abnormally positioned in the uterus, or devices that have perforated the uterus and are lying in the peritoneal cavity). Experience in other settings suggests these complications occur rarely (one in 500-1000 cases). On the basis of experience elsewhere, however, the program should anticipate that there will be an estimated 150 lost Cu-Ts in 1986; 250 in 1987; 500 in 1988; and 800 in 1989.

According to a recent IUD evaluation (Program for the Introduction and Adaptation of Contraceptive Technology [PIACT], 1985), Cu-Ts are becoming increasingly popular for "limiters" who do not wish to have a surgical procedure and to "spacers" after one or two children. The one-year continuation rate was 66 percent. Second generation Cu-Ts (Cu-T 380) will soon be available. These will require less frequent replacement--(perhaps up to 8-10 years). This should accelerate client demand and diminish frequency of removal. USAID has acted to expedite the introduction of this improved device.

At Matlab, ICDDR,B is conducting a pilot project of home Cu-T insertion by appropriately trained family welfare assistants. Details of the evaluation are not available at this time; however, home delivery in private should contribute to extended use, especially in rural Bangladesh where demand is fragile and convenience an important factor affecting initial acceptance and continuation.

Recommendations

In its efforts to promote long-lasting, effective contraceptive methods, USAID should focus on ways to increase the availability of IUDs and to ensure their safety and affordability. Specifically:

Availability

- Availability through the domiciliary insertion program should be increased, if it is demonstrated to be successful, and through NGOs. Both avenues should be pursued.

Safety

- USAID should seek to improve the safety of the procedure by
 - o Providing technical assistance needed to design and implement a system for diagnosing and removing lost Cu-Ts. Use of brief protocols for diagnosis and referral is recommended.
 - o Monitoring the ICDDR,B home-based Cu-T insertion trial and providing needed supplies and appropriate technical assistance to evaluate side effects, especially those related to lost devices, and encouraging this program's expansion, if it is successful.
 - o Encouraging the expansion of the VSST to include supervision of clinical contraceptive services, particularly the IUD.

Affordability

- USAID should continue to provide reimbursements.

3.2.4 Contraceptive Prevalence Surveys

Contraceptive prevalence surveys (CPS) are designed to provide rapid feedback to improve family planning program performance by collecting information on contraceptive use that is of immediate value to family planning program implementors and policy makers. In Bangladesh the CPS serves a critical monitoring function by providing an independent estimate of levels and trends of family planning performance and thus is crucial for evaluating the success of both the FPSP and that of the national family planning program in general. The current Project has funded two CPSs, one at the end of 1983 and a second that began at the end of 1985 and was still in the field at the time of the evaluation. Two previous CPSs were carried out in 1979 and 1981. The 1979 CPS was funded by AID as part of its global CPS project, under an agreement between the Bangladesh government and Westinghouse Health Systems. The 1981 CPS was funded directly by USAID through its Dhaka office. Both the 1979 CPS and 1981 CPS were executed by the GOB. USAID awarded the contract for the 1983 and

1985 CPSs to Mitra and Associates, a private Bangladeshi research organization.

The major objectives of the 1983 and 1985 CPSs were to ascertain levels and trends in family planning knowledge and use; to examine differentials in use by selected background characteristics of the family planning target population; to assess reasons for non-use and future intention to use among non-users of contraception; to investigate knowledge of contraceptive availability in terms of awareness of services and supplies; and to ascertain sources of supplies for current users of modern methods.

CPSs are usually conducted by interviewing samples of women eligible for family planning services, and both the 1979 CPS and the 1981 CPS were done this way, by interviewing a sample of ever married women under 50 years of age. Because of concern that condom use might be underreported by female respondents, it was decided that the 1983 CPS should include interviews with three nationally representative samples: the eligible woman sample, the husband sample, and the couple sample. The eligible woman sample was the conventional CPS sample consisting of only ever married women under 50 years of age. The husband sample was made up of husbands of non-interviewed currently married women under 50 years of age, while the couple sample was made up of both partners of the same couple with the wife under 50 years of age.

Data based on the 1983 husband and couple samples have proven very valuable in assessing the extent of underreporting of male methods and are incorporated in the "working rate" CPR discussed in Section 3.1.1. At the time of this evaluation, the design of the ongoing 1985 CPS was to interview only an eligible woman sample. This is a mistake given that the "condom gap" is still very much a live issue and that determining the true level of condom prevalence is of critical importance for assessing the impact of the SMP component. Moreover obtaining accurate measures of male methods is important for the determination of true overall contraceptive prevalence level.

In general, Mitra and Associates, the firm responsible for carrying out both the 1983 and 1985 CPS, appears to be doing a good job. The quality of the field work and analyses appear high and results have been produced promptly.

Future CPSs, scheduled to take place in 1987 and 1989, are to be funded by the World Bank's Population and Family Health III project, however, and undertaken by the National Institute

for Population Research and Training (NIPORT). Thus USAID funding for this component will be discontinued. This was not a decision that was advocated by USAID. A number of knowledgeable persons have indicated some concern that this development may compromise the comparability of results with previous surveys and the promptness with which results will become available. Apparently when NIPORT was in charge of the 1979 CPS, results were quite often late.

The issue of comparability, however, is more critical. MIS, NIPORT and other members of the Population Directorate had little input into the questions asked in the 1983 and 1985 CPSs or into the design of the survey. They also appeared to be not fully informed of a number of issues of concern to USAID staff and persons connected with the national family planning program that could be addressed by additional analysis of existing CPS data.

With the exception of the 1985 CPS, no information has been collected on breastfeeding and in none of the CPSs has information been collected on postpartum amenorrhea. Results from studies of some local areas, most notably Matlab, indicate that postpartum amenorrhea is of very long duration in Bangladesh and serves as one of the most important factors keeping fertility below its potential biological maximum. Thus changes in breastfeeding patterns and the associated duration of postpartum amenorrhea have great potential for counteracting the fertility effects of contraception. In addition infant feeding patterns have important implications for infant health and mortality.

Likewise, only rudimentary data on fertility preferences have been collected in any CPS. For example, no direct question on desired family size is included. Such information is essential for monitoring changes in receptivity to family size limitation. In addition, no fertility preference information at all was collected from male respondents. Hence male/female differences, often alleged to be important, cannot be determined from CPS data. Also it is generally recognized that there are a number of important constraints to adoption of family planning in Bangladesh (see discussion in Section 5.1.1 on latent demand). Some of these constraints probably are changing over time and differ among regional or social subgroups in the population. While some of these barriers are difficult to measure and monitor through a survey approach, some useful information on levels, trends and differentials could be usefully collected in the CPS without unduly lengthening the interview schedule.

Recommendations

Because of the crucial role played by the CPSs, both in monitoring the project and the national program and in helping guide future program decisions, these surveys should be continued and their quality improved. Specifically,

The 1985 CPS

- The ongoing 1985 CPS should be expanded to include interviews with a subsample of couples in which both husband and wife are interviewed to determine actual condom use.
- Second stage analysis both of a general and issue specific nature should be continued and perhaps expanded. Additional consultants, either national or expatriates, in collaboration with the principal investigator, could facilitate fuller exploitation of the CPS data. One important area that could be more fully explored is comparisons between the male and female samples.

Future CPSs

- High quality surveys should continue to take place at two-year intervals. Future surveys should preserve continuity with previous surveys to ensure accurate determination of trends. Each CPS should be conducted in a manner that permits prompt reporting of results. If the new arrangement to be financed by the World Bank does not fulfill these needs, USAID should consider funding its own CPS as it has done successfully in the past.
- Several additional topics of critical importance for monitoring the demographic situation and its determinants specific to Bangladesh should be included in future CPSs. These include questions that would yield basic information on infant feeding practices, postpartum amenorrhea, family size preferences, attitudes concerning religious objections to family planning in general as well as particular methods and attitudes concerning female seclusion. Such questions could be relatively straightforward and care should be taken to avoid overly lengthening the interview schedule.

- Parties involved in the national family planning program should be included at the design phase of the CPS questionnaire to ensure that appropriate information is collected. The execution and analysis, however, should remain as independent as possible from the program.

USAID's Role

- A USAID staff member trained and experienced in demography should be hired to facilitate utilization of all CPS findings.

3.2.5 Technical Resources, Research and Training

Background

A new Project component--"Technical Resources, Research and Training"--was created in the 1984 amendment to the FPSP, utilizing \$713,952 of FY 1981-83 pipeline funds from the training, operations research, local family planning, MCH materials, printing and evaluation budget headings. The 1984 amendment states that this component will be used for "short- and long-term consultants, evaluations and other discrete activities as they are identified." Activities funded under this component may be identified by the MOHFP, NIPORT, the Director General (Implementation), and by USAID according to the Project Implementation Letter (#57, dated November 5, 1984) creating this component.

Findings

To date funds have been earmarked and/or used for the following activities:

- o Translation and printing of 10,000 copies of Pathfinder's IUD manual for use by MOs, FWVs and NGOs.
- o A focus group study of the VS decision-making process.
- o Training of trainers and orientation/training of central, regional, district, and upazila personnel in the use of the revised supply manual and logistics system.
- o Employment of a specialist to work with the Population and Health Division of USAID on the voluntary sterili-

zation program, with special emphasis on PD-3 compliance.

- o Printing of 24 monthly issues of Porikrama, a publication on population activities in Bangladesh, and new techniques for family planning clinic- and field-level workers of MOHFP.
- o A conference of the NGOs working in family planning.
- o A seminar on operations research findings.

The creation of this new Project component from funds which were unspent in the original project period is considered to be a useful action. TRRT funds have been put to good use.

Recommendation

The budget line item and mechanism for ready response funding of useful small and discrete project activities should be retained for the remainder of the present project and continued at an increased level in future projects.

3.3 Non-Governmental Organizations

3.3.1 Background

Non-governmental organization (NGO) activity in family planning began in 1953 and increased slowly during the 1960s and 1970s in both the public and private sectors, with the NGOs playing an important role in information and education efforts as well as in limited service provision. Many of these NGO efforts were supported by AID through centrally funded grants and contracts. With the initiation of the FPSP in 1981, USAID began providing bilateral funding to a number of NGOs which were implementing major programs for family planning services and training. These activities are designed to complement the GOB national program. Overall, NGOs are currently estimated to cover 10 to 15 percent of the population, primarily in urban areas.

The main NGO activities funded under this component of the FPSP fall into two general categories--programs for community-based distribution (CBD) of contraceptives and clinical activities focused on the provision of high quality VS services. A proportion of the funds in this component has been devoted to other NGO activities including the development of a curriculum

for GOB program staff training (CARE), operations research on the transfer of findings from a successful NGO program (ICDDR,B/Matlab) to the GOB program, a pilot project designed to encourage late marriage and reduced fertility through female secondary education (funded through The Asia Foundation), and research to determine the appropriate contraceptives for use in Bangladesh (The Bangladesh Fertility Research Program [BFRP]).

The GOB recognizes the contribution being made by the NGOs to the national population effort and has assisted in these efforts through the provision of contraceptive commodities and other inputs from time to time. Through the creation of a Family Planning Council of Voluntary Organizations (FPCVO) (Memo No. PP-II/354/78) in 1978, and the Council's secretariat, the Family Planning Services and Training Centre (FPSTC), the GOB made an initial attempt to ensure coordination of the NGOs' various and scattered activities. A GOB circular dated December 4, 1983 sets out very clear and specific guidelines regulating the activities of NGOs working on family planning in Bangladesh.

3.3.2 USAID's NGO Strategy

Since the beginning of the FPSP, the NGO component has been guided by two USAID/Bangladesh Population Sector NGO Strategy papers, which were developed collaboratively by USAID and the NGOs. The first strategy (1981-84) gave priority to replication and expansion of the three existing NGO approaches of CBD, quality clinical programs for VS, and social marketing (see Section 3.4). The present strategy, designed to cover the period 1985-88, calls for consolidation, review and improvement of existing projects; selective and innovative expansion; and for development of better systems for evaluation of ongoing projects.

3.3.3 Levels of Support to NGOs and Outputs

The NGOs currently active and receiving funds under this component of the FPSP are the Association for Voluntary Surgical Contraception (AVSC)/Bangladesh Association for Voluntary Sterilization (BAVS), The Asia Foundation (TAF), the Bangladesh Family Planning Association (BFPA), Family Planning International Assistance (FPIA), Family Planning Services and Training Centre (FPSTC), and The Pathfinder Fund (PF). Since 1981, FPSP support has totaled more than \$16 million.

The early years of the project were devoted to expansion of on-going efforts in CBD and the provision of quality VS services--primarily in the urban areas. By the end of CY 1985, the NGO component had grown to a total of 86 projects (of varying size) operating in 292 sites (see Table L).

Overall, the NGO component of the FPSP has made considerable progress in achieving projected outputs. In CY 1984, projected outputs were exceeded by 12-15 percent for temporary methods, 59 percent for VS referrals, and 23 percent for VSs performed (see Table M).

3.3.4 Descriptions of the NGOs

3.3.4.1 Bangladesh Association for Voluntary Sterilization.

Background

For the past 10 years, BAVS has been in the vanguard of the delivery of VS services in Bangladesh, pioneering quality VS services and providing both primary and refresher technical training for GOB and NGO medical personnel. BAVS expanded its clinics to meet the growing demand for voluntary sterilization and now supports 33 clinics (2 for vasectomy only). The recent national decline in numbers of voluntary sterilizations (see Section 3.1.2) has been especially dramatic at BAVS clinics, which have experienced a 62 percent decline in the number of VS procedures over the past 16 months, compared with a 52 percent fall in demand in the government program. The decline in sterilization now presents BAVS with the problem of unused capacity. This is particularly acute in 15 locations where BFPA clinics exist side-by-side with BAVS clinics.

Recommendations

In addition to consolidating its facilities (Section 3.2.2.5), BAVS should experiment with new activities that would capitalize on its proven skills in innovation and training and its excellent surgical facilities.

Clinical Experiments

- BAVS would be an ideal choice for gradual introduction of the contraceptive implant (Norplant), which requires surgical approaches to

insertion and removal. USAID should support such pilot efforts, subject to FDA approval of Norplant.

- USAID should support a clinical trial, perhaps by BFRP or BAVS, of oral ampicillin, intramuscular procaine, penicillin, and tetracycline as peri-operative antibiotics to decrease infection.

Training

- In addition to continuing its current training of GOB personnel, BAVS could (1) make on-site teaching services available to selected upazila Health and Family Welfare Centers (see Section 3.2.2.5) and (2) train other providers nationwide in Norplant insertions. USAID should support both efforts, subject to FDA approval of Norplant.

Service Delivery

- USAID should support a BAVS pilot project on maternal health and safe delivery among urban women under 18 years of age.

3.3.4.2 Asia Foundation. Family planning subprojects supported by TAF began in Bangladesh with a private voluntary agency (PVO) co-financing grant of \$500,000 in 1979. Between that date and 1981, when TAF received FPSP bilateral funds, nine subprojects had been developed with indigenous PVOs. By 1983 the number of subprojects, in both urban and rural areas, had grown to 18 and by the end of 1985 TAF was supporting 25 family planning projects in 60 sites, many of them rural based.

Since 1985 TAF has also funded two subprojects that are pilot efforts to lower fertility while improving the educational status of females in Bangladesh. This is done through provision of scholarships for female students in secondary, higher intermediate and BA courses. One of the two projects, carried out by the Bangladesh Association for Community Education (BACE), was directly funded by USAID for two years (1982-84) prior to TAF's involvement.

TAF's objectives for its USAID-funded family planning subprojects are to provide services and education to the

residents of project catchment areas. In some projects, TAF also provides loans for income generation activities.

TAF is recognized by the NGO community, USAID, and by its evaluators as having several special strengths in regard to programming. It has fostered the development of existing local NGOs through awarding them subproject grants and providing the technical assistance required to enhance their project development and management capabilities--in particular by means of an operations manual it has developed and its system for subproject monitoring through regular program staff visits to the project. TAF has encouraged innovative service delivery activities including the use of depot holders and or resupply agents in high prevalence project areas and the use of traditional birth attendants (TBA) to motivate clients and distribute contraceptives in rural areas.

Recommendation

USAID's decision to expand the Female Secondary Education subprojects based on an evaluation by Martin et al. should be postponed until their educational impact has been assessed. TAF has agreed to collect the data necessary for this assessment (see Appendix H for the reasons for this recommendation and suggestions as to how the data should be collected).

3.3.4.3 Bangladesh Family Planning Association. The BFPA, which was founded in the early 1950s and has a certain status as the first family planning organization in Bangladesh, is the Bangladesh affiliate of the International Planned Parenthood Federation (IPPF). The overall objectives of the organization include the provision of education and services which supplement the national family planning program, primarily through involvement of volunteers, youth and women. Demonstrating innovative family planning activities with the ultimate goal of self-reliance is another organizational objective. BFPA's primary sources of funding are USAID and IPPF.

BFPA provides sterilization services in 18 centers (see Section 3.3.4.1 for problem of overlap with BAVS).

With FPSP funding, the BFPA has developed and carried out two innovative CBD subprojects--one with traditional healers and the other with local clubs and voluntary agencies. Each subproject works in 20 sites scattered primarily in rural areas throughout Bangladesh. Some 2,000 volunteers who work in the two

subprojects receive Tk. 100 (U.S. \$3) per month to cover travel and incidental expenses. The excellent record-keeping systems developed for use by the volunteers is one of the major strengths of these efforts. As of September 1985, the two subprojects reported contraceptive prevalence rates of 51 and 63 percent for traditional healers and voluntary agencies, respectively.

Of benefit to the other NGOs is BFPA's assumption of a central role in contraceptive commodity distribution; in an arrangement worked out in cooperation with USAID, it obtains commodities from the GOB warehouse and distributes these supplies to most of the other USAID-funded NGOs. BFPA also carries out several demand creation activities: seminars for opinion leaders, including religious leaders, and showing of two color films with family planning themes through its mobile film unit.

It also has played an important role in IEC. Resource development activities are gathering momentum and BFPA's experience in this area should be tapped by the other NGOs.

BFPA's main weakness is a frequent lack of central direction, stemming both from the wide geographic dispersion of its small innovative projects and its dependence on volunteer leadership (which must also be viewed as a strength). More direction at the top level might allow for documentation of innovative activities and rapid expansion and/or transfer of innovations to other organizations.

3.3.4.4 Family Planning International Assistance. FPIA, the international division of the Planned Parenthood Federation of America, has funded projects in Bangladesh through its AID/W central cooperative agreement since 1972, but only began receiving bilateral funds from the FPSP in the amendment period. To increase close and regular monitoring of projects in Bangladesh, FPIA reestablished a country office in Dhaka in 1985, using a portion of the bilateral funds.

The innovative nature and size of FPIA's subprojects make them unique among NGO efforts. Several of its large subprojects are rural based. One is implemented by government workers of the Department of Social Services, another by local NGOs, while a recently approved project will work through Village Defence Party volunteers.

These projects include such innovations as the use of part-time fieldworkers with reduced caseloads and a forced

savings scheme for project workers which withholds a portion of each paycheck to be used for skill training and to back loans to the workers for income generating projects.

In three cases, FPIA plans or practices have met objections that remain unresolved. First, it has made a concerted effort to design subprojects directed at specific target groups. This runs counter to the traditional government-directed policy that NGOs should focus their activities on selected geographic areas. The second relates to FPIA's record-keeping and reporting systems, and specifically to its reluctance to change its definition of continuing user (which it uses in its projects worldwide) to conform to the definition used by the other NGOs. As a result, FPIA's data are not comparable with those of the other NGOs. The third relates to funding cycles and specifically to difficulties for FPIA in changing to the extended project approval cycles called for in the NGO 1984-87 policy paper. Since FPIA's bilateral funds are added to its central cooperative agreement, Bangladesh projects are approved through the same mechanism as centrally funded activities. Although the FPIA country office recognizes the managerial advantages of extended project approval cycles, AID/W and FPIA headquarters do not approve projects for longer than 18 months' duration.

Recommendation

FPIA's efforts to gain GOB approval for projects that do not follow the traditional geographic area coverage design need a review and solution.

3.3.4.5 Family Planning Services and Training Center. The FPSTC is a local Bangladesh organization formed in 1978 to serve as secretariat for the FPCVO (see Section 3.3.1). Originally funded by the Ford Foundation and FPIA, the FPSTC began receiving direct USAID support with the initiation of the FPSP in 1981. These three donors still provide the bulk of support to FPSTC.

The organizational objectives of the FPSTC include the encouragement and facilitation of coordination among and the provision of technical assistance to family planning NGOs. FPSTC also develops, funds and monitors family planning service projects, some combined with MCH and income generation activities, which are carried out by local NGOs.

Two previous evaluations concurred that FPSTC has made a significant contribution to the overall family planning program in Bangladesh. Its particular strengths include involvement of local opinion leaders in project development and management, its training program for project managers and supervisors (both for its own projects and for those of other NGOs), and its efforts to improve the flow of NGO program information both to the GOB and to field staff. In keeping with USAID's NGO strategy, FPSTC plans to limit the addition of new projects, to expand selectively, and to add project innovations.

Various problems have also been identified in regard to FPSTC's role, both as a funder of subprojects and as a coordinator for other NGOs. FPSTC funds multiple small subprojects in almost 50 widely scattered sites. The monitoring and evaluation of these projects, which are renewed annually, places an enormous management burden on FPSTC, the subgrantees and the donors (USAID and FPIA). Furthermore, the Governing Body of FPSTC, which is comprised primarily of busy GOB officials, takes a very active role in the review and approval of new and renewal project proposals, further complicating smooth project management. Because the Governing Board is composed primarily of Government officials, a situation putting FPSTC into the position as neither NGO nor GOB, the NGO community tends to resist somewhat being "coordinated" by it. The FPSTC has been relatively dormant in recent months, reportedly due to lack of funds, but probably equally because of the other NGOs' skepticism about its coordinating role.

3.3.4.6 The Pathfinder Fund. PF has been active in Bangladesh since the early 1950s when it was involved with the establishment of the BFPA. Its recent involvement began with the opening of a country office in 1978. Between 1978 and 1981, a variety of clinical and CBD project activities were carried out with AID central funds and private resources. At the initiation of bilateral funding to PF, there were three multi-site clinical subprojects with Bangladesh Railroads and the Ministry of Labor (industrial sites) as well as a number of satellite clinics in and around Dhaka. Four CBD projects were also in operation. These activities have now grown to 24 CBD subprojects and three clinic-based projects at 10 sites.

PF has done an excellent job of developing an urban CBD model which has been replicated in many sites throughout Bangladesh. With the installment of new program staff in May, 1985, new project management systems were developed for record

keeping and reporting and for CBD fieldworkers' daily workplans and quarterly subproject manager meetings in Dhaka have been inaugurated. PF also plans family planning orientation workshops for upazila chairmen, a type of activity in which it is recognized as having been successful. The Country Representative has encouraged evaluations of PF's work, including mini-CPSs for several of the ongoing CBD projects (see Section 3.1.3). As of year-end 1985, 20 of PF's 24 CBD subprojects were reporting CPRs ranging from 19-64 percent, but mostly in the 30-40 percent range, quite good by Bangladesh standards.

PF has also recently taken the lead in activities affecting the larger NGO community. These include sponsorship of a workshop in Chittagong to rationalize and reassign working areas to eliminate gaps in family planning coverage of Chittagong city and the chairing of a committee of all USAID-funded NGOs established to solve current shortages in available training resources.

Recommendation

PF and USAID should consider whether this is an appropriate time to review the present PF subproject portfolio. The review could focus on PF's role--specifically whether it should further adapt its urban CBD model for rural areas or whether its focus should be on innovations such as the Chittagong workshop, coordination of training, and the upazila chairmen workshop.

3.3.4.7 Bangladesh Fertility Research Program. BRFP, organized in 1976, is partially funded by USAID through Family Health International. This contraceptive research effort is expected to have data processing capability in Dhaka in early 1987. By then, several projects of considerable local significance will have been completed:

- o 400 cases (two centers) comparing acceptability and effectiveness of the multiload Cu device with the Cu-T 380.
- o 1,200 cases (four centers) comparing combination birth control pills containing 50 micrograms of ethinyl estrodiol with those containing 35 micrograms. The latter are likely to offer fewer side effects (head-ache, dizziness, nausea) which are the major causes of

discontinuance among Bangladeshi women who are slight of stature and weigh less than 100 pounds.

- o 600 Norplant insertions (three centers) one-year interim results of a five year study. Norplant has a contraceptive life of five years from a single subcutaneous insertion of six rods. Results from long-term studies in the U.S., Finland, Egypt, Ecuador, Indonesia, and Thailand are very promising. Momentum and continued use will enhance the ability and skill of those few clinicians who have done insertions. Extraction techniques will also be kept current.

Recommendations

Low Dose Pills

- If BFRP research demonstrates the acceptability of low-dose oral contraceptive preparations, USAID should encourage their introduction into the program, including the provision of funding, if necessary.

Norplant

- USAID should consider funding the expansion of BFRP's current Norplant studies and be ready to expand Norplant services as soon as FDA approval occurs in the U.S., if the first year research results in Bangladesh confirm the method's effectiveness and acceptance.

3.3.4.8 CARE--Family Welfare Visitors Faculty Training Program. The purpose of this grant was to enable CARE to provide financial and technical assistance to NIPORT to develop and carry out a comprehensive training program for faculty of the 12 Family Welfare Visitor Training Institutes (FWVTI). The grant, which was to be funded entirely under the first project (1981-84), was extended and finally completed in mid-1985. Funds obligated for this activity totaled \$525,000.

Training under this grant began in June 1982, one year after the agreement was signed between USAID and CARE, and continued until May 1985, almost one year beyond the expected duration of the project. Over the course of the project, NIPORT and CARE project staff jointly developed, translated, and obtained GOB approval for a six-month FWVTI Trainers Training Curriculum. In addition, a total of 10 manuals, booklets and

handouts were prepared for use in refresher training courses for field trainers, for staff of the Regional Training Center and in the social sciences and home economics, and for an FWVTI principals' workshop.

The original plan to train 70 new staff through Trainer Training Courses was dropped after the first two courses produced only 34 trained staff. Meanwhile, the GOB decided to reduce the number of field trainer posts so that the 34 trained staff were adequate. More recently therefore, emphasis has been given to refresher training for various levels of faculty of FWVTIs and Regional Training Centers. A total of 25 refresher courses have been given over the life of the project for a total of 196 participants.

Three evaluations carried out over the course of the project indicated a continuing need for upgrading the quality of teaching and knowledge level of staff. The need to place more emphasis on the practical components of the training courses was also indicated by these evaluations.

Conclusions

Although NIPORT's project plan for the Third Five-Year Plan indicates an intent to continue providing training opportunities for FWVTI faculty, according to the final CARE project report, no courses were held between the end of the CARE project in June and November 1985. With the current slowdown in intake of new FWV trainees, the need for continued Trainer and refresher training of FWTVI staff is uncertain at best.

3.3.5 Overall NGO Component: Issues and Recommendations⁵

3.3.5.1 Operational Issues.

3.3.5.1.1 Coordination Among NGOs. The need for better coordination among NGOs has increased as, mostly thanks to FPSP inputs, their programs have grown and matured. Efforts at coordination have occurred (e.g. BFPA's commodity distribution,

⁵ Section 3.3.4 contains recommendations on solving current issues specific to individual NGOs. This section includes recommendations on ways each NGO might contribute to the solution of general problems that affect the entire component.

PF's efforts to coordinate training, etc.), but in part because of the reluctance of most NGOs to accept FPSTC as a coordinating body, these efforts have not yet crystalized.

Recommendations

Individual NGOs should be encouraged to take a leadership role in areas where their strengths lie, with responsibilities distributed as follows:

- FPSTC's efforts to provide a forum for the other family planning NGOs should be further assessed and promoted if found to be useful and acceptable to the NGO community.
- BFPA should continue to take the lead in managing the NGO commodity system.
- PF should be encouraged to take a leading role in such activities as coordinating training and assessing whether services are overlapping (Chittagong workshop).

USAID should explore the feasibility and desirability of reactivating the FPCVO as a strong body to work with the NGO community, and provide funding, if necessary, for this purpose.

A new mechanism should be created to allow the entire NGO community to participate in an active forum that meets regularly to discuss/debate problems and issues of mutual concern. Position papers, minutes and other documentation from these sessions could be put forward to the FPCVO for action.

3.3.5.1.2 **Minimizing Management Burdens.** The six NGO programs have presented an excessive management burden for USAID, mirrored at a lower level by the burden on NGOs of supervising multiple subprojects. To reduce the management load at all levels, USAID has made efforts to consolidate subprojects (funding multiple subprojects or multisite subprojects) and to approve activities for longer periods of time. In many subprojects, field staff are spending a disproportionate amount of time in the central office, carrying out record-keeping and clerical duties. USAID is making efforts to standardize and evaluate service statistics through its MIS. If successful, these efforts will not only allow the GOB and USAID to compare the performance of NGOs with each other and with the GOB; they may also help reduce the time field staff are giving to record keeping. With

some exceptions, the NGOs are cooperating with USAID's efforts to consolidate and systematize NGO management procedures.

Recommendations

Project Cycles

USAID should continue to work with the NGOs that have not yet agreed to examine ways to extend their project development and approval cycles. Extended project cycles, however, should not be allowed to reduce opportunities for the NGOs to provide technical assistance to subprojects. This recommendation applies specifically to

- FPSTC, which is urged once again to seek approval from its Governing Body and FPIA to extend the length of project cycles. USAID should provide assistance in this matter if necessary.
- FPIA, which currently is bound by its headquarters and AID.W.

Service Statistics

Steps should be taken to improve the accuracy of NGO service statistics through improving record-keeping systems and ensuring their consistency throughout the NGO community.

- A systematic study attempting to determine the accuracy of service statistics-based prevalence rates for NGO subprojects funded by AID should be undertaken. This study should also attempt to identify the source of the discrepancies and suggest ways to improve the accuracy of active user and eligible couple data. External TA should be sought to rationalize and standardize the NGO record-keeping and reporting systems. This should include a close examination of the time spent by CBD field staff in clerical and office duties.
- If FPIA does not agree to adjust its definition of continuing users for the purpose of reporting to USAID, its service statistics should be listed separately from those for other NGOs so FPIA performance is not unjustly compared with that of the other NGOs.

3.3.5.2 Program Issues

3.3.5.2.1 **NGOs as Innovators.** One of the NGO component's major purposes has been to experiment with new techniques of service delivery and to document successes (or

failures) for the benefit of other service delivery organizations. Many NGO pilot and demonstration projects have been noteworthy. The NGOs' potential as disseminators of lessons learned, however, remains largely untapped. Successes and failures are neither well documented nor widely disseminated, and as a result, few examples of successful undertakings have been transferred among them or to the GOB.

Recommendations

Experimentation

NGOs should continue to experiment with new approaches, focusing particularly on

MCH

- Since the integration of family planning and MCH is established GOB policy, USAID should continue to encourage the gradual expansion of integrated programming by the NGOs. NGO funding for efforts in this area might best be used to encourage innovations and to document the impact of integration.

Opinion leaders

- More funding for opinion leader seminars like those arranged by TP should be considered and additional emphasis placed on educating religious leaders and newly-elected upazila and union officials, as well as possibly Parliamentarians.

Documentation and Dissemination

The success and failure of NGO innovations must be better documented and communicated. More effort should be made to transfer successful initiatives to the program of other NGOs and the GOB. Specifically

- BFPA should look for ways to consolidate its two CBD efforts, attempt further documentation of their impact and cost effectiveness, and look for an appropriate forum in which to share this experience. Particular attention should be given to promoting replication of the record-keeping systems.

- TAF's experience in designing and implementing rural projects should be documented and shared with other NGOs planning to work in rural areas. Special attention should be given to describing the interaction between these TAF subprojects and local GOB family planning officials and staff. Other project innovations introduced in TAF projects--particularly the use of depots or resupply agents--also deserve a close assessment for possible replication by other NGOs and/or the GOB.

- FPIA's innovative, rural-based activities also should be documented and shared.

3.3.5.2.2 Expansion of Services. The NGO component has made an important contribution to the national family planning program by providing services in limited geographic areas, mostly urban. Recently, however, the NGOs have learned that the maximum coverage they thought they were providing was in some cases still not complete (Chittagong workshop--see Section 3.3.4.6) while in others they found duplication (BAVS and BFPA--see Section 3.3.4.1). As the NGOs expand into rural areas, the major problem may prove to be duplication, since the GOB program will already be in place in most areas. As yet, no guidelines have been developed to divide the areas or to work out smooth integration of services.

Recommendations

More attention should be directed to the problem of overlap, both among NGOs and between the NGO and government services, particularly as NGOs expand into rural areas.

- USAID should encourage the NGOs to collaborate with the GOB (particularly with the Deputy Director/Family Planning in each district) in a review to identify gaps or duplication in services with the objective of ensuring adequate coverage of all municipal and periurban areas within the next two to three years.

- The NGOs should also strive for regular and better coordination and collaboration among themselves to maximize coverage and avoid duplication.

- Prior to rapid expansion of NGO efforts in rural areas, guidelines should be developed on ways to minimize competition and enhance cooperation between the NGO and the GOB service providers. These guidelines should be based in part on the experience to date of NGOs that have operated in rural areas (e.g., FPIA, TAF, BFPA).

Based on the above survey and resultant guidelines, NGOs should be encouraged to utilize a portion of USAID funding to channel subgrants to local rural NGOs through local elected officials, e.g., upazila and/or union chairman and the local family planning committees. The objective would be to ensure the involvement and commitment of the local community leaders while at the same time to foster cooperation and collaboration between the GOB and NGOs in rural areas. This scheme should be limited to a few pilot areas and perhaps to a few NGOs initially, but the experience should be reviewed and communicated to the other NGOs as soon as possible for potential replication.

3.4 Social Marketing Project.

Background

The SMP has been operating in Bangladesh since 1975. Technical support has been provided by Population Services International (PSI) from the start. Funded initially by AID/W, in 1981 SMP has become bilaterally funded under the FPSP. In 1984, PSI funding shifted from a contract to a cooperative agreement.

The purpose of the project is to provide universal access to, and to increase the use of safe and effective temporary methods of contraception in both urban and rural areas. Basic principles of marketing and advertising and, where possible, existing distribution networks were to be employed in this effort. Between the initiation of bilateral funding in 1981 and March 1986, the cumulative number of SMP retail outlets had reached almost 130,000, although it was believed that the number of currently active outlets was much smaller. The Project currently sells three condom brands (Raja, Panther, and Majestic), standard (Maya) and low-dose (Ovacon) oral contraceptives, vaginal spermicides (Joy), safe delivery kits, injectables (Noristerat), and oral rehydration salts. USAID obligations for

the SMP, exclusive of contraceptives, from FY '81 through FY '85 totaled \$16,852,617.

Findings

Annual sales of SMP commodities are shown in Table 7. As seen in this table, commercial sales of all SMP products increased steadily up until 1985, when sales of Raja condom (the largest selling SMP product) began to decline. This apparent decline appears to be due in part to heavy overstocking which occurred just prior to an announced price rise (from 15 to 20 paisa per piece). No decrease in sales, however, was noted at the retail level.

In addition to product sales, the SMP was also engaged by USAID in 1983 to undertake a general (not brand- or methodspecific) promotional campaign for family planning. Under a sub-contract with Manoff International (totaling about \$1.0 million over a three-year period), research was initiated regarding constraints to access to modern contraception. Issues such as religion, fear, side effects, and husband indifference were identified and were used as the basis for developing a media campaign. At the request of the GOB, constraints related to religion were not included.

The major media used were radio, which reaches 40-50 percent of the population, and films, directed primarily at males. SMP staff estimated that about 10 million families are reached annually through the film shows.

According to SMP, profit margins at the retailer level are 15-20 percent and are similar to usual commercial margins at that level. The highly subsidized price and relatively low sales volume, however, yield relatively small profits, in absolute terms, at the retail level. Initially, SMP tried to use the existing commercial distribution system to move product to the retail level. Due to a lack of interest on the part of wholesalers and stockists, however, it soon learned that it would have to employ staff to perform this function. Increasingly, SMP fieldstaff work for the wholesalers in moving product to the retail level.

According to SMP staff, the Project currently recovers about 30 percent of operating costs and 10 percent of overall costs. The cost effectiveness of SMP, however, as calculated by Simmons et al. in a recent paper, is \$15.33 per

TABLE 7

SMP DISTRIBUTION OF CONTRACEPTIVES BY YEAR

| <u>METHOD</u> | <u>1981</u> | <u>Year (Calendar Year Jan - Dec)</u> | | | <u>1985</u> |
|-------------------------|-------------|---------------------------------------|-------------|-------------|-------------|
| | | <u>1982</u> | <u>1983</u> | <u>1984</u> | |
| Condom (pieces) | 47,367,494 | 68,916,320 | 88,255,792 | 108,973,062 | 85,342,734 |
| Pill (cycles) | 852,605 | 1,143,241 | 1,543,061 | 2,080,906 | 2,230,711 |
| Foam tablet (pieces) | -- | 3,506,395 | 4,505,474 | 3,157,068 | 3,059,080 |

CYP, which compares favorably with other elements of the national family planning program.

Of major concern to USAID and SMP staff is the existence of the so-called "condom gap" (see Section 3.1.3 and Table N). Studies of the condom gap are contained in the 1983 Condom User Survey, a report by Deloitte Haskins, and Sells, and most recently by John Laing of The Population Council in a 1986 memo to USAID. According to Laing, the bulk of the gap of 42.8 million condoms under the SMP is explained by an underestimate of coital frequency and wastage among married couples, and the accuracy of the survey data (i.e., that husbands' responses, which convert into a 2.7 percent active user prevalence rate [see Table 5], is more accurate). While acknowledging the "softness" of the data, Laing nevertheless believes that his analysis, plus the first four factors (growth of the pipeline, contraceptive use by unmarried persons, ex-country sales, and misuse) contained in the Deloitte, Haskins and Sells report, account for the bulk of the discrepancy.

Conclusions

At this point, the SMP has met the objectives of making modern contraceptives widely available in Bangladesh. With sales of selected products either leveling off or declining, however, there is a need to rethink whether simply increasing the number of outlets is the most cost-effective strategy for increasing contraceptive availability and use. This is particularly important in view of the "condom gap," concerns about condom and pill use-effectiveness, and the lack of information about the role of the condom, in particular, in introducing couples to modern contraception. With USAID beginning to consider a follow-on bilateral family planning project, it is an opportune time to investigate these issues further and to explore the extent to which revisions in the current SMP strategy are warranted.

Recommendations

SMP should develop a new strategy based on market segmentation. *

- SMP should begin to shift its focus to those sub-groups of the population where sales and effective use of SMP products are apt to be greatest. The challenge will be to do this without undermining the urban commercial market

and without a substantial drop in clientele. SMP should engage the services of a qualified marketing and advertising firm to help design this new strategy.

- SMP should undertake a retail audit to determine what the market is, what share it has, and how its market share can be increased. This audit should also analyze the relative efficiency of the marketing system, perhaps eliminating or substituting for inactive retailers.

SMP should continue new initiatives in the health field.

- SMP should take advantage of its recent entry into the health field, making an effort to improve its visibility among the pharmacists and physicians to whom they sell.
- SMP should try, initially on a pilot basis, the use of trained TBAs as sales agents for the safe delivery kits. The TBAs would have already developed rapport with potential users in their respective neighborhoods and would be well prepared to discuss the benefits of safe birth practices with their clients.

SMP should continue to investigate the use, use effectiveness, and cost effectiveness of SMP products.

- High priority should be given to the completion of the on-going pill and condom use-effectiveness study. Such studies should probably be repeated periodically for all SMP methods. }
- One important potential justification for social marketing activities is the extent to which they serve as a vehicle for introducing couples to modern contraception. Data should be collected that will indicate the extent to which this occurs with SMP products and, in the case of the condom, whether users move on to more effective methods. (This information is available from the CPS, but not specifically for SMP product use--Tables O and P.)

- Cost effectiveness of the SMP needs to be monitored effectively. Laing's suggested methodology--i.e., dividing SMP costs by the number of CYP implied by survey-based prevalence data--seems appropriate. An improved MIS is needed to provide feedback from the retail level, either through a sample of retailers or periodic studies of retailers and consumers.

SMP should continue to receive USAID support pending the implementation of some, or all, of the recommendations provided above. USAID should not, at this time, encourage efforts to institutionalize SMP by financing construction of a permanent headquarters.

3.5 International Center for Diarrheal Disease Research, Bangladesh-Extension Project

Background

In the course of its evolution, ICDDR,B (1965-present) has moved beyond its original scope--the evaluation of cholera vaccines--into the field of family planning. On the basis of published experience of the ICDDR,B MCH and family planning project carried out from 1977-1982 in Matlab thana (Phillips et al. and Stinson et al. Studies in Family Planning, May 1982), the following conclusions were drawn: 1) contraceptive distribution in the absence of regular home visits is insufficient to fulfill latent demand on a sustained basis; 2) effective service delivery can result in substantial increases in modern contraceptive use; 3) on a national level the low CPR may be due more to poor program implementation than to an absence of client motivation; and 4) rural Bangladesh holds considerable promise for achieving significant demographic change.

On the basis of this successful experience, the GOB requested ICDDR,B assistance in testing the transferability of selected elements of the Matlab program within the MOHFP system. In 1982, therefore, ICDDR,B, with assistance from USAID, initiated the so-called Extension Project. Under this project, ICDDR,B staff worked with GOB counterparts to identify the barriers to implementation and to encourage changes where indicated in the organization and training of MOHFP personnel.

Two geographically separate upazilas were chosen and baseline data were collected for both the experimental and surrounding control areas. In the trial areas, existing government workers were utilized and staffing patterns remained essentially unchanged.

Project interventions concentrated on 1) human resource development (fieldworker training including utilization of Matlab project counterparts), 2) improvement of field management (client-based information system), 3) improvement of technical services, and 4) improvements in district level management.

In addition, on the basis of Matlab research, which found fieldworker to population ratios and distance from the client's home to be critical determinants of success, increased fieldworker densities will be established in the two project areas.

A sample registration system (SRS) has been established in the two project areas to monitor implementation and changes in contraceptive use. A client-based longitudinal information system involving handheld registers in which the family welfare assistant (FWA) records information about the client's status and services performed has also been introduced in the experimental areas. At this point, however, discrepancies exist between the SRS and the longitudinal system, with the former yielding lower estimates of prevalence. If ultimately proven successful, this record-keeping system may be adopted by the MIS unit of the Family Planning Directorate.

Field staff involved in trial areas generally agreed that 1) the new record system allows greater ease of client identification and worker self-evaluation; 2) there is a noticeable shift away from VS acceptance; 3) the "no target" system with worker evaluation based on visits and verifiable field work is important; and 4) increased worker density allows more frequent visits to non-acceptors and those experiencing side effects associated with contraceptive use.

An additional component of the activities funded by USAID under the Extension Project is policy-relevant research based on data collected in connection with work in the ICDDR,B experimental area in Matlab. The project yielding data for this research is the Matlab Family Planning Health Services Project (FPHSP). Under this component, ICDDR,B is continuing to assess the impact of family planning and MCH services on contraceptive use, fertility, and mortality.

Conclusions

Findings from the earlier Matlab MCH/Family Planning Project clearly show that high quality domiciliary-based service delivery can have a profound effect on temporary method use and overall contraceptive prevalence. These data also show that reasonable fieldworker to population densities are essential to achieving this kind of coverage. Largely on the basis of the work done in Matlab, the GOB has made a commitment, with assistance under the third World Bank-assisted population project, to reduce the fieldworker to population ratio from one to 7,000 - 8,000 to one to 4,000.

Under the FPHSP, important data on the impact of family planning on maternal and infant/child mortality is beginning to emerge. This information is receiving attention both among high-level policymakers in Bangladesh and in the developing world more broadly. The status of this important research is discussed more fully in Section 3.1.4.

Finally, the Extension Project, though still in the early stages of implementation, can be credited with a number of important "lessons learned" (see Section 4.5.1 for a list of the major lessons). Through this project, a number of additional innovations are either under way or planned. These include the definition and application of criteria for recruiting and placing FWAs and alternative approaches to facilitating access to voluntary sterilization services. Despite the recent organizational and budgetary problems within ICDDR,B, the MCH-family planning Extension Project activities have continued to function smoothly. Current staffing limitations, however, are constraining the ability of the Project to undertake new priority research activities.

In sum, FPHSP has been confronting the most fundamental family planning issue facing both Bangladesh and the rest of South Asia--how can services delivered through large government programs (which must play the key role for the foreseeable future) be made more effective?

The ICDDR,B component has been in the vanguard of the search for answers to this question. Its research activities have generated high quality policy-relevant research which feeds directly into the policy making process in Bangladesh. Regular meetings are held with GOB counterparts at the national level to identify important research issues and review the status of

ongoing activities. This linkage between policymakers, program planners and the researchers is considered by many to be a model.

Recommendations

High priority should be given to continued USAID support of the ICDDR,B Extension Project, including expansion of its research activities from the Matlab FPHSP. Steps should be taken to avoid decreases in project personnel. USAID should support efforts to apply the lessons learned to date elsewhere in Bangladesh, both in the public and the NGO service delivery programs.

Systematic research should be undertaken to determine why the CPR estimates yielded by the client-based registers differ from those produced by the SRS. If it is found that the registers are yielding inaccurate information, efforts should be made to revise the system so that greater accuracy can be achieved.

4. KEY ISSUES

Any future assistance in the area of family planning should be guided by consideration of a number of key issues.⁶ Much has been learned about these issues in the past few years, both through experience in the Project and through research undertaken in the ICDDR,B and the CPSs. The issues are both of a general nature and specific to the various Project elements. Issues related to the level of demand for services, an appropriate strategy to meet that demand, and the feasibility of meeting the government's Third Five-Year Plan goals are discussed immediately below. This is followed by a discussion of programmatic issues relating to the four major program components.

4.1 General

4.1.1 Potential Demand for Contraception

To what extent does latent demand or unmet need exist for both permanent and temporary methods of contraception (i.e., should greater emphasis be given to indirect or demand-related determinants of fertility)? What effect does availability of contraceptives have on demand?⁷

4.1.1.1 Unmet Need. The primary strategy of the FPSP, like that of the National Family Planning Program of the GOB, is premised on the assumption that there is a substantial proportion of couples in the population who desire to limit family size or space childbearing but who do not have adequate access to appropriate means of birth control. Thus, critical to the present strategy is the assumption of a substantial unmet need for family planning, with the implication that contraceptive prevalence could be raised substantially if effective contraceptive methods were made widely available in an acceptable way to prospective clients.

Unmet need for family planning is typically assessed through analysis of survey responses on contraceptive practice in conjunction with responses about whether additional

6 See Scope of Work Section C.

7 The second question was added during the writing of this report.

children are desired and, if they are, information on how soon they are wanted. Couples who indicate they do not want more children and are not using a method of birth control are considered to have an unmet need for limiting, while those who want more children but wish to delay the birth and are not using contraception are considered to have an unmet need for spacing. A recent analysis of 1983 CPS data indicates that between 27 and 37 percent of currently married women under age 50 had an unmet need for family planning in order to limit family size. Since no data were collected about desired birth spacing, no estimate of the unmet need for spacing could be calculated.

Measures of unmet need calculated from survey data are criticized on a number of grounds as being poor indicators of the genuine potential demand for family planning. Questions about desire for additional children may have little meaning to the respondent. Indeed, surveys in Bangladesh often show a substantial number of respondents who reply the number of children they want is "up to God." On the other hand, recent research in the ICDDR,B Extension Project shows that statements about wanting no more children and future intent to use contraception collected in the base-line survey are by far the best predictors of subsequent acceptance (Phillips et al., 1985).

That there is considerable unmet need can also be inferred from the experience in the Matlab FPHSP service areas. Here, where the project provides an ample supply of high quality service, the CPR rose to almost 50 percent. This rise could not have occurred had there not been latent demand for family planning services.

4.1.1.2 Temporary and Permanent Methods. Related to the issue of potential demand for family planning is the question of possible differential receptivity to temporary and permanent methods. This can be divided into two issues: 1) To what extent is there an unmet need for spacing compared to limiting? and 2) For those interested in limiting, what proportion prefer to use temporary rather than permanent methods?

Evidence from the 1983 CPS concerning active practice of contraception indicates most use of contraception at that time was for the purpose of limiting: among all contraceptive users, 79 percent said they wanted no more children, 2 percent said they were uncertain if they wanted no more children, and 19 percent said they wanted more children. Thus, almost four-fifths were limiters and less than one-fifth were clearly spacers. In addition, contraceptive use was far higher among

woman who said they want no more children (31 percent prevalence) than among those who said they want more children (8 percent prevalence) (see Table Q).

With respect to spacing, the experience of most family planning programs shows that as prevalence rises, the proportion of couples who use contraception for spacing purposes also rises. This sequence of events is likely to occur in Bangladesh in the future.

One focus group research project suggests there is considerable interest in spacing births at longer intervals than would occur in the absence of birth control (Choudhury et al., 1985). More systematic research clearly is needed in this area. Also of interest are data from the 1983 CPS presented in Table R showing contraceptive practice among woman who want more children, according to the number of additional children wanted. Those who only wish one more child are far more likely to be spacing than any other category. Those who believe the number of additional children is "up to God" are by far the least likely to be practicing.

There are no direct data on preferences available to answer the second question about whether couples who wish to limit family size prefer permanent or temporary methods. The data from the 1983 CPS (see Table Q), however, indicate that about half the couples who are practicing some method of contraception for limiting purpose (i.e., who say they want no more children) are using a non-permanent method. Furthermore, the 1983 CPS findings on the method of choice among non-users who intend to use contraception sometime in the future indicated that, of those who intend to use and can specify a method, less than one-fifth said they intend to use a permanent method (see Table S). Although it is not known from the survey if those who intend to use are planning to use for limiting or spacing purposes, many probably plan to limit. Thus, it seems safe to conclude that there is considerable interest in temporary methods not only among spacers but also among limiters or potential limiters.

It should be noted that future unmet need will be influenced by changes in fertility preferences, both with respect to family size and birth spacing. If desired family size decreases and/or desire for prolonging birth intervals increases, unmet potential demand for contraception could persist even as contraceptive prevalence rises and could continue to serve as a force providing new clients for the program.

4.1.1.3 Role of Availability of Contraceptives.

The Matlab FPHSP gives credence to USAID's assumption that there is a link between availability and contraceptive prevalence. Since in the Matlab FPHSP service areas, there was no basic improvement in development levels, it can be assumed that the determining factor in the increase of CPR to almost 50 percent was the widespread availability of family planning services. The rise in CPR has been accompanied by a substantial fall in fertility. Moreover, the impact of the project has been maintained for close to a decade, demonstrating that effects are not temporary but rather have been substantial and sustained.

Additional evidence is provided by the recent experience in the ICDDR,B extension areas, where the intensity and quality of services are considerably less than in Matlab and where inputs more closely approximate normal GOB personnel and resources. The fact that the prevalence increases in these areas are so well documented lends credence to the CPS data indicating the less dramatic yet still significant rises in national prevalence rates. In addition, a number of NGO subproject areas show very impressive levels and gains in CPR (see Section 3.1.3). While the accuracy of any particular subproject CPR can be called into question as indicated by those few areas where mini-CPSs were conducted, even the mini-CPS estimates confirmed that a number of areas had CPRs at 40 percent or higher.⁸

4.1.1.4 Summary of Conclusions.

In sum, it has been found that there continues to be considerable unmet need throughout Bangladesh for family planning services. While most contraceptive use is aimed at limiting births, a considerable proportion of those who limit use temporary methods. If modern contraceptives are made available, substantial increases in modern contraceptive use can occur prior to or in the absence of social change--previously felt to be a prerequisite to fertility decline.

⁸ In one upazila that the team visited, which was not the target of a special program but which had an energetic and committed Family Planning Officer, a CPR of 52 percent was recorded in a special survey undertaken by the upazila Family Planning Officer. Because of our initial skepticism about his claims, with the help of ICDDR,B workers, the team went to several of the villages covered by the survey and checked the accuracy of his records. They were correct in virtually every respect and the team was convinced that the recorded CPR was not grossly exaggerated.

4.1.2 Current Program Method Mix

Does the current program method mix reflect informed choice? Or, does it focus too heavily on "limiters," giving priority to voluntary sterilization and not providing adequate access to information and services relevant to temporary methods of contraception?

Clearly, the program has given priority to the relatively more effective methods of contraception, particularly sterilization and the IUD. On the other hand, as Table 8 illustrates, an effort has been made to make temporary methods of contraception available from a wide variety of outlets nationwide. In addition, data from the 1985 CPS indicate that an increasing portion of current contraceptive users are adopting temporary methods. It is also known that the majority of contraceptive users in Bangladesh want to terminate childbearing. It is not unreasonable, therefore, to expect that a large portion of those couples would choose a permanent contraceptive method. Numerous surveys and studies have found this to be the case and have confirmed both high levels of satisfaction with the procedure and few cases of regret.

Under the FPSP, the majority of USAID's support has been for non-permanent methods of contraception. This assistance finances the SMP and community-level distribution programs being implemented by and through NGOs. The bulk of USAID's support for voluntary sterilization has been in the form of reimbursements to the GOB, BAVS, and BFPA for the costs associated with service delivery. With the dramatic decline in the number of VS clients since October 1984, this element of USAID's support has decreased considerably.

While it is difficult to argue that the program is heavily biased in favor of permanent methods, there are a number of factors that continue to hamper the availability and use of temporary methods. Access to information and services, particularly for women, continues to be constrained. Women do not feel comfortable purchasing contraceptive supplies directly from SMP outlets and there are simply not enough trained field-workers to make the regular home visits that seem to be critical to reaching this group. Because of perceptions about relative use-effectiveness, there remains a tendency for program planners to communicate a sense of priority for VS to field personnel. Finally, there are important limitations to the temporary methods that are available. Availability of the injectable, which does appear to be highly acceptable, is still limited. The probable addition of the contraceptive implant (Norplant) long-acting

TABLE 8

SERVICES AVAILABLE BY CONTRACEPTIVE METHOD.
NUMBER AND TYPE OF OUTLET

| CONTRACEPTIVE METHOD | NUMBER OF OUTLETS PROVIDING SERVICES | | | | | | | | TOTAL |
|----------------------|--------------------------------------|------------------------------|----------------------------------|------------------|--------------|-----------|------|------|-----------|
| | Upazila Health Complex | Health and FP Welfare Center | District Hospital (sub-division) | Model MCH Clinic | CBD Projects | SMP | BAVS | BPPA | |
| Orals | 477 | 1.220 | 58 | 91 | 134 | 63,379 | 33 | 40 | 65,432 |
| Injectables | 477 | 1.220 | 58 | 91 | 25 | 40 | -- | 18 | 1,434 |
| IUD | 477 | 1.220 | 58 | 91 | 75 | -- | 33 | 18 | 1,972 |
| VS | 477 | • | 58 | 91 | -- | -- | 33 | 18 | 677 |
| Condoms | 477 | 1.220 | 58 | 91 | 134 | 129,346** | 33 | 40 | 131,399** |
| Poon | 477 | 1.220 | 58 | 91 | 134 | 63,379 | 33 | 40 | 65,432 |

* Mobile teams may use temporary sites.

** Note previos in Section 3.4 that 129,346 SMP outlets for condoms is a cumulative figure, and that the number of currently active outlets is much smaller. This also affects the total number of outlets carrying condoms.

reversible method will fill an important gap for couples who want to terminate childbearing, but do not want a permanent method.

4.1.3 Third Five-Year Plan Goals

How realistic are the demographic goals as expressed in the GOB's Third Five-Year Plan?

The GOB recently began implementing its Third Five-Year Plan which runs from mid-year 1985 to mid-year 1990. Given USAID's commitment to assist in achieving the demographic goal set forth in the plan, an assessment of how realistic these goals are is appropriate.

According to the Plan, the GOB is aiming at a reduction in the total fertility rate (TFR) from its assumed level of 5.5 at the start of the plan to 3.4 by mid-year 1990 and a reduction in the population growth rate from 2.4 to 1.8 percent. In order to accomplish this, contraceptive prevalence (of all methods) is to be increased from a presumed level of 25 percent at the start to 40 percent by midyear 1990.

An assessment of the feasibility of these contraceptive prevalence goals depends in part on how the goals are interpreted. Different interpretations are possible because the assumed baseline level of 25 percent may be too low. Examination of the Plan reveals that the GOB based its calculations of prevalence goals on rates that make allowance for underreporting of male methods, i.e., the "working rate" such as was developed based on the 1983 CPS rather than the conventional rate based only on prevalence as reported by the eligible women sample of the CPS.

A "working rate" of overall prevalence based on preliminary findings of the 1985 CPS can be roughly estimated as follows. In 1983 the "working rate," allowing for underreporting of condom use and vasectomy, was 2.4 percentage points above the conventional rate. If 2.4 percentage points are added to the 25.1 percent prevalence estimated on the basis of the preliminary results of the 1985 eligible women sample (see Table 2), a "working rate" of 27.5 percent results. This estimate is conservative since vasectomy and condom prevalence probably increased between 1983 and 1985. Thus the correction due to underreporting of these methods would add somewhat more than 2.4 percentage points. A reasonable estimate of overall prevalence based on the "working rate" would be approximately 28 percent. Given that

overall prevalence is estimated to have increased by six percentage points (three points per year) between 1983 and 1985, and allowing for the fact that the start of the Plan refers to mid-year 1985 (and hence a half-year earlier than the time of the CPS), the "working rate" CPR should be reduced by 1.5 percentage points. This yields a rate of about 26.5 percent as the correct baseline figure rather than 25 as is stated in the Plan.

In sum, the Plan goal can be seen either as raising CPR by 15 percentage points (25-40 percent) or by 13.5 percentage points (26.5-40 percent) during the Plan period. These increases would require an annual rate of increase in CPR of from 2.7 to 3.0 percentage points per year from mid-1985 to mid-1990. Although overall prevalence rose by 3.0 per year during the two years between the 1983 and 1985 CPS, this is well above the average annual increases experienced during previous periods. Moreover, there is reason to doubt that this rate of increase can be sustained during the next few years given the recent downturn of VS. Thus a goal of 40 percent prevalence by mid-1990, while not completely out of the question, seems too optimistic.

Another issue relates to the stated demographic goal of achieving a growth rate of 1.8 percent. A recent analysis by Barkat-e-Khuda and S.R. Howlader (1985) of Dhaka University suggests that even if a CPR of 40 percent were achieved, this would not be sufficient to reduce the growth rate to 1.8. Instead, CPR would need to rise to at least 43 percent and probably higher to meet this demographic goal. If this is so, then the demographic goal must be judged to be even more optimistic than the CPR goal. One unknown variable is the role that changes in female age at marriage might play. Increase in age at marriage would add to fertility reduction. Substantial changes in age at marriage, however, seem unlikely over a five-year period.

4.2 Programmatic Issues Relating to MOHFP

4.2.1 Integration of Health and Family Planning

How has integration of health and family planning affected implementation in the field? What changes, if any, are needed in this field structure to improve program effectiveness?

Since 1980, the government has been attempting to integrate the family planning bureaucracy, with 25,000 personnel, into the even larger work force of its health bureaucracy.

While integration has been accomplished at the top levels of the MOHFP, there are considerable problems below, particularly at the upazila and union levels. The Deputy Director/Family Planning and upazila-level Family Planning Officers are disturbed by their loss of autonomy and clear supervisory responsibilities. For the Family Planning Officers, the new situation is particularly unpalatable. They have been placed under the control of the upazila Health and Family Welfare Officer, who is from the Health Wing. Only 50 percent of the Family Planning Officers have been encadred (given permanent status), and they have been removed as members of the upazila parishad. In August 1985, their national organization agreed to a work slow-down. This threatened the only realm where integration had worked to date--the VS program, in which both Wings had a large and identifiable role.

In addition, there are strained relations between the Medical Assistants and Family Welfare Visitors at the union Health and Family Welfare Center level; here lack of clarity of their respective roles is a major problem.

It is well known that while family planning is one of the Health Assistant's prime responsibilities, in reality little attention is given to this service. Although the Health Wing is in administrative control at the upazila level and below, its staff generally has little interest in family planning and concentrates instead on clinic-based curative care. Moreover, scant attention is given to MCH services, which have been delegated to the Family Planning Wing.

Frustration, low morale and lack of clear lines of communication and responsibility among the Family Planning Wing field organization is resulting in generally low levels of performance. Nevertheless, some workers and managers continue to function at a remarkably high level of effectiveness, demonstrating what could be achieved if adequate work incentives existed.

In short, employees of the Family Planning Wing feel as though they are being treated as second class citizens. This is having a major impact on program performance and, if left unresolved, will seriously undermine efforts to reach the Third Five-Year Plan demographic goal.

While the issue of integration and the attendant problems are very complex and solutions not within easy grasp, it is clear that action must be taken. The solutions recommended below appear to be the most workable among those made by Bangladeshi counterparts and members of the donor community.

- o Continue efforts to encadre the remaining upazila Family Planning Officers;
- o Given the critical importance of population, support efforts to make the Family Planning Officers members of the upazila parishad;
- o As health assistant vacancies arise, give priority to filling these positions with qualified female workers;
- o Reestablish a clear line of authority between the Deputy Director of Family Planning and the upazila Family Planning Officers;
- o Ensure that upazila Family Planning Officers receive office space and other authorized accommodations and logistical support within the upazila Health Complexes;
- o Find ways to involve the Health Assistants more actively in family planning particularly in contacts with males; and
- o Clarify the respective roles of Medical Assistants and Family Welfare Visitors regarding family planning.

Another important integration issue is the role of clinical methods of contraception in the program and the need to ensure that the responsible persons from the Health Wing (e.g., Medical Officers at the upazila Health and Family Welfare Center) are technically proficient. These services include male and female sterilization, insertion of IUDs, and perhaps later, the introduction of the contraceptive implant. Ways in which technical proficiency might be ensured are explored in Section 3.2.2. It is also important to note that these clinical methods require medical back-up and follow-up to ensure continued use.

4.2.2 Motivation of Fieldworkers

What is the role of method-specific targets, both with respect to NGOs and MOHFP in the program? Do they contribute in a positive way to overall program achievement, or should alternative measures of performance be used?

Method-specific targets for fieldworkers have been used by both the MOHFP and the NGOs as a means of encouraging and monitoring fieldworker performance. Though formalized in circulars issued by the MOHFP, these modest targets appear not to be used as a basis for rewarding or punishing field personnel, and, while regarded as general guidelines that define minimum expected levels of achievement, appear not to be enforced. NGO fieldstaff, however, tend to adhere more closely to the targets than do MOHFP fieldworkers.

While time did not permit a thorough investigation of this issue, the preliminary impression, on the basis of discussions with program officials and field personnel, was that, while the targets were not particularly useful, neither were they an obvious detriment to the program. The target system is not, as some had thought, heavily biased in favor of permanent methods of contraception.

On the other hand, an effort should be made to identify and test alternative measures of performance. Some possible alternative measures at the fieldworker level include number of home visits, completeness of client records, or perhaps some effort to assess systematically the extent to which fieldworkers are communicating effectively with clients. USAID and the GOB should discuss alternative means of motivating fieldworkers and monitoring performance, using operations research, perhaps through the ICDDR,B subproject.

4.2.3 Institutional Capacity

Are there any areas where USAID might assist in strengthening the MOHFP's institutional capacity?⁹

⁹ This question was added at the time the evaluation was being written.

o Information, Education and Communication

A number of factors serve to weaken the motivation for practicing family planning in Bangladesh. Specifically, its socioeconomic and cultural context may inhibit people who appear to have an unmet need for family planning from actually using it. To cite but one important example, Islamic religious orientation of the majority and the associated pattern of male-female interactions, including the practice of female seclusion, operate against women taking independent initiative to seek contraceptive services actively outside the home. Moreover, substantial segments of the population may perceive family planning in general or specific methods in particular to be contradictory to their religious convictions. Evidence indicating that opposition to family planning on religious grounds is an important barrier to family planning among at least some sectors of the Muslim majority in Bangladesh is presented in Appendix I. Another constraint may be opposition by the spouse or other family members to family planning.

The apparent existence of relatively widespread but fragile potential demand for contraception in Bangladesh poses a particularly difficult challenge to the national program. Compared to some areas in Southeast Asia, where motivation to practice family planning is both widespread and strong, the task of converting latent demand into actual practice is more difficult in Bangladesh. However, the examples of Matlab, the Extension Project, and NGO projects indicate that the task is not an impossible one.

The challenge is to translate these isolated success stories into a national effort, involving both the MOHFP and local leaders. The Information, Education and Motivation (IEM) unit of the MOHFP is currently without sufficient experience in marketing and communications to develop the strategy implied; only one of 34 master's level staff in the IEM unit has received long-term training overseas. There is, however, considerable interest, within the unit, in mounting a major IEC program.

o Information on Service Delivery

Problems in comparing results of national CPSs with the data from the MIS unit of the MOHFP point to the need for improvements in both systems. AID's current efforts to improve the collection of NGO statistics and implementation of recommendations in this report (see Section 3.3.5.1.2) should help improve the quality of the data from NGOs that feed into the MIS unit. The suggestions that the SMP improve its own (see

Section 3.4) MIS would also help improve the quality of the data provided to the MIS.

The question remains of the competence of the MIS to collect and analyze data from MOHFP service areas. The ICDDR,B's experimental new record-keeping system is currently being introduced in eight upazilas while the World Bank is supporting introduction of another system covering pilot service statistics activities being implemented in 40 wards. Both these systems are aimed at helping improve the level of GOB record keeping.

o New Headquarters

Despite the existence of a national family planning program for more than 20 years, no central headquarters has ever been established for population. At the moment, various units of the MOHFP are located in rented space scattered around Dhaka. This obviously creates inefficiencies and makes coordination of family planning activities difficult. The government recognizes the problem and has apparently purchased a plot of land to construct a headquarters. It has no funds, however, to cover construction costs.

4.2.4 Donor Coordination

Does AID's assistance in population/family planning, particularly with respect to the MOHFP, overlap or duplicate what other donors are doing? To the extent that major weaknesses remain, what role can/should AID play in helping to address these deficiencies?

USAID coordinates closely with the other donors supporting the population program. The World Bank's Third Family Planning Project includes several bilateral co-financiers-- Australia, Canada, Norway, Netherlands, FRG, and the British Overseas Development Administration (ODA). Table T summarizes the individual components of the World Bank Project. Major support for IEM is not funded due to the withdrawal of SIDA from the Project. Oral contraceptives needed by the program will continue to be funded by CIDA and the FRG during the Third Five-Year Plan period. The ODA plans significant support for NGOs in this project.

The other key population donor is UNFPA. Although funding levels during the period 1986-1990 remain uncertain, it

NGOs are playing a major role in the Bangladesh family planning program, both in testing new ideas and in increasing the availability and use of modern contraception. As a result of a period of rapid growth since 1980, there are more than 80 subprojects operating in nearly 300 sites. Recently, the strategy has begun to shift from one of encouraging development of large number of new subprojects to one of consolidating and improving existing subprojects. This shift in focus is appropriate: new subproject development should be limited and geared toward addressing well-defined gaps in service availability.

To date, NGO activities have been largely concentrated in the urban areas at the behest of the GOB. Recently, NGOs have been encouraged by the GOB to begin to expand their activities into the rural areas. A selective and gradual expansion of NGO service programs into the rural areas is desirable.

In general, however, NGOs should concentrate on filling remaining service delivery gaps in urban areas, moving into contiguous geographic areas once programs and moderately high prevalence rates (perhaps 40 percent or above) have been established. In the rural areas, a similar approach should be used: i.e., gradually extending services into contiguous geographic areas once existing service programs and use levels are well established.

It is anticipated that the NGOs will continue to play a leadership role in testing new approaches to service delivery. Such innovations might include techniques for training fieldworkers, improved management information systems, and new modes of supervision. NGOs should also be looked to as key actors in the transfer of lessons learned from Matlab and the Extension Project to both the Government programs and their own. They may also play a major role in efforts to involve the upazila parishads in the planning and implementation of local level initiatives to improve the delivery of family planning service delivery. The possible revival of the Indonesia-based training program may provide an opportunity to do this.

Finally, NGOs should continue efforts already begun to incorporate selected MCH services into their programs. Integration of health and family planning services, while fraught with difficulties in the Government system, is now official policy. While keeping in mind the importance of maintaining strong family planning service programs, where appropriate, the

NGOs should gradually add services such as immunizations, oral rehydration therapy, growth monitoring, and pre- and post-natal care.

4.3.2 Minimizing Duplication of Effort

What can be done to ensure that duplication of effort is kept to a minimum, especially as services are selectively expanded to rural areas?

As the NGOs begin to move into rural areas, it will be important to ensure that duplication of effort is kept to a minimum. At present, no specific guidelines to ensure such coordination of Government and NGO efforts have been developed. Issues such as demarcation of geographic work areas for field personnel, reporting systems and channels, contraceptive logistics, and credit and/or reimbursement of fieldworkers who assist acceptors of clinical methods are but a few areas of potential conflict and misunderstanding.

In order to minimize duplication, the NGOs should work closely with the GOB, especially at the district level and below, to identify gaps in service delivery. On the basis of such assessments, it may be possible to identify discrete geographic areas which can be assigned to GOB and NGO fieldworkers respectively. The recent workshop in Chittagong sponsored by the Pathfinder Fund may be a model that could be repeated elsewhere. Another approach may be a team approach whereby GOB and NGO fieldworkers work in tandem in the same geographic area. At this stage, the highest priority is to strive for a close working relationship with local GOB program officials and to try various approaches.

4.3.3 Minimizing Management Burdens

What can be done to minimize the management burden of NGO activities, both on USAID and the NGOs themselves?

There are several levels of management relating to the NGO component that must be considered: USAID management of the overall component and its various participants; the NGOs' management of their various subprojects; and finally the management of each subproject by its staff. Dealing first with the USAID level, important actions have been taken on several fronts to reduce the management burden of the NGO component.

Several years ago, all grants under this component were switched to cooperative agreements. Now USAID is gradually moving these agreements towards consolidation (funding multiple subprojects or multi-site subprojects all at once) and also approving activities for longer periods of time. To the extent that the headquarters of the international NGOs allow these consolidated and extended project approvals, the management burdens all the way down the line are reduced.

Efforts to standardize and evaluate the service statistics of USAID-funded NGOs through the USAID MIS system and mini-CPS activities have the potential of reducing management burdens. These efforts are complicated by the use of different terms and definitions, the desire of USAID and the GOB to be able to compare the performance of NGOs with each other and the GOB, and the use of different means to calculate catchment area denominators (eligible couples).

The NGOs, with USAID's continued input and the GOB's input or at least blessing, should strive to achieve a standardized MIS which meshes with that of the GOB in order to make the desired comparisons between NGO and GOB performance valid.

Over the past year the NGOs, encouraged by USAID, have been taking a closer look at their staffing patterns. BAVS is thought to have some excess capacity and the CBD activities have been found to have a wide range of fieldworker to eligible couple and supervisor to fieldworker ratios. Also, the NGO Evaluation Team found in most subprojects visited that excessive time was being spent by CBD fieldworkers and their supervisors in doing clerical and record-keeping tasks. Furthermore, field staff of most of these projects spend several hours each day and several whole days each month in the project office. Technical assistance should be obtained to help rationalize and standardize NGO subproject record keeping and reporting in an effort to reduce clerical and office time spent by CBD staff.

4.3.4 Coordination

Is the existing national NGO coordinating entity adequate? Should it be strengthened or replaced?

Over the years that NGOs have been involved in family planning in Bangladesh, these organizations have worked relatively independently, focusing on their specific project

activities and geographic areas of operation. More recently, however, the NGOs and their programs have grown in size and number reaching a stage where effective communication and coordination have become critical. When only a few NGOs were involved, issues such as coverage, duplication of services, joint training needs and commodity distribution could often be adequately handled on an ad hoc basis. This is no longer the case.

Efforts to encourage NGO coordination by the GOB include the creation of the FPCVO and its secretariat, the FPSTC. Some feel this action was premature--the NGOs had not yet reached their present stage of strength or maturity; neither had the national program, in which the NGO projects are seen to play an important role, reached its current situation. Furthermore, because the Governing Body of the FPSTC is composed primarily of GOB officials, the NGO community was (and still is) somewhat reluctant to be too closely watched or "coordinated" by this entity.

Several of the USAID-funded NGOs have taken an important lead, with USAID's assistance, in coordinating NGO activities, to the mutual benefit of all. Examples include the coordination of training needs and resources and the Chittagong workshop on reallocation of work areas, the commodity distribution program of the BFPA and the upcoming NGO conference sponsored by BAVS.

The family planning NGOs and their programs in Bangladesh appear to have reached a point at which they are eager for better channels of communication, collaboration and coordination. To date, a few limited actions have been undertaken to coordinate NGO activities and these have met with various degrees of success. An official entity having the specific purpose of NGO coordination exists, but the FPCVO has been somewhat dormant in recent months reportedly due to a lack of funds but probably also to a lack of enthusiasm on the part of the NGOs, which remain skeptical about this group and its real purpose or intent.

With NGOs planning on a larger and increasingly important role in the national family planning program, it is clear that better coordination of NGO and public sector efforts will be needed.

USAID should explore the steps required to reactivate the FPCVO as a mechanism for addressing issues

currently constraining the NGOs' ability to contribute fully to the national program. This support should be conditioned, however, on assurances that the NGOs are truly and well represented in this body. It should also be done in such a way that the dynamism and innovativeness of the NGO community is encouraged.

It is also suggested that a new mechanism be created, perhaps through a USAID grant to Voluntary Health Services Society or a similar NGO which is not implementing family planning projects, to allow the entire NGO family planning community to participate in an active forum which meets regularly to discuss/debate problems and issues of mutual concern. Position papers, minutes and other documentation from these sessions could then be put forward to the FPCVO for action.

4.4 Programmatic Issues Related to the SMP

4.4.1 SMP's Role in Regard to Increasing Access and Use of Modern Contraception

How important a role does the SMP play in increasing access and use of modern contraception?

As this discussion suggests, the SMP has greatly increased the number of outlets where contraceptive products are available. It has also contributed to current levels of contraceptive use, although the existence of the "condom gap" suggests the difficulty in obtaining a precise estimate of this contribution. What is even less well known, however, is the extent to which the increase in outlets has enhanced "access" for women. Surveys indicate that women generally do not feel comfortable purchasing contraceptives from these outlets, although intermediaries (husbands or children) may purchase for them.

One important role of the SMP has been to apply modern marketing and communications techniques to the promotion of the concept of family planning. Here again, while these campaigns are generally believed to have played an important role in creating a favorable climate for family planning, the precise contribution of this effort to increased contraceptive use is unknown.

SMP may also serve to introduce couples to modern contraceptive, or may play a role in facilitating a shift to more

effective methods. A preliminary analysis (shown in Tables O and P), though not specifically of SMP users, does not, however, reveal such a role.

4.4.2 Improvement of SMP Effectiveness

What steps can and should be taken to improve the effectiveness of SMP?

This issue is discussed in some detail in Sections 3.1.3 and 3.4. Primary attention should be given to completing a program audit to determine ways in which the SMP can be made more efficient and cost effective. It should be noted that this will require some modification of the original objective of SMP, which emphasized availability, regardless of the marginal costs to reach deep into the rural areas. Given the level of maturity of SMP, which has been functioning for 11 years in Bangladesh, the recent decline in some of its key products, the expanded availability of condoms and orals through the Government, commercial outlets, and community-based distribution programs, it is an appropriate time to reassess the existing strategy.

Given the controversy surrounding the "condom gap," USAID should continue to support efforts to learn more about the use and use effectiveness of SMP projects. In particular, further study is warranted of the role of SMP in introducing couples to modern contraception, how it contributes to movement from less to more effective methods, and the extent to which it increases use effectiveness (because of the reliability and easy access to SMP outlets), versus those of Government and the NGOs.

4.5 ICDDR,B

4.5.1 Lessons Learned

What "lessons learned" through Matlab and the Extension areas are relevant for the larger program?

Several important lessons have been learned through Matlab and the Extension areas that are relevant for the larger government family planning program. The following findings are felt to be applicable:

- o Substantial increases in modern contraceptive use can occur prior to or in the absence of social change, previously felt to be a prerequisite to fertility decline.
- o Declines in fertility, as studied in the Matlab area, appear to contribute to lower neonatal, child and maternal mortality. The addition of carefully selected MCH services (e.g., tetanus toxoid immunizations) can result in further declines in mortality.
- o Prior to introducing new services, it is important to determine whether the workers can reasonably be expected to absorb these additional tasks.
- o The most effective way of reaching rural Bangladeshi couples with basic health and family planning services is through home visits. This requires a much larger number of workers than has been planned and budgeted for.
- o Clear delineation of work roles is essential in combination with the establishment of working relationships at various levels of service delivery which are mutually supportive. Use of a problem solving team approach and development of clear work routines are also important.
- o Repeated home visits by Government fieldworkers (i.e., Family Welfare Assistants) to a reasonably sized/dispersed population in their locale can result in a substantial increase in contraceptive prevalence. Fieldworker to population densities of one to two thousand are felt to be necessary to successfully accomplish this.

4.5.2 ICDDR,B's Future Role and Key Issues

High priority should be given to continued support for ICDDR,B and the Extension Project activities over the next 3-5 years. This Project is confronting the most fundamental family

planning issue facing Bangladesh, as well as the rest of South Asia: how can services delivered through large Government programs (which must play the key role for the foreseeable future) be made more effective? Answers to this question will determine, in large part, whether or not objectives with respect to the availability and use of contraception are met.

Issues likely to continue to be important in the short-run are:

- o What techniques, replicable in nature, can be employed to motivate an effective field organization for family planning?
- o How can the upazila parishads play a leadership and supportive role in family planning?
- o Given the current emphasis on selected MCH services, in addition to family planning, how can service programs be structured so as not to undermine the ability of family planning workers to serve the population in their catchment area.

5. FUTURE ASSISTANCE

5.1 Recommended Goals and Strategies

The overriding consideration in AID's family planning efforts in Bangladesh should be to support the GOB as it attempts through the Third Five-Year Plan to reduce the rate of population growth. These goals are very ambitious and unlikely to be achieved by the end of the Plan period (see Section 4.1.3).

AID's primary focus in the population sector should continue to be expanding and improving the delivery of family planning services. The levels of modern contraceptive use achieved in Matlab, the Extension project areas, NGO community-based distribution projects, and selected areas served by the Government programs (e.g., Phultala Upazila in Khulna Division), demonstrate that significant receptivity to quality family planning services persists. Where quality service programs are in place, CPRs of 40 percent or more are not uncommon. In urban areas as a whole, preliminary data from the 1985 CPS show rates approaching 50 percent. All of this suggests that significant changes in demographic behavior are under way and efforts to segment the market (i.e., to target selected subgroups within the population) could result in a substantially higher overall CPR for Bangladesh.

This is not to say that the demand side of the equation should be ignored. A renewed and expanded effort to identify and reach selected subgroups of the population with meaningful information and education regarding contraception is badly needed. There have been few refinements in direct demand-creation strategies within the last decade. Although there are important fertility differentials in Bangladesh (e.g., rural-urban, age at marriage, educational level, etc.), the extent to which USAID can, in a cost-effective manner, influence these indirect determinants is unclear. For this reason, relatively lower priority should be accorded to interventions to affect fertility indirectly, while increased attention should be given to demand creation through more direct communication approaches.

5.2 Recommended Program Composition and Funding Mechanisms

Some changes are likely regarding the relative emphasis of the MOHFP, NGOs, and the SMP. With respect to the

MOHFP, there will be a relatively smaller requirement for support of VS than previously anticipated. On the other hand, technical assistance, training, and operational support are urgently needed by the IEM unit of MOHFP. In keeping with the increasing importance of selected MCH services within the GOB program, USAID should support pilot studies of the effects of adding such new duties to the Family Welfare Assistant workscope as oral rehydration therapy, selected immunizations (especially tetanus, measles, and pertussis), and advice regarding safe deliveries. This approach could also be tested by selected NGOs.

NGO activities should also continue to be expanded, on a selective basis, focusing initially on expanding coverage in those urban and rural areas where contraceptive prevalence is high. The SMP should take a number of steps to increase both the efficiency and cost effectiveness of its operation. A greater degree of efficiency may lead to a reduction of the portion of the USAID population portfolio needed for SMP.

5.3 Possible Program Components

5.3.1 MOHFP

Information, Education and Communications

o Assistance to IEM Unit

USAID should consider making a substantial commitment over the next five years to strengthening and improving the planning and implementation of IEC activities within the Bangladesh family planning program. This assistance would include both short- and long-term training, technical assistance, and support for program operations. Primary emphasis should be given to the application of modern marketing research and communication strategies, drawing upon the skills of the commercial sector for technical assistance. Preliminary discussions with IEM staff revealed a strong felt need for such assistance and a willingness to work with the private sector on such an endeavor. The IEM unit has prepared a detailed plan which should be reviewed by an outside consultant(s) prior to making any commitment to finance activities in this area.

Contraceptive Services

o Voluntary Sterilization and IUDs

USAID should continue to finance reimbursements for the costs associated with the delivery of VS and IUD services. USAID should also retain one full-time person to monitor program implementation and to manage any special studies which may be needed.

o Commodities and Logistics

USAID should anticipate the need to continue to provide condoms, vaginal spermicides, and IUDs (moving as soon as possible to the new Cu-T 380A). When and if Norplant receives U.S. FDA approval, USAID should be prepared to finance supplies needed by the GOB program. Additional commodities needed in support of the VS program should also continue to be supplied. USAID may wish to consider financing the training of warehouse managers and the construction/renovation of storage space, perhaps on a fixed amount reimbursement basis, at the upazila level.

Information on Service Delivery

o Management Information

The MIS Unit is in need of long-term technical assistance to help with data collection and analysis and to assist with the introduction of the two new record-keeping systems currently being implemented (Section 4.2.4). MIS staff at all levels will need training in the implementation of both new systems while USAID and the World Bank will need to coordinate their efforts. A senior statistician is needed to help maintain quality control in the MIS.

Expanding and Improving Service Delivery

o Expansion of Extension Project and NGO Service Delivery Approach

Important lessons have been learned regarding the training, deployment, and supervision of family planning fieldworkers in Matlab, the Extension Project, and by NGOs. Specifically, it is clear that certain innovations related to record keeping, work routines, and the team approach to problem solving are having a beneficial effect on worker morale and performance. It is time, therefore, that an effort begin to

transfer these "lessons learned" to other upazilas. ICDDR,B, GOB Extension Project, and NGO personnel should be encouraged and supported in their efforts to transfer these important lessons to NIPORT, MIS staff, and to the Training, Equipment and Maintenance Organization (TEMO), the unit at the central level of the government responsible for procurement, storage and distribution of contraceptive commodities. Costs for research, training, and field operations could be financed under the new project.

o Support for an Expanded Fieldworker Force

In view of the seriousness of the demographic situation in Bangladesh, the shortage of existing field staff and the recognized importance of providing domiciliary services, USAID may wish to consider with the GOB various alternatives for expediting and augmenting this coverage, perhaps through the hiring of temporary local workers (e.g., such as the paid volunteers who are assisting with the immunization program in the extension areas). Another possibility may be to link up with one of the large NGO social service organizations. These organizations often have large, national networks and could potentially play a role in family planning service delivery. USAID could assist by financing the honoraria and other expenses involved in supporting this cadre of workers.

o Maternal and Child Health (MCH) Services

USAID should consider financing pilot studies of alternative approaches to adding selected MCH services to the field operations of health and family planning staff. Three interventions--oral rehydration therapy, immunizations, and safe delivery practices--have been identified by the GOB as the highest priorities, and efforts are currently under way to add these services.

While it may be possible to add these functions over a period of time without seriously diminishing family planning performance, implementation should begin on a pilot basis and be carefully monitored. Among the alternatives, recent evidence from the field suggests that Health Assistants and Family Welfare Assistants may be able to work in tandem on these efforts. To date, the ICDDR,B-tested combination of a Health Assistant, peon, and a village worker (who is given an honorarium), seems to be working best. (USAID might want to finance these honoraria.) Nevertheless, efforts to encourage team efforts by Family Welfare Assistants and Health Assistants should be studied as a possible alternative. Family Welfare Assistants and Family Welfare Visitors might also be taught to

use a simple screening/referral protocol for high-risk mothers in their service areas.

o Local Support Costs

It is clear from field observations and discussions with program personnel that the lack of essential support costs is constraining worker effectiveness. This includes such minor items as record books, as well as funding for travel and per diem, especially during the monsoon season. USAID should consider providing additional local cost support needed to facilitate supervision and outreach.

Institutional Capacity

o Construction of a Headquarters for the Family Planning Directorate

While this is not the type of activity USAID generally prefers to finance, for the reasons stated in Section 4.2.3, in this case the need deserves serious consideration.

5.3.2 Non-Governmental Organizations

Factors Affecting Demand for Family Planning

o Support to Upazila Parishads for Family Planning

Involvement of upazila parishads in family planning activities is suggested. Funds could be provided to one or two NGOs on a pilot basis to cover costs of selected activities, for example, meetings with local religious leaders or financing of FWA transport.

o Secondary Education for Females

Funding for this pilot activity should be continued, contingent upon the analysis of the additional data to be collected as suggested in Annex H. If these data suggest that there is favorable impact on education, the project should be continued and evaluated early in the final year of the Amendment.

o Other Socio-Cultural Barriers

Since religion continues to be cited as an important constraint to the adoption of modern contraception,

USAID may wish to consider expanding some of the pilot NGO activities that have attempted to address this issue (see Section 3.3.4.3) through meetings and seminars with religious leaders, both locally and at the national level. Any undertaking of this nature should be preceded by a careful review of the experience to date.

Family Planning Service Delivery

o Selective Expansion of Service Areas

Where NGO subproject prevalence rates appear to be 40 percent or more, USAID should support the gradual expansion of these CBD activities into contiguous geographic areas which are underserved and/or where contraceptive prevalence is known to be low. This would require some increased funding, but it also assumes that the level of staff intensity would be reduced in those areas where contraceptive use is already well established. Close coordination with GOB fieldworker counterparts and other NGOs would obviously be important in order to minimize duplication of effort. Priority should be given to expanding those NGOs that have been most effective.

o Maternal and Child Health Services

Both BAVS and BFPA should consider broadening their service programs to include selected MCH services. These would include perinatal care (two antenatal visits in the third trimester), education in safe home delivery, tetanus toxoid for all reproductive age women, immunizations for children under five, and specific identification as a referral point for high risk pregnant mothers in their service area. Initiation of such a broadened service program would necessitate relocation where BAVS and BFPA clinics are situated close to each other.

Of highest priority in the MCH area should be the identification of the proposed attendant at delivery, and a short indoctrination for groups of these attendants in the major signs of danger in labor, delivery, and postpartum, plus the basics of immediate newborn care and the initiation of breastfeeding. It is suggested that USAID identify an appropriate NGO to prepare an urban pilot project to manage a group of young mothers having their first child in a structured program emphasizing safe delivery.

5.3.3 Social Marketing

SMP should continue to receive funding under the Amendment. Funding beyond FY 1988, however, should be contingent upon a review of the Project, probably in late FY 1987. Recommendations regarding that review and other ways that SMP might improve its operations are provided in Section 3.4.

5.3.4 ICDDR,B MCH-Family Planning Extension Project

Assuming staff constraints can be addressed, USAID should plan for an expanded role for ICDDR,B in the future. Priority should be given to supporting efforts (primarily the provision of technical assistance) to facilitate the transfer of lessons learned in Matlab and the Extension Project areas to other organizations and parts of the country. The Project should both continue and expand research activities that serve to diagnose implementation constraints and test alternative approaches to improving both quality and availability of family planning services.

6. SUMMARY OF RECOMMENDATIONS

Detailed suggestions on how the following major recommendations might be implemented are provided in the referenced sections earlier in the report. These sections should be consulted as plans are laid and action taken. The purpose of this summary is just to provide a checklist, not to substitute for the more comprehensive suggestions provided in the report itself.

6.1 Ministry of Health and Family Planning (MOHFP) (Section 3.2.1)

6.1.1 Commodities

Management of inventories

1. Policies governing the management of inventories need revision, and persons currently responsible for managing the central and regional warehouses need additional training in commodity management. The post of senior logistics advisor should be filled without delay.

Contraceptive storage space

2. Central warehouse capacity needs to be increased, or policy changed to permit more commodities to be stored in the regional warehouses, where space exists, and perhaps at the upazila level as well. If new regional warehouses are put in place, staff will need to be recruited and trained to manage them.

6.1.2 The Voluntary Sterilization Program (Section 3.2.2.5)

Adjustment to overcapacity

3. Both the NGOs and the government should seek ways to adjust to the excess service capacity brought on by the leveling off of sterilizations.

Continuation of VSSTs

4. Efforts should be made to ensure and expand the effective functioning of the VSSTs.

5. Greater efforts should be made to ensure that reported deficiencies in both training and communications are corrected. The efforts to improve training should be directed to ensuring that Family Welfare Visitors are given additional exposure to basic sterilization procedures and to equipment maintenance. Efforts to improve communication should focus on lines of communication between the VSST, the Health and Family Planning Wings and the operating level.

Continuation of Monitoring

6. Intensive monitoring of the VS program should be continued and strengthened, including USAID's employing a full-time person to fill the role of Clinical Services Quality Assurance Advisor.

Continuation of Reimbursements

7. USAID should continue, in real terms and in principle, to support monetary reimbursement to providers, clients, and staff. An annual review of reimbursement levels is suggested.

6.1.3 The IUD Program (Section 3.2.3)

8. In its efforts to promote long-lasting, effective contraceptive methods, USAID should focus on ways to increase the availability of IUDs and to ensure their safety and affordability.

6.1.4 Contraceptive Prevalence Surveys (Section 3.2.4)

9. Because of the crucial role played by the CPSs, both in monitoring the project and the national program and in helping guide future program decisions, these surveys should be continued and their quality improved.

10. A USAID staff member trained and experienced in demography should be hired to facilitate utilization of all CPS fundings.

6.1.5 Technical Resources, Research and Training
(Section 3.2.5)

11. The budget line item and mechanism for ready response funding of useful small and discrete project activities

should be retained for the remainder of the present project and continued at an increased level in future projects.

6.2 NGOs (see Sections 3.3.4 for recommendations on specific NGOs and Section 3.3.5 for more detail on the following recommendations)

6.2.1 Operational Issues (Section 3.3.5.1)

Coordination

12. Individual NGOs should be encouraged to take a leadership role in areas where their strengths lie.

13. USAID should explore the feasibility and desirability of reactivating the FPCVO as a strong body to work with the NGO community and provide funding, if necessary, for this purpose.

14. A new mechanism should be created to allow the entire NGO community to participate in an active forum that meets regularly to discuss/debate problems and issues of mutual concern. Position papers, minutes and other documentation from these sessions could be put forward to the FPCVO for action.

Minimizing Management Burdens

Project Cycles

15. USAID should continue to work with the NGOs that have not yet agreed to examine ways to extend their project development and approval cycles. Extended project cycles, however, should not be allowed to reduce opportunities for the NGOs to provide technical assistance to subprojects.

Service Statistics

16. Steps should be taken to improve the accuracy of NGO service statistics through improving record-keeping systems and ensuring their consistency throughout the NGO community.

6.2.2 Program Issues (Section 3.3.5.2)

Experimentation

17. NGOs should continue to experiment with new approaches particularly in the area of MCH and in working with opinion leaders.

Documentation and Dissemination

18. The success and failure of NGO innovations must be better documented and communicated. More effort should be made to transfer successful initiatives to the programs of other NGOs and the GOB.

Expansion of Services

19. More attention should be directed to the problem of overlap, both among NGOs and between the NGO and government services, particularly as NGOs expand into rural areas.

20. NGOs should be encouraged to utilize a portion of USAID funding to channel subgrants to local rural NGOs through local elected officials, e.g., upazila and/or union chairman and the local family planning committees. The objective would be to ensure the involvement and commitment of the local community leaders while at the same time to foster cooperation and collaboration between the GOB and NGOs in rural areas. This scheme should be limited to a few pilot areas and perhaps to a few NGOs initially, but the experience should be reviewed and communicated to the other NGOs as soon as possible for potential replication.

6.3 Social Marketing Program (Section 3.4)

21. SMP should develop a new strategy based on market segmentation.

22. SMP should continue undertaking new initiatives in the health field.

23. SMP should continue to investigate the use, use effectiveness, and cost effectiveness of SMP products.

24. SMP should continue to receive USAID support pending the implementation of some, or all, of the recommendations provided above. USAID should not, at this time, encourage efforts to institutionalize SMP by financing construction of a permanent headquarters.

6.4 International Center for Diarrheal Disease Research, Bangladesh-Extension Project (Section 3.5)

25. High priority should be given to continued USAID support of the ICDDR,B Extension Project, including

expansion of its research activities from the Matlab FPHSP. Steps should be taken to avoid decreases in project personnel. USAID should support efforts to apply the lessons learned to date elsewhere in Bangladesh, both in the public and the NGO service delivery programs.

26. Systematic research should be undertaken to determine why the CPR estimates yielded by the client-based registers differ from those produced by the SRS. If it is found that the registers are yielding inaccurate information, efforts should be made to revise the system so that greater accuracy can be achieved.

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TABLES

TABLE A
WORKING RATES OF CURRENT USE BY METHOD, 1983

| Methods | Rates |
|------------------------------------|--------------|
| Modern Methods (total) | 16.2 |
| Oral pill | 3.3 |
| Condom | 2.7 |
| Vaginal method | 0.3 |
| Injection | 0.2 |
| IUD | 1.0 |
| Tubectomy | 6.2 |
| Vasectomy | 2.5 |
| Traditional Methods (total) | 5.5 |
| Safe period | 2.4 |
| Withdrawal | 1.3 |
| Abstinence | 0.4 |
| Other | 1.4 |
| Any method | 21.7 |
| No method | 78.3 |
| Total | 100.0 |

Source: Bangladesh Contraceptive Prevalence Survey 1983, Final Report, 8.2, p. 198.

TABLE B

CONTRACEPTIVE PREVALENCE RATES BY BROAD CATEGORIES
OF METHOD FROM NATIONAL SURVEYS 1975-1985

| Survey: Year ^a | <u>BFS^b</u> | <u>CPS^c</u> | | | 1985 (projected) ^d |
|---|------------------------|------------------------|-------|-------|----------------------------------|
| | 1975 | 1979 | 1981 | 1983 | |
| % Using: | | | | | |
| Modern method | 4.7 | 8.9 | 10.9 | 13.8 | (18.7) |
| Traditional method | 3.0 | 3.8 | 7.7 | 5.4 | (6.4) |
| Any method | 7.7 | 12.7 | 18.6 | 19.1 | (25.1) |
| % Not using any method | 92.3 | 87.3 | 81.4 | 80.9 | (74.9) |
| TOTAL | 100.0 | 100.0 | 100.0 | 100.0 | (100.0) |
| Annual increase in CPR of modern methods between surveys ^e | | 1.1 | 1.3 | 1.2 | (2.5) |

Source: All results except 1985 results are taken from Bangladesh Contraceptive Prevalence Survey 1983 Final Report. The 1985 partial results were provided by Mitra and Associates to the evaluation team.

Notes: See Table JK-2 for definition of CPR and definition of modern methods.

^aAll surveys refer approximately to the end of the year except for the year except for the 1981 CPS which corresponds to roughly midyear.

^bBangladesh Fertility Survey

^cContraceptive Prevalence Survey

^dBased on results from approximately 73 percent of the rural and 46 percent of the urban sample spots. The adjustments made to project national results are described in Table JK-2. These results are in parentheses since they are only a rough approximation of what will be the final results once the survey is completed.

^eCalculated based on assumption that 1981 survey refers to mid-year and all others to end of year;

TABLE C

PERCENTAGE OF CURRENTLY MARRIED WOMEN UNDER 50 YEARS OF AGE
USING CONTRACEPTION BY METHOD, BANGLADESH 1975, 1979, 1981, AND 1983

(The Eligible Woman Sample)

| Methods | BFS ¹ 1975 | CPS ² Year | | |
|-----------------------------|--------------------------|-----------------------|-------------------|-------------------|
| | | 1979 | 1981 ^a | 1983 ^a |
| Modern methods (total) | 4.7 | 8.9 | 10.9 | 13.8 |
| Oral pill | 2.7 | 3.6 | 3.5 | 3.3 |
| Condom | 0.7 | 1.5 | 1.6 | 1.5 |
| Vaginal method | -b | 0.1 | 0.3 | 0.3 |
| Injection | -b | 0.2 | 0.4 | 0.2 |
| IUD | 0.5 | 0.2 | 0.4 | 1.0 |
| Tubectomy | 0.3 | 2.4 | 4.0 | 6.2 |
| Vasectomy | 0.5 | 0.9 | 0.8 | 1.2 |
| Traditional methods (total) | 3.0 | 3.8 | 7.7 | 5.4 |
| Safe period | 1.0 | 2.2 | 3.9 | 2.4 |
| Withdrawal | 0.6 | 0.2 | 1.8 | 1.3 |
| Abstinence | 1.1 | 0.8 | 1.2 | 0.4 |
| Other | 0.3 | 0.6 | 0.7 | 1.4 |
| Total use rate | 7.7 | 12.7 | 18.6 | 19.1 |

¹Source: BFS - Bangladesh Fertility Survey (data derived from Table-2.4.5 and Table-4.4.1).

²Source: CPS - Contraceptive Prevalence Survey.

^aThe sum of individual rates may not, in some cases, be equal to their relevant total. The difference is due to rounding error.

^bThese methods were not given as a separate category in the 1975 BFS and may be included in "other."

Source: Bangladesh Contraceptive Prevalence Survey 1983 Final Report, Table 7.4, p. 166.

TABLE D

MONTHLY TRENDS IN CLINICAL CONTRACEPTIVE METHODS, 1984-85
(MIS Distribution Statistics)

| | <u>Sterilizations (cases)</u> | | <u>IUDs (cases)</u> | | <u>Injectables (doses)</u> | |
|-----------|-------------------------------|-------------|---------------------|-------------|----------------------------|-------------|
| | <u>1984</u> | <u>1985</u> | <u>1984</u> | <u>1985</u> | <u>1984</u> | <u>1985</u> |
| January | 59,744 | 32,791 | 33,195 | 42,286 | 11,196 | 15,483 |
| February | 67,007 | 30,488 | 33,332 | 39,898 | 9,455 | 17,332 |
| March | 60,250 | 28,749 | 31,157 | 41,825 | 11,021 | 16,245 |
| April | 48,154 | 25,684 | 32,959 | 38,483 | 12,301 | 15,082 |
| May | 44,337 | 20,741 | 34,371 | 32,138 | 11,835 | 15,292 |
| June | 30,797 | 18,379 | 22,598 | 24,965 | 9,355 | 10,963 |
| July | 54,166 | 26,501 | 30,674 | 30,702 | 11,643 | 16,683 |
| August | 52,970 | 17,920 | 34,972 | 27,780 | 12,225 | 14,664 |
| September | 62,327 | 31,236 | 31,025 | 31,048 | 11,410 | 15,687 |
| October | 88,607 | 39,202 | 32,289 | 32,481 | 14,360 | 17,325 |
| November | 46,720 | 24,995 | 38,427 | 31,864 | 12,585 | 17,700 |
| December | 29,977 | 17,365 | 39,483 | 29,950 | 13,583 | 16,845 |

Source: MIS unit, Family Planning Directorate.

TABLE E

QUARTERLY TRENDS IN MAJOR CONTRACEPTIVE METHODS, JULY 1982 - DECEMBER 1985
(MIS Distribution Statistics)

| | <u>Sterilizations</u> | | <u>IUD Insertions</u> | | <u>Pill Cycles</u> | | <u>Condom Pieces</u> | | <u>Injectables</u> | |
|---------------|-----------------------|--------------------|-----------------------|--------------------|--------------------|--------------------|----------------------|--------------------|--------------------|--------------------|
| | Cases | Index ^a | Cases | Index ^a | In 1,000's | Index ^a | In 100,000's | Index ^a | Doses | Index ^a |
| 07/82 - 09/82 | 85,766 | .77 | 22,031 | .30 | 1,792 | .70 | 254 | .70 | 14,582 | .45 |
| 10/82 - 12/82 | 112,445 | 1.01 | 29,445 | .40 | 2,153 | .85 | 333 | .99 | 10,755 | .33 |
| 01/83 - 03/83 | 101,960 | .91 | 32,561 | .44 | 2,120 | .83 | 299 | .89 | 20,996 | .65 |
| 04/83 - 06/83 | 62,986 | .56 | 33,706 | .45 | 2,193 | .86 | 281 | .84 | 26,364 | .82 |
| 07/83 - 09/83 | 71,652 | .64 | 42,780 | .58 | 2,297 | .90 | 310 | .92 | 29,811 | .93 |
| 10/83 - 12/83 | 170,110 | 1.52 | 72,946 | .98 | 2,261 | .89 | 388 | 1.15 | 27,529 | .86 |
| 01/84 - 03/84 | 187,001 | 1.67 | 97,684 | 1.32 | 2,495 | .98 | 307 | .91 | 31,672 | .99 |
| 04/84 - 06/84 | 123,288 | 1.10 | 89,928 | 1.21 | 2,673 | 1.05 | 306 | .91 | 33,491 | 1.04 |
| 07/84 - 09/84 | 169,463 | 1.51 | 96,671 | 1.30 | 2,667 | 1.05 | 402 | 1.19 | 35,278 | 1.10 |
| 10/84 - 12/84 | 165,304 | 1.48 | 116,199 | 1.57 | 3,111 | 1.22 | 558 | 1.66 | 40,528 | 1.26 |
| 01/85 - 03/85 | 92,028 | .82 | 124,009 | 1.67 | 2,997 | 1.18 | 320 | .95 | 49,060 | 1.53 |
| 04/85 - 06/85 | 64,804 | .58 | 95,586 | 1.29 | 2,778 | 1.09 | 240 | .71 | 41,067 | 1.28 |
| 07/85 - 09/85 | 75,657 | .68 | 89,530 | 1.21 | 2,846 | 1.12 | 342 | 1.02 | 47,024 | 1.46 |
| 10/85 - 12/85 | 81,562 | .73 | 94,295 | 1.27 | 3,231 | 1.27 | 373 | 1.11 | 51,870 | 1.61 |

Source: MIS Unit, Family Planning Directorate.

Notes: ^aThe index value expresses the quarterly performance for each specific method as a ration of the average quarterly performance during the entire period from 07/82 to 12/85.

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TABLE F

PERCENTAGE DISTRIBUTION OF CURRENT USERS OF ORAL PILLS AND
CONDOMS BY PHYSICALLY VERIFIED BRAND NAMES

| | Type of Sample | | | |
|-------------------------|-------------------|---------------|------------|------------|
| | Eligible Women | Couple sample | | |
| | | Wives | Husbands | Husbands |
| Oral Pills | | | | |
| GOB Brands ^a | 39.0 | 46.4 | 49.1 | 66.3 |
| SMP Brands | 19.3 | 14.3 | 13.1 | 10.9 |
| Private Brands | 40.6 | 39.2 | 37.7 | 22.8 |
| Other, not stated | <u>1.1</u> | <u>0.0</u> | <u>0.0</u> | <u>0.0</u> |
| Total percent | 100 | 100 | 100 | 100 |
| Total N ^a | 255 | 56 | 61 | 58 |
| Condoms | | | | |
| GOB Brands ^a | 33.4 | 38.5 | 27.4 | 25.5 |
| SMP Brands | 64.0 | 61.5 | 72.6 | 74.5 |
| Other, not stated | <u>2.6</u> | <u>0.0</u> | <u>0.0</u> | <u>0.0</u> |
| Total percent | 100 | 100 | 100 | 100 |
| Total N ^a | 117 | 26 | 51 | 47 |

Source: Eligible women sample results are from Bangladesh Contraceptive Prevalence Survey 1983 Final Report, Table 9.6, p. 213. Results for other samples are based on special tabulations provided by Mitra and Associates.

Note: ^aNGOs also distribute GOB Brands.

TABLE G

PERCENTAGE DISTRIBUTION OF CURRENT USERS OF NON-CLINICAL¹
FAMILY PLANNING METHODS BY REPORTED SOURCE OF SUPPLY

(The Eligible Woman Sample)

| Source of Supply | National | Rural | Urban |
|--|--------------------|-------------------|-------|
| Pharmacy | 38.5 | 31.2 | 54.4 |
| General stores | 6.0 | 6.3 | 5.4 |
| Pan/Cigarette shop | 2.1 | 1.9 | 2.5 |
| Village doctor | 0.8 | 1.1 | - |
| Qualified doctor | 0.6 | 0.7 | 0.3 |
| Govt. clinic hospital | 7.5 | 9.3 | 3.4 |
| Voluntary/private clinic/hospital | 0.7 | - | 2.3 |
| Collect from Govt. field worker's house | 4.5 | 5.9 | 1.4 |
| Home delivery by Govt. field worker | 23.9 | 27.9 | 15.0 |
| Home delivery by non-Govt./unspecific field worker | 1.1 | 0.7 | 2.0 |
| Other | 0.8 | 0.4 | 1.7 |
| Don't know | 13.6 | 14.5 | 11.6 |
| Total | 100.1 ^a | 99.9 ^a | 100.0 |
| N ² | 391 ^b | 269 | 353 |

¹ Non-clinical methods: oral pill, condom, and vaginal methods.

² N in this table is the total number of current users of non-clinical family planning methods, excluding NS (Not Stated) cases, if any, for the question about source.

^a Total is more or less than 100 percent due to rounding errors.

^b Weighted total of the current users of non-clinical family methods, excluding NS cases.

TABLE H

COMPARISON OF CONTRACEPTIVE PREVALENCE RATES BASED ON MINI-CPS AND ON SERVICE STATISTICS

| NGO and Subproject | <u>Mini-CPS</u> | | <u>Service Statistics</u> | |
|------------------------|-----------------|-----------------|---------------------------|------------|
| | <u>Date</u> | <u>CPR</u> | <u>Date</u> | <u>CPR</u> |
| <u>Pathfinder</u> | | | | |
| Saidpur | May 1985 | 42 ^b | June 1984 | 70 |
| Rajshahi | Nov 1984 | 39 ^c | Mar 1985 | 49 |
| Pabna | Nov 1984 | 42 ^c | Oct 1984 | 67 |
| Bhola | Nov 1984 | 17 ^c | Sept 1984 | 54 |
| Moulvi Bazar | Nov 1984 | 16 ^c | July 1984 | 59 |
| <u>Asia Foundation</u> | | | | |
| DWFP (Comilla) | Nov 1985 | 65 ^d | Mar 1985 | 58 |
| SKP (Kushtia) | Nov 1985 | 48 ^d | Apr 1985 | 28 |
| PSKS (Kushtia) | Nov 1985 | 33 ^d | Nov 1985 | 28 |
| FREHC (Mirsarai) | Nov 1985 | 18 ^d | Nov 1985 | 55 |

Notes: ^a From NGO factsheets provided by USAID. An attempt was made to choose the active user rate which was judged to be the most appropriate comparison with the mini-CPS result from the data made available to the evaluation team.

^b From Nihar Ranjar Sorcan, "Mini-CPS of Pathfinder Fund CBS Project, Saidpur" Dhaka, June 10, 1985.

^c From M. Kabir et al., "Mini Contraceptive Prevalence Survey, 1984" Dept. of Statistics, Jahangirnagar University, July 1985.

^d Associates for Community and Population Research, "Evaluation of Subprojects of the Asia Foundation's Family Planning/Population Program," Dec. 17, 1985.

TABLE I

BANGLADESH
NATIONAL VSC PERFORMANCE CY 1980-85
(Includes BAVS and Other NGOs)

| MONTH | PROCEDURES | Y E A R S | | | | | |
|------------|------------|-----------|---------|---------|---------|---------|---------|
| | | 1980 | 1981 | 1982 | 1983 | 1984 | 1985 |
| JANUARY | Vasectomy | 1,744 | 1,313 | 3,789 | 5,300 | 22,650 | 15,271 |
| | Tubectomy | 17,973 | 20,996 | 18,477 | 24,402 | 37,094 | 17,365 |
| | TOTAL | 19,717 | 22,309 | 22,266 | 29,702 | 59,744 | 32,636 |
| FEBRUARY | Vasectomy | 2,340 | 2,455 | 5,821 | 5,691 | 22,314 | 13,350 |
| | Tubectomy | 24,370 | 24,779 | 27,823 | 29,585 | 43,528 | 16,086 |
| | TOTAL | 26,710 | 27,234 | 33,644 | 35,274 | 65,842 | 29,436 |
| MARCH | Vasectomy | 2,440 | 1,332 | 6,860 | 7,067 | 22,799 | 14,430 |
| | Tubectomy | 22,156 | 19,576 | 31,251 | 29,794 | 37,436 | 14,319 |
| | TOTAL | 24,596 | 20,908 | 38,111 | 36,861 | 60,235 | 28,749 |
| APRIL | Vasectomy | 1,015 | 2,074 | 8,591 | 4,426 | 20,316 | 13,288 |
| | Tubectomy | 13,146 | 21,284 | 28,335 | 19,938 | 27,805 | 12,396 |
| | TOTAL | 14,161 | 23,358 | 36,926 | 24,364 | 48,121 | 25,684 |
| MAY | Vasectomy | 231 | 3,133 | 7,015 | 4,502 | 21,201 | 12,560 |
| | Tubectomy | 2,480 | 19,491 | 28,540 | 17,970 | 23,136 | 8,181 |
| | TOTAL | 2,711 | 22,624 | 35,555 | 22,472 | 44,337 | 20,741 |
| JUNE | Vasectomy | 675 | 3,395 | 8,723 | 3,484 | 19,950 | 12,176 |
| | Tubectomy | 7,600 | 16,175 | 25,296 | 12,438 | 10,061 | 6,203 |
| | TOTAL | 8,275 | 19,570 | 34,019 | 15,922 | 30,011 | 18,379 |
| JULY | Vasectomy | 1,132 | 2,647 | 8,470 | 4,006 | 28,732 | 14,336 |
| | Tubectomy | 13,777 | 7,736 | 12,531 | 12,217 | 25,434 | 12,147 |
| | TOTAL | 14,909 | 10,383 | 21,001 | 16,223 | 54,166 | 26,483 |
| AUGUST | Vasectomy | 1,260 | 3,509 | 5,892 | 5,641 | 29,786 | 10,935 |
| | Tubectomy | 10,333 | 13,235 | 22,082 | 18,381 | 23,140 | 6,985 |
| | TOTAL | 11,593 | 16,744 | 27,974 | 24,022 | 52,926 | 17,920 |
| SEPTEMBER | Vasectomy | 3,655 | 6,552 | 11,397 | 10,147 | 33,699 | 16,117 |
| | Tubectomy | 24,134 | 11,175 | 25,631 | 20,951 | 28,528 | 15,097 |
| | TOTAL | 27,789 | 17,727 | 37,028 | 31,098 | 62,227 | 31,214 |
| OCTOBER | Vasectomy | 3,011 | 9,138 | 17,106 | 21,205 | 46,411 | 21,514 |
| | Tubectomy | 20,643 | 19,815 | 37,578 | 41,194 | 42,196 | 17,726 |
| | TOTAL | 23,654 | 28,953 | 54,684 | 62,399 | 88,607 | 39,240 |
| NOVEMBER | Vasectomy | 1,503 | 4,754 | 10,718 | 29,136 | 24,398 | 14,257 |
| | Tubectomy | 14,599 | 13,194 | 24,766 | 41,476 | 22,322 | 10,729 |
| | TOTAL | 16,102 | 17,948 | 35,484 | 70,612 | 46,720 | 39,240 |
| DECEMBER | Vasectomy | 1,098 | 3,744 | 4,333 | 14,928 | 13,951 | 10,353 |
| | Tubectomy | 14,210 | 15,752 | 17,923 | 22,171 | 15,428 | 7,012 |
| | TOTAL | 15,308 | 19,496 | 22,256 | 37,099 | 29,379 | 17,365 |
| YEAR TOTAL | Vasectomy | 20,104 | 44,046 | 98,715 | 115,531 | 306,207 | 158,234 |
| | Tubectomy | 185,421 | 203,208 | 300,233 | 290,517 | 336,106 | 137,234 |
| | TOTAL | 205,525 | 247,254 | 398,948 | 406,048 | 642,315 | 295,468 |

TABLE J

PRESENT AND PROPOSED VOLUNTARY STERILIZATION MONITORING AND RESEARCH ACTIVITIES
FOR 19861. USAID - Supported Activities

| | <u>Present</u> | <u>Proposed</u> |
|---|----------------|-----------------|
| 1. <u>Program Monitoring</u> | | |
| a. Quarterly Evaluations (Quasem & Co.) Random sample of 2,000 women. Examines informed consent, client characteristics, and receipt of payments. | X | |
| b. Quarterly Client satisfaction Monitoring (Quasem & Co.) to be incorporated in "a" above. | | X |
| c. Field trips by P&H Staff (Investigation of "irregularities" and routine surveillance) | X | |
| d. Review of MIS. (MOHPC & BAVS) and follow-up. | X | |
| e. Review of evaluations and follow-up, as necessary. | X | |
| f. Attendance at monthly VSST meetings and follow-up, as necessary., | X | |
| g. Hiring of PSC for V.S. program oversight. | | X |
| 2. <u>Research/Studies</u> | | |
| a. Ten Focus Group Interviews of tubectomy and vasectomy clients (Quest) to determine motives for V.S. To be completed April 1, 1986. | X | |
| b. Study of client compensation and voluntarism (Knowles and Pillsbury). Completed Dec. 1985. | X | |
| c. Role of saris and lungis as surgical garments and possible alternatives. To be completed August 1986. | | X |

- d. Survey of the two surgeons performing V.S. reversals to determine the rate and reasons for reversal requests. To be completed June 1986. X
- e. The 1981 and 1983 CPS. Client characteristics, access and the need for V.S., V.S. prevalence. Completed. X

II. Non-USAID Sponsored

- a. Client satisfaction survey. A national sample of 1,000 women acceptors of BAVS services, AVS. To be completed Feb. 1986. X
- b. Client satisfaction survey. A national sample of 1,000 vasectomy acceptors of BAVS services, AVS. To be completed late 1986. X
- c. Client satisfaction survey. A national sample of 2,700 tubectomy and vasectomy clients, P & M Consultants, MOHPC. To be completed May 1986. X
- d. Client satisfaction survey. A national sample of 900 V. S. clients, EEU, Planning Commission. To be completed Jan. 1986. X
- e. Determinants of contraceptive choice, worker performance and motivation, ICDDR,B. To be completed June, 1986. X
- f. Study of the V. S. compensation system, client satisfaction, and worker knowledge, attitudes and practice, MOHPC through the World Bank. This is a major study of all aspects of the V. S. program and will be completed Dec. 1986. X
- g. Study of reasons for differentials of V. S. performance AVS. To be completed end of 1986. X

TABLE K

CURRENT VOLUNTARY STERILIZATION REIMBURSEMENT LEVELS AND
ESTIMATED AVERAGE COSTS

| <u>TUBECTOMY</u> | <u>Estimated Average Costs (in Tks)</u> | <u>Current Reimbursement (in Tks)</u> |
|---------------------------|---|---|
| 1. Client Compensation | | |
| Work Time | 90 | 75 |
| Transport | 35 | 40 |
| Food | <u>36</u> | <u>60</u> |
| <u>Subtotal</u> | 161 | 175 |
| 2. Helper Reimbursement | | |
| Transport | 30 | 30 |
| Food | <u>24</u> | <u>15</u> |
| <u>Subtotal</u> | 54 | 45 |
| 3. Provider Reimbursement | | |
| Physicians | 20 | 20 |
| Clinic Workers | <u>15</u> | <u>15</u> |
| <u>Subtotal</u> | 35 | 35 |
| <hr/> | | |
| <u>VASECTOMY</u> | <u>Estimated Average Costs (in Tks)</u> | <u>Current Reimbursement (in Tks)</u> |
| 1. Client Compensation | | |
| Work Time | 150 | 117 |
| Transport | 30 | 40 |
| Food | <u>12</u> | <u>18</u> |
| <u>Subtotal</u> | 192 | 175 |
| 2. Helper Reimbursement | | |
| Transport | 30 | 30 |
| Food | <u>12</u> | <u>15</u> |
| <u>Subtotal</u> | 42 | 45 |
| 3. Provider Reimbursement | | |
| Physicians | 20 | 20 |
| Clinic Workers | <u>15</u> | <u>15</u> |
| <u>Subtotal</u> | 35 | 35 |
| <hr/> | | |
| TOTAL | <u>269</u> | <u>255</u> |

TABLE L

USAID-FUNDED FAMILY PLANNING NGOS BY NUMBER OF PROJECTS AND SITES
1986 (January)

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

* Includes Concerned Women for Family Planning (12 sites)

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

TABLE M
 USAID-FUNDED FAMILY PLANNING NON-GOVERNMENTAL ORGANIZATIONS**
 PROJECTED AND ANNUAL, OUTPUTS
 1984
 ('000s)

| <u>Outputs</u> | <u>AVSC/BAVS</u> | | <u>FPSTC</u> | | <u>BFPA</u> | | <u>Pathfinder</u> | | <u>TAF</u> | | <u>Total</u> | | <u>Excess of A over P (%)</u> |
|---|------------------|-----------|--------------|----------|-------------|----------|-------------------|----------|------------|----------|--------------|----------|-----------------------------------|
| | <u>P*</u> | <u>A*</u> | <u>P</u> | <u>A</u> | <u>P</u> | <u>A</u> | <u>P</u> | <u>A</u> | <u>P</u> | <u>A</u> | <u>P</u> | <u>A</u> | |
| <u>Temporary Methods (Year End)</u> | | | | | | | | | | | | | |
| Active Users | - | - | 35 | 41 | 60 | 85 | 93 | 91 | 120 | 141 | 308 | 358 | 15 |
| Couple Years Protection | - | - | 28 | 30 | 45 | 51 | 69 | 68 | 90 | 110 | 232 | 259 | 12 |
| VSC Referred | - | - | 4 | 4 | 8 | 15 | 9 | 4 | 6 | 9 | 27 | 43 | 59 |
| VSC Performed | 82 | 103 | - | - | - | - | 10 | 10 | - | - | 92 | 112 | 22 |

* P = Projected, A = Actual

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

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TABLE N
ANALYSIS OF THE CONDOM GAP

| Type of condom and measure of performance | Data Source | | Gap |
|--|-----------------------|--------|------|
| | Program Statistics | Survey | |
| <u>GOB</u> | | | |
| Condoms distributed (million) | 33.7 | 23.8 | 9.9 |
| CYP (000) | 234 | 165 | 69 |
| Prevalence (percent) | 1.28 | .90 | .38 |
| <u>SMP</u> | | | |
| Condoms (million) | 88.3 | 45.5 | 42.8 |
| CYP (000) | 613 | 316 | 297 |
| Prevalence (percent) | 3.35 | 1.73 | 1.62 |
| <u>BDG + SMP</u> | | | |
| Condoms (million) | 122 | 69.3 | 52.7 |
| CYP (000) | 847 | 48.1 | 366 |
| Prevalence (percent) | 4.63 | 2.63 | 2.00 |

Table 22 reveals a large gap of 42.8 million SMP condoms and a relatively small gap of 9.9 million GOB condoms. The total gap of about 55 million condoms is less than the 78 million used by Deloitte Haskins & Sells, presumably because of the difference between my 144 condom/CYP factor and the more conventional factor of 100.

Source: John Laing memorandum to the USAID mission, 1985

TABLE O
 PERCENT OF CURRENT USERS WHO HAVE USED NO PREVIOUS
 MODERN METHOD
 1983

| <u>Current Method</u> | <u>Eligible Women</u> | <u>Couple</u> <u>Wives</u> | <u>Sample</u> <u>Husbands</u> | <u>Husband Sample</u> |
|-----------------------|-----------------------|-------------------------------|----------------------------------|-----------------------|
| Pill | 59 | 61 | 50 | 55 |
| Condom | 41 | 44 | 43 | 39 |
| Vaginal | 24 | a | a | 10 |
| Injection | 47 | a | a | a |
| IUD | 31 | 26 | 52 | 24 |
| Tubectomy | 73 | 72 | 60 | 59 |
| Vasectomy | 80 | 82 | 64 | 71 |
| Rhythm | 88 | 93 | 86 | 89 |
| Withdrawal | 82 | 72 | 75 | 62 |
| Abstinence | 88 | 90 | 89 | 91 |
| Other | 91 | 97 | 82 | 91 |

Source: 1983 CPS, special tabulations by Mitra and Associates.

Notes: a) Less than 10 weighted cases.

TABLE P

PERCENT OF CURRENT USERS OF MODERN METHODS WHO EVER USED
MODERN METHODS PREVIOUSLY
1983

| <u>Sample and Previous Method</u> | <u>Method Currently Used</u> | | | | | |
|---------------------------------------|------------------------------|---------------|------------------|------------|------------------|------------------|
| | <u>Pill</u> | <u>Condom</u> | <u>Injection</u> | <u>IUD</u> | <u>Tubectomy</u> | <u>Vasectomy</u> |
| <u>Eligible Women</u> | | | | | | |
| Pill | - | 55 | 51 | 58 | 21 | 17 |
| Condom | 29 | - | 9 | 36 | 8 | 7 |
| Injection | 7 | 3 | - | 4 | 3 | 1 |
| IUD | 5 | 5 | 16 | - | 5 | 2 |
| <u>Husband Sample</u> | | | | | | |
| Pill | - | 51 | a | 63 | 33 | 24 |
| Condom | 38 | - | a | 55 | 16 | 16 |
| Injection | 8 | 2 | a | 4 | 13 | 2 |
| IUD | 3 | 5 | a | - | 6 | 2 |

Source: Special tabulations from 1983 CPS by Mitra and Associates.

TABLE Q
 CONTRACEPTIVE USE ACCORDING TO METHOD BY DESIRE
 FOR ADDITIONAL CHILDREN

(Eligible Women Sample, CPS 1983)

| <u>Contraceptive Use</u> | Desire for Additional Children | | |
|--------------------------|--------------------------------|------------------|------------------|
| | <u>No More</u> | <u>Undecided</u> | <u>Want More</u> |
| Any method | 31.4 | 6.7 | 7.8 |
| Pill | 4.3 | 2.3 | 2.4 |
| Condom | 1.7 | 0.8 | 1.4 |
| Vaginal | 0.3 | 0.0 | 0.2 |
| Injection | 0.5 | 0.2 | 0.0 |
| IUD | 1.5 | 0.0 | 0.6 |
| Tubectomy | 12.7 ^a | 0.0 | 0.0 |
| Vasectomy | 2.5 | 0.3 | 0.0 |
| Safe period | 3.1 | 1.9 | 1.7 |
| Withdrawal | 1.5 | 0.6 | 1.1 |
| Abstinence | 0.6 | 0.0 | 0.1 |
| Other | 2.7 | 0.6 | 0.1 |

Source: Special tabulations provided by Mitra and Associates.

Notes: ^a Including 0.3 percent with both tubectomy and vasectomy.

TABLE R

PERCENT PRACTICING CONTRACEPTION AMONG THOSE WANTING MORE
CHILDREN BY NUMBER OF CHILDREN WANTED

(Eligible Women Sample, CPS 1983)

| <u>Additional Children Wanted</u> | <u>Percent Practicing Contraception</u> |
|-----------------------------------|---|
| 1 | 18.9 |
| 2 | 10.0 |
| 3+ | 6.2 |
| "Up to God" | 1.9 |
| Wants more but number uncertain | 3.7 |

Source: Special tabulations provided by MITRA and Associates.

TABLE S

PERCENTAGE DISTRIBUTION OF CURRENTLY MARRIED WOMEN UNDER 50 YEARS
OF AGE NOT CURRENTLY USING CONTRACEPTIVES HAVING INTENTION TO USE IN
FUTURE BY METHOD INTENDING TO USE

(The Eligible Woman Sample)

| Methods | National | Rural | Urban |
|--|-------------------|-------|--------------------|
| Oral pill | 28.5 | 28.3 | 30.1 |
| Condom | 2.2 | 2.1 | 2.6 |
| Vaginal Method | 0.3 | 0.3 | 0.3 |
| Injection | 16.3 | 16.6 | 14.6 |
| IUD | 2.1 | 1.9 | 3.5 |
| Female sterilization | 11.4 | 11.2 | 12.8 |
| Male sterilization | 0.2 | 0.1 | 0.3 |
| M. R. | 0.2 | 0.1 | 0.3 |
| Safe period | 1.2 | 1.2 | 1.5 |
| Withdrawal | 0.6 | 0.7 | 0.3 |
| Other | 3.4 | 3.6 | 2.0 |
| Uncertain/none of the above methods/don't know | 33.7 | 33.9 | 31.8 |
| Total | 100.0 | 100.0 | 100.2 ^a |
| N ² | 2329 ^b | 2072 | 742 ^c |

¹ N in this table is the total number of currently married women having intention to use contraceptives in future, excluding the current users and the NS (Not Stated) cases, if any, for the question about the methods intended to use in future.

^a Total is more than 100 percent due to rounding errors.

^b Weighted total.

^c The number of NS cases was 1 for urban.

Source: 1983 CPS Final Report, p. 249.

TABLE T
 THE WORLD BANK'S
 BANGLADESH POPULATION AND FAMILY HEALTH, III PROJECT
 Financing Plan by Disbursement Category
 (US\$ '000)

| | AUSTRALIAN GOVERNMENT | | CANADIAN INTERNATIONAL DEVELOPMENT AGENCY | | FEDERAL REPUBLIC OF GERMANY | | NETHERLANDS | | NORWAY | | OVERSEAS DEVELOPMENT ADMINISTRATION | | INTERNATIONAL DEVELOPMENT ASSOCIATION | |
|---|-----------------------|------|---|------|-----------------------------|------|-------------|------|---------|------|-------------------------------------|------|---------------------------------------|-------|
| | Amount | % | Amount | % | Amount | % | Amount | % | Amount | % | Amount | % | Amount | % |
| A. Niport Training | - | - | - | - | 11,374.0 | 93.8 | - | - | - | - | - | - | - | - |
| B. UHFWC Construction and Furniture | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| C. Facilities and Maintenance Program | - | - | - | - | - | - | - | - | - | - | - | - | 41,149.8 | 91.3 |
| D. DDS Kits | 2,910.4 | 8.5 | - | - | 13,312.4 | 38.9 | 1,232.6 | 3.6 | 3,714.0 | 50.0 | - | - | - | - |
| E. MCH Equipment and Supplies | - | - | - | - | - | - | 281.3 | 58.6 | 5,136.0 | 15.0 | - | - | 11,648.4 | 34.0 |
| F. <u>Medical & Surgical Equipment/Supplies</u> | - | - | - | - | - | - | - | - | 158.3 | 33.0 | - | - | - | - |
| Lungees/Sarees | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Medical & Surgical Requisites | - | - | - | - | - | - | - | - | - | - | - | - | 9,639.1 | 80.0 |
| Sub-Total Medical and Surgical Equip/Supplies | - | - | - | - | - | - | - | - | - | - | - | - | 5,879.8 | 100.0 |
| G. Management Development Unit | - | - | - | - | - | - | - | - | - | - | - | - | 15,518.9 | 86.6 |
| H. Clin Contraceptive Surv Team | - | - | - | - | - | - | 715.9 | 24.9 | 715.9 | 24.9 | 1,431.5 | 49.8 | - | - |
| I. FWA Salaries | 1,221.2 | 4.3 | 11,466.8 | 40.0 | 2,838.0 | 9.9 | - | - | 2,071.1 | 97.2 | - | - | - | - |
| J. SR FWV Salaries | - | - | - | - | 905.2 | 38.0 | 1,588.2 | 5.5 | 7,181.1 | 25.1 | 4,371.7 | 15.3 | - | - |
| K. Supervision Directorate | - | - | - | - | - | - | - | - | 1,476.9 | 62.0 | - | - | - | - |
| L. Worker Travel Allowances | - | - | - | - | - | - | - | - | - | - | - | - | 154.6 | 94.8 |
| M. Vehicles /a | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| N. MCH Program /b | - | - | - | - | - | - | - | - | - | - | - | - | 4,093.9 | 56.7 |
| O. <u>Communications</u> | - | - | - | - | - | - | 355.8 | 9.8 | 2,896.3 | 79.9 | - | - | - | - |
| RAPID Bangladesh and TV Bangladesh | 436.2 | 31.4 | - | - | - | - | - | - | - | - | - | - | - | - |
| Health Educ. Bureau, Swanirvar, IEM Unit | 182.1 | 2.4 | 499.2 | 6.5 | - | - | - | - | - | - | - | - | - | - |
| Sub-Total Communications | 618.3 | 6.8 | 499.2 | 5.5 | - | - | 641.6 | 8.4 | - | - | - | - | - | - |
| P. NGO Support | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Q. Innovative Activities | - | - | - | - | - | - | - | - | - | - | 4,545.1 | 99.1 | 8.1 | 6.2 |
| R. Evaluation and Research | 2,203.9 | 77.6 | - | - | - | - | - | - | - | - | - | - | 5,000.1 | 100.1 |
| S. <u>Project Management Support</u> | - | - | - | - | - | - | - | - | - | - | - | - | 419.3 | 14.8 |
| Project Population Office | 200.0 | 18.0 | 222.2 | 20.0 | 244.4 | 22.0 | 166.7 | 15.0 | 277.8 | 25.0 | - | - | - | - |
| Sub-Total Project Management Support | 200.0 | 18.0 | 222.2 | 20.0 | 244.4 | 22.0 | 166.7 | 15.0 | 277.8 | 25.0 | - | - | - | - |

| | <u>AUSTRALIAN GOVERNMENT</u> | | <u>CANADIAN INTERNATIONAL DEVELOPMENT AGENCY</u> | | <u>FEDERAL REPUBLIC OF GERMANY</u> | | <u>NETHERLANDS</u> | | <u>NORWAY</u> | | <u>OVERSEAS DEVELOPMENT ADMINISTRATION</u> | | <u>INTERNATIONAL DEVELOPMENT ASSOCIATION</u> | |
|---|------------------------------|------------|--|-------------|------------------------------------|-------------|--------------------|------------|-----------------|-------------|--|------------|--|-------------|
| | <u>Amount</u> | <u>%</u> | <u>Amount</u> | <u>%</u> | <u>Amount</u> | <u>%</u> | <u>Amount</u> | <u>%</u> | <u>Amount</u> | <u>%</u> | <u>Amount</u> | <u>%</u> | <u>Amount</u> | <u>%</u> |
| T. <u>Women's Programs</u> | | | | | | | | | | | | | | |
| Women's Vocational Inservice Trg Program | - | - | - | - | - | - | 1,114.8 | 94.8 | - | - | - | - | - | - |
| Mothers Ctrs.BRBD, Wom Vocational Trg | - | - | 11,294.9 | 82.2 | - | - | - | - | - | - | - | - | - | - |
| Sub-Total Womens Programs | - | - | 11,294.9 | 75.7 | - | - | 1,114.8 | 94.8 | - | - | - | - | - | - |
| U. <u>Other Operating Expenses</u> | | | | | | | | | | | | | | |
| Vehicle Oper and Maintenance | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Project Finance Cell | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| MOHPC Procurement | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| CMC Administration | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Sub-Total Other Operating Expenses | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Total Disbursement | 7,153.7 | 3.3 | 23,483.1 | 11.0 | 28,674.1 | 13.4 | 6,096.9 | 2.9 | 23,627.3 | 11.0 | 10,348.3 | 4.8 | 77,993.1 | 36.5 |

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TABLE U
PLANNED UNFPA ASSISTANCE DURING IIIRD COUNTRY PROGRAMME

| | | (in US Dollars) | | | | | | |
|--------------------------------------|--|-----------------|------------------|------------------|------------------|------------------|-----------------------------|-------------------|
| | | <u>1985</u> | <u>1986</u> | <u>1987</u> | <u>1988</u> | <u>1989</u> | <u>1990</u> (Jan - June) | <u>Total</u> |
| A. Under Regular Funding | | | | | | | | |
| BGD/85/P01 | Support to the Population Planning Section | | 168,265 | 133,079 | 100,629 | 50,096 | 23,925 | 475,994 |
| BGD/85/P02 | Strengthening of Integrated MCH/FP: Logistics, Supplies, Services | | 1,954,100 | 2,593,050 | 2,507,650 | 2,393,200 | 2,405,050 | 11,853,050 |
| BGD/85/P03 | Advisory Support to P.C. Wing of the MPH & PC | | 138,350 | 108,130 | 76,020 | - | - | 322,500 |
| BGD/85/P06 | Strengthening IEM Activities | | 802,912 | 579,002 | 484,166 | 279,582 | 149,473 | 2,295,135 |
| BGD/85/P13 | Institutional Development Assistance Project (IDAP) for Bangladesh | | 15,000 | 15,000 | - | - | - | 30,000 |
| TOTAL (A): | | - | <u>3,078,627</u> | <u>3,428,261</u> | <u>3,168,465</u> | <u>2,722,878</u> | <u>2,578,448</u> | <u>14,976,679</u> |
| B. Under Multilateral Funding | | | | | | | | |
| BGD/85/P04 | Supply and Distribution Monitoring Unit for the Bangladesh Population Programme | 57,700 | 135,000 | 113,000 | 18,800 | - | - | 324,500 |
| BGD/85/P09 | Strengthening the Population Component of Agricultural Extension Services | - | 60,000 | 55,000 | 50,000 | 50,000 | 25,000 | 240,000 |
| BGD/85/P10 | FW Education & Motivation for FP Services Through Rural Cooperatives | - | 172,000 | 87,650 | - | - | - | 259,650 |
| BGD/85/P11 | MCH/FP Services at Union and Ward Levels | - | 1,049,623 | 1,091,524 | 1,135,101 | 1,180,422 | 613,778 | 5,070,448 |
| BGD/85/P12 | Improvement of the Management Capabilities | - | 185,336 | 143,007 | 104,715 | - | - | 433,058 |
| TOTAL (B): | | <u>57,700</u> | <u>1,601,959</u> | <u>1,490,108</u> | <u>1,308,616</u> | <u>1,230,422</u> | <u>638,778</u> | <u>6,327,656</u> |
| GRAND TOTAL (A&B): | | <u>57,700</u> | <u>4,680,586</u> | <u>4,918,442</u> | <u>4,447,081</u> | <u>3,953,300</u> | <u>3,217,226</u> | <u>21,304,335</u> |

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APPENDICES

APPENDIX A

STATUS OF RECOMMENDATIONS CONTAINED IN THE
MID-TERM PROJECT EVALUATION

Appendix A

STATUS OF RECOMMENDATIONS CONTAINED IN THE
MID-TERM PROJECT EVALUATION

A mid-term evaluation¹ of the FPSP was conducted in August 1982. A number of recommendations were made concerning both current and future AID population assistance to Bangladesh. Many of these, while useful, go beyond what could reasonably be expected under this Project. For that reason, progress is noted only on those recommendations that are most directly related to the activities financed by the Project. These include:

- (a) Improvement of commodity logistics, including training, warehousing, transportation, and provision of long-term technical assistance.

USAID hired a long-term logistics advisor, added a local employee to the staff, worked with The United Nations Fund for Population Activities (UNFPA) to set up a donor coordinating committee and implemented, or will be implementing, all of the recommendations contained in the report.

Further discussion of logistics activities is included in Section 3.3.1.

- (b) Improvement of the quality and availability of voluntary sterilization services.

USAID played a key role in improving the quality of the VS program. As a result of direct USAID intervention, drawing upon the services of the CDC, changes were made in the anesthesia regimen which sharply reduced the mortality associated with VS. The current rates of approximately two deaths per 100,000 cases is roughly equivalent to that in the U.S., making VS one of the safest surgical procedures in Bangladesh. USAID also engaged the services of a full-time expatriate physician to monitor the quality of the VS program during the period September 1981 through June 1984. This monitoring was supplemented by the four donor-supported VSSTs. Numerous other efforts have been made by USAID (as discussed in Section 3.2.2 above and shown in Table 18) to monitor the quality of VS services.

- (c) Changes in the local cost reimbursement system to ensure the prompt and continued flow of program funds for local costs.

¹ "Mid-Term Evaluation of USAID Family Planning Project in Bangladesh," published by the American Public Health Association.

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The GOB submits vouchers on a quarterly basis for reimbursement under the VS program. Prior to making a reimbursement, however, USAID waits until the completion of the quarterly evaluation ("audit"), which is conducted by M.A. Quasem and Co. This has resulted in considerable delays in reimbursing the GOB for costs already incurred. About 18 months ago, USAID began reimbursing the GOB on the basis of the quarterly voucher, subtracting from that amount any reimbursements which were disallowed on the basis of the previous quarter's "audit." This change has resulted in a more expeditious flow of funds.

- (d) Continued support for contraceptive prevalence surveys. USAID-funded surveys were conducted in 1983 and 1985.

The response to this recommendation is described in Section 3.2.4.

- (e) As part of USAID's dialogue with the GOB, increased emphasis on the promotion of a small family norm, the relationship of development to rapid population growth, and the health benefits of family planning.

USAID believes that senior level officials in the GOB are already fully aware of the negative consequences of rapid population growth and the importance of modifying norms regarding family size. These concerns are reflected in the Third Five Year Plan (TFYP) and in the IEM strategy of the MOHFP. Despite this, it is still of concern that only four percent of the GOB's development budget under the TFYP is devoted to the GOB's stated highest priority--population and family planning.

Under a special project with the ICDDR,B, USAID has supported research on the health benefits of family planning. The findings of this research are being disseminated in various papers and forums, and have helped to further strengthen the GOB's and the donors' commitment to population.

- (f) Strengthening of fieldworker training through improved planning, curricula development, training of trainers, and establishment of a high level training task force.

Efforts to improve fieldworker training have thus far met with limited success (see Section 3.3.4.8 to review the CARE effort). Under the Bangladesh BPFH III Project, the Federal Republic of Germany will make a major commitment (\$11.4 million) to NIPORT to upgrade all aspects of training that are managed and coordinated by NIPORT. In addition, on their own, the six NGOs being supported by USAID have joined together to carry out a training needs assessment (see Section 3.3.4.6 for involvement of PF in this effort). Outside TA may be employed for this purpose, with the focus on across-the-board training for sub-project

staff. Pathfinder will take the lead in organizing the non-clinical training (e.g., project planning, record-keeping, etc.), with BAVS focusing on physicians, Lady Health Visitors, FWVs, and clinic counselors.

- (g) Encouragement of continued efforts to decentralize the administration of health and family planning services.

USAID efforts to support decentralization through the training of UFPOs in Indonesia was discontinued by the GOB when martial law was introduced in 1982, as was the Local Family Planning component of the FPSP. The reason given by the GOB for discontinuing the Indonesia training was the President's view that such training could be better carried out in Bangladesh by bringing Indonesians to Bangladesh. The MOHFP, however, disagreed with this view, saying that the two programs are quite different and therefore required on-site visits by Bangladesh program personnel. The MOHFP has raised the issue again, as has the Indonesian Ambassador, at the highest levels of government and it is hopeful that the program can be resumed soon.

Regarding other support for local family planning, USAID has recently reopened discussions with the MOHFP regarding the possibility of channeling funds to the Upazila chairmen to support local family planning activities. Similar efforts are already under way by some of the NGOs.

- (h) Support for "beyond family planning" measures, including use of mass media to encourage delayed marriage and spacing programs to increase enrollment and retention of females in school, and strengthening of related MCH services. A health needs assessment was also recommended.

On the basis of information suggesting the existence of significant unmet demand for family planning services, plus a lack of clear evidence on how to affect demand, USAID decided to proceed slowly in this area. It did, however, expand the Female Secondary Education Scholarship Program (see Section 3.3.4.2) and encourage the introduction of some additional MCH services and income-generating activities among selected NGOs.

- (i) Continued emphasis on donor coordination and involvement of senior GOB counterparts in evaluations.

USAID has played a leadership role in the area of donor coordination, calling the first donors meeting in February 1982. USAID worked with UNFPA to form a logistics donor coordination group and in December 1985 obtained the agreement of other donors to meet on a quarterly basis to discuss relevant program issues. Although USAID has been a leader in this area, differences in

priorities among the donors have made it difficult to reach a consensus on some major issues (e.g., emphasis on other MCH services in relation to family planning). USAID has participated in all World Bank population missions since early 1984 and there has been close coordination with regard to the funding of various program needs.

At USAID's request, the MOHFP assigned Col. Md. Abdul Latif Mallik, the Director General of the Population Control Directorate, and Md. Azizul Karim, Deputy Chief of the Population Control Wing, to serve as team members on this evaluation. Their time and contribution to the evaluation effort has been invaluable.

- (j) Introduction of an improved IUD and alternative (low dose) oral contraceptives. Changes in method mix, focusing on increased availability and use of temporary methods.

Since 1983, USAID has been supplying the Cu-T 200 IUD to the Bangladesh FP program. IUD use has risen substantially during this period, in part due to the availability of this improved device. Low dose oral contraceptives have yet to be introduced into the program, pending the completion of clinical trials (see Section 3.3.4.7).

While the reasons for the dramatic downturn in the use of permanent methods of contraception are not entirely clear, one result has been a markedly different method mix in the program (see Table 7). It is also clear that major increases in the availability of temporary methods has occurred, particularly through the SMP and CBD programs being supported by the NGOs (see Table 10). Further increases in the availability of temporary methods is anticipated, as 10,000 FWAs are added to the MOHFP workforce.

- (k) Assistance in the establishment of a performance-based reward system for fieldworker supervisors.

USAID proposed the initiation of such a system on a pilot basis in the the 1984 amendment. During the course of the Amendment review in Washington, however, this component was deleted.

- (l) Encouragement of setting of priorities and focus on a realistic set of MCH/family planning activities at the service delivery level.

In addition to FP, the GOB has identified oral rehydration therapy (ORT), immunizations for children and women of reproductive age, and safe delivery practices, as the highest

priorities for MCH services. It is still unclear, however, what role the FWA can and should play in helping to deliver these services, given that her current family planning responsibilities are already excessive. Under the ICDDR,B component of the Project, both in Matlab and the Extension Areas, these issues are being studied on a pilot basis.

APPENDIX B
REVISED WORKSCOPE

APPENDIX B

Revised Workscope

A. Project Accomplishments

(1) This section will describe purpose level achievements (as expressed in terms of contraceptive prevalence) during the life of the Project. An effort will be made to assess the extent to which the Project outputs, in the aggregate, have contributed to these observed changes in prevalence. This section will also examine the extent to which the Project and the program more generally, may have contributed to reduced infant and maternal mortality.

(2) This section will also describe the extent to which planned outputs and inputs were achieved, as stated both in the original Project Paper and the Amendment. To the extent possible, this description will be related to the individual components of the Project. Summary findings, conclusions, and recommendations with regard to each of these components will also be included in this connection.

(3) To the extent that Project objectives have been unmet or exceeded, the reasons for this will be described. Important lessons learned, if any, will also be identified.

B. Status of Recommendations of the Mid-Term Evaluation

(1) Improvements in commodity logistics, including training, warehousing, transportation, and provision of long-term technical assistance;

(2) Improvements in the quality available of voluntary sterilization services;

(3) Changes in the local cost reimbursement system to ensure the prompt and continued flow of program funds for local costs;

(4) Continued support for contraceptive prevalence surveys;

(5) Increased emphasis on promoting a small family norm, the relationship of development to rapid population growth, and the health benefits of family planning as part of USAID's dialogue with BDG;

(6) Strengthening of fieldworker training through improved planning, curricula development, training of trainers, and establishment of a high level training task force;

(7) Encourage continued efforts to decentralize the administration of health and family planning services;

(8) Support for "beyond family planning" measures, including use of mass media to encourage delayed marriage and spacing, programs to increase enrollment and retention of females in secondary school, and strengthening of related MCH services. A health needs assessment was also recommended.

(9) Continued emphasis on donor coordination and involvement of senior of BDG counterparts in evaluations;

(10) Introduction of an improved IUD and alternative (low dose) oral contraceptives. Changes in method mix, focusing on increased availability and use of temporary methods.

(11) Assist in the establishment of performance-based reward system for field workers supervisors; and

(12) Encourage setting of priorities and a focus on a realistic set of MCH/family planning activities at the service delivery level.

C. Key Issues Related to Past and Future Assistance

The Team will attempt to address a number of key issues related both to AID population assistance to date, and possible future assistance. These include issues both of a general nature, as well as those relevant to discrete elements of the program.

(1) General or Strategic Issues

o To what extent does latent demand or unmet need exist for both permanent and temporary methods of contraception (i.e., should greater emphasis be given to indirect or demand-related determinants of fertility?)?

o How realistic are the demographic goals as expressed in the BDG's Third Five-Year Plan?

o Does the current contraceptive mix reflect informed choice, or is access to certain methods of contraception constrained (and/or overly emphasized)?

o Related to this, does AID's population assistance strategy focus too heavily on "limiters" rather than "spacers"? If yes, can the Team identify programmatic initiatives which could improve access and use of temporary methods by those couples wanting to space, rather than terminate, childbearing or those who wish to terminate but do not wish to use a permanent method?

(2) Programmatic Issues Related to Specific Project Components

(a) MOHPC

- o How has integration of health and family planning affected implementation in the field? What changes, if any, are needed in this field structure to improve program effectiveness?
- o What has been/is the role of reimbursements in facilitating access to voluntary sterilization services?
- o Has significant progress been made in the area of commodity management, particularly with regard to contraceptive planning, collecting and analysis of logistics data, warehousing, and distribution? What important unmet needs, if any, remain?
- o Does AID's assistance in population/family planning, particularly with respect to the MOHPC, overlap of duplicate what other donor are doing? To the extent that major weaknesses remain, what role can/should AID play in helping to address these deficiencies?
- o What is the role of method-specific targets, both with respect to NGO's and MOHFP, in the program? Do they contribute in a positive way to overall program achievement, or should alternative measures of performance be used?

(b) Non-Governmental Organizations

- o Given the current status of the Bangladesh Family Planning Program, what role should NGO's play in the program over the next five years (i.e., are any major strategic changes needed)?
- o What can be done to ensure that duplication of effort is kept to a minimum especially as services are selectively extended to the rural areas?
- o What can be done to minimize the management burden of NGO activities, both on USAID and the NGO's themselves?
- o Is the existing national NGO coordinating entity adequate? Should it be strengthened or replaced?

c. Social Marketing Project (SMP)

- o How important a role does the SMP play in increasing access and use of modern contraception?

This analysis should go beyond the issue of the "condom gap" or "data discrepancy", as it is now called (i.e., is it an important means of introducing couples to modern contraception; do SMP users move from less effective to more effective methods?).

- o What steps can and should be taken to improve the effectiveness of SMP?

d. ICDDR/B

- o What "lessons learned" through Matlab and the Extension Areas are relevant for the larger program?

- o What is/should be the role of ICDDR/B in helping to examine important strategic and/or programmatic issues over the next 3-5 years?

- o What are some of these issues.

D. Potential Areas of Future AID Population Assistance to Bangladesh

The team will review current and projected needs of the Bangladesh population program through 1991. This analysis will assess both BDG and other planned expenditures in population, and will attempt to identify unmet needs suitable for AID funding. Given the limited time available to the Team, however, some of the potential areas of assistance will obviously require more detailed analysis.

E. Evaluation Methodology

The assessment of purpose level accomplishments will be based on a review and analysis of service statistics (from both Government and NGO outlets), national contraceptive prevalence surveys (CPS), and mini-surveys of prevalence conducted by several of the NGOs. Secondary computer analysis of selected CPS data may be undertaken to address several evaluation issues. Data and published papers provided by ICDDR/N will be used to estimate the possible mortality effects of the Project.

Project achievement at the output level will be based on information contained in the three recently-completed evaluation of the Social Marketing, NGO, and ICDDR/B components of the Project. This information will be supplemented through interviews with AID staff and key personnel involved in all facets of the Project. Field visits will be made, focusing especially on the MOHPC Project component, to selected sites to obtain first hand information and/or confirm the findings of previous evaluation teams.

The status of mid-term Project evaluation recommendation will be assessed through interviews with key GOB and USAID staff supplemented with documentation related to selected recommendations.

The key issues will be examined largely through interviews with relevant GOB, NGO, and USAID staff supplemented with information contained in three recent separate evaluations, and through discussions with team members from the Social Marketing and NGO evaluation teams.

Finally, potential areas of future AID population assistance will be assessed on the basis of GOB documents (e.g., Third Five-Year Plan) and discussions with GOB officials and members of the donor community.

APPENDIX C

PRINCIPAL PERSONS INTERVIEWED AND SITES VISITED

APPENDIX C

Principal Persons Interviewed and Sites Visited

Bangladesh Government
Ministry of Health and Family Planning

Mr. Manzoor-ul Karim, Secretary

Mr. Aminul Islam, Additional Secretary

Mr. Md. Azizul Karim, Deputy Chief - Family Planning Wing (also member, USAID evaluation team)

Mr. Mostafa Jamal, Deputy Secretary, (Coordination)

Mr. Zahirul Islam, Deputy Secretary, (Development)

Family Planning Wing

Col. Md. Abdul Latif Mallik, Director General for Implementation (also member, USAID evaluation team)

Lt. Col. Shams-Ud Dowla, Director, Logistics & Supply

Mr. Najmul Hoque, Director, IEM

Mr. S. R. Choudhury, Director, MIS

National Institute of Population Research and Training (NIPORT)

Dr. S. Waliullah, Director General

Mr. Rafiquzzaman, Director, Training

Bangladesh Institute of Development Studies

Mr. M. R. Khan, Research Director

Bangladesh Bureau of Statistics

Dr. A. K. M. Rabbani, Director General

Planning Commission, Population Section

Mr. M. A. Mabud, Planning Officer

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Ministry of Commerce

Mr. Ghulam Mostafa, Secretary (former Secretary, MOHFP)

Directorate of Women's Affairs

Ms. Gule Afruz Mahbub, Directorate

U. S. Embassy

Mr. Howard B. Schaffer, Ambassador

USAID/Dhaka

Mr. John Westley, Mission Director

Mrs. Bonnie Pounds, Deputy Director

Ms. Suzanne Olds, Chief Health and Population Office

Ms. Sharon Epstein, Deputy Chief, Health and Population Office

Ms. Turra Bethune, Program Officer

Mr. Jesse Brandt, Logistics Management Advisor

Mr. Jan Van der Veen, Program Economist

Mr. Stephen Allen, Legal Advisor

Ms. Louisa Gomes, Program Specialist

Mr. Sk. Ali Noor, Population Program Analyst

Dr. Michael Calavan, Rural Development Specialist

Bangladesh Association for Voluntary Sterilization

Dr. Azizur Rahman, President

Dr. A. B. Choudhury, Deputy Executive Director

Dhaka University, Department of Economics

Dr. Barkat e Khuda, Professor

Association for Voluntary Surgical Contraception
Asia Regional Office (AVSC/ARO)

Mr. Farruk Ahmed Chaudhuri, Director

Mr. Gary Newton, Assistant Director

Mr. Ahmed al Kabir, Program Officer

International Center for Diarrhoeal Disease Research, Bangladesh

Mr. Michael Rowland, Associate Director, Community Services Working Group

Dr. Marjorie Koblinsky, Director, Extension Project

Dr. Michael Koenig, Acting Director, FP/MCH Project

Dr. Yunus, Senior Physician, Matlab Field Station

Dr. J. Chakraborty, Supervisor, Matlab Field Station

Voluntary Sterilization Surveillance Team, Dhaka Division

Dr. I. B. Peters, WHO Team Leader

Col. Hashmat Ali, Consultant

Khulina Division

Major Akhter Ahmed, Consultant

The Pathfinder Fund

Dr. M. Alauddin, Country Representative

Bangladesh Fertility Research Program

Dr. Halida Akhter, Director

James H. McMahan, Regional Representative, Family Health International

The Asia Foundation

Mr. Geoff Taylor, Chief Population Officer

UNICEF

Mr. Anthony Kennedy, Representative

Ms. Nancy Terreri, Assistant Program Officer

Bangladesh Womens' Health Coalition

Ms. Sandra Kabir, Executive Director

UNFPA

Mr. Hasse Gaenger, Deputy Representative

SIDA

Mr. Hans Ehrenstrahle
First Secretary (Development)

British High Commission

Mr. Stephen Chard
First Secretary (Aid)

Voluntary Health Services Society

Mr. Rezaul Islam, Director

Family Planning International Assistance

Mr. Abdul Hashem, Associate Regional Director

Family Planning Services and Training Center

Mr. Abdur Rouf, Chief Executive

Program for the Introduction and Adoption of Contraceptive Technology

Mr. Abu Yusuf Choudhury, Executive Director

Bangladesh Rural Advancement Committee

Mr. F. Abed, Executive Director

Social Marketing Program

Mr. Robret Ciszewski, Country Representative

Mr. S. Anwar Ali, General Manager

Mr. M. Anwar, Development Manager

Private Firms

Mitra & Associates

Sites Visited

Kalinganj Upazila (Gazipur District) VS surveillance

Tangerchar Union (Chittangong Division)

Unspecified Upazila (Jessore) site of ICDDR/B Extension Project

Abhoynagar Upazila (Jessore) site of ICDDR/B Extension Project

Phultala Upazila and nearby villages for observation of FWA/client interaction of Zamira FWC

Office of the District Director FP (Jessore), Mr. Jahiruddin Ahmed

APPENDIX D
REVISED BUDGET

APPENDIX D
Revised Budget

March 16, 1986

Actual FY 81-85 Obligations of the Family Planning Services Project by Component and Year and Proposed FY 86 Obligation Amounts

| Component | 1981 | 1982 | 1983 | 1984 | 1985 | Proposed 1986 (in 000s) (Tentative) |
|---|-----------|-----------|-----------|------------|----------------------------|--|
| A. MOPHC GRANT | | | | | | |
| 1. Voluntary Sterilization | 3,234,581 | 1,757,762 | 6,500,000 | 4,200,000 | 9,000,000 ^{>a} | 1,315 |
| 2. Training* | 100,000 | 344,000 | 0 | 0 | - | - |
| 3. Operations Research* | 100,000 | 200,000 | 0 | 0 | - | - |
| 4. Local Family Planning* | 50,000 | 200,000 | 0 | 0 | - | - |
| 5. MCH Materials* | 65,000 | 200,000 | 150,000 | 0 | - | - |
| 6. Printing* | 0 | 15,000 | 0 | 0 | - | - |
| 7. Evaluation* | 0 | 50,000 | 0 | 0 | - | - |
| 8. TRKT* | - | - | - | (713,952)* | - | 2,250 |
| 9. Demand Creation* | 100,000 | 556,000 | 0 | 900,000 | - | - |
| 10. Family Planning Services and Training Center (FPTC) | 100,000 | 350,000 | 200,000 | 200,000 | 300,000 | 900 |
| 11. Commodities and logistics (contraceptives, equipment, construction and supplies)*** | 450,000 | 3,358,000 | 2,592,895 | 0 | 2,000,000 | 3,250 |
| 12. CPS | 50,000 | 100,000 | 0 | 50,000 | 0 | 185 |
| 13. IUD Reimbursement Program** | - | - | - | 600,000 | 740,000 | 1,100 |
| Subtotal | 4,249,581 | 7,130,762 | 9,442,895 | 5,950,000 | 12,040,000 | 8,900 |

* Uncommitted FY 81-83 funds in these categories were reprogrammed in the FY 84 grant agreement amendment to a new element "Technical Resources, Research and Training" (TRKT). There is now \$713,952.40 available for TRKT (PILs #57 and 72.)

** In FY 81-83 these funds were mainly used for the "Strengthening of the IUD" reimbursement program. In FY 84, a new category was added to the Grant for this program (#13). FY 84 Demand Creation funds were for the proposed BIG Individual and Community Awards Program. As the financing of this program has not been approved by AID, the \$900,000 has been reprogrammed to VS.

*** Includes \$1 million for condoms for FY 86 condom requirement and 1 million for FY 86 purchase of emko foam and Cuf.

>a Forward funding using funds (\$3,000,000) intended for AVS.

| Component | 1981 | 1982 | 1983 | 1984 | 1985 | Proposed 1986 (in 000s) (Tentative) |
|---|-------------------|------------------------|-------------------|-------------------|-------------------|--|
| C. <u>PSI/SMP</u> | 1,130,00 | 4,180,918 | 2,000,000 | 5,500,000 | 4,041,699 | 0 |
| D. <u>CENTRALLY PROCURED COMMODITIES</u> | | | | | | |
| 1. For SMP Program: | | | | | | |
| - Condoms | 2,693,802 | 5,308,000 | 5,832,051 | 7,346,000 | 5,704,000 | 2,100 |
| - Pills | - | 252,039 | 507,000 | >c | 896,000 | 500 |
| 2. For HDG Program: | | | | | | |
| - Condoms | 1,206,198 | 3,360,936 | 2,495,949 | 312,000 | 4,100,000 | 2,700 |
| - Pills | 600,000>d | - | - | - | - | - |
| 3. USAID Obligated C&T | - | - | 350,000 | - | - | - |
| Subtotal | 4,500,000 | 8,920,000>e | 9,165,000 | 7,658,000 | 10,208,000 | 5,300 |
| E. <u>GRAND TOTAL</u> | | | | | | |
| 1. MOHPC Grant | 4,249,581 | 7,130,762 | 9,442,895 | 5,950,000 | 12,040,000 | 8,900 |
| 2. PSI/SMP | 1,130,000 | 4,180,918 | 2,000,000 | 5,500,000 | 4,041,699 | 0 |
| 3. NGO Grants/Contracts/Cooperative Agreements and Technical Assistance | 1,120,419 | 4,228,320 | 4,192,105 | 6,892,000 | 5,710,301 | 14,800 |
| 4. Centrally-procured Commodities | 4,500,000 | 8,782,000>e | 9,165,000 | 7,658,000 | 10,208,000 | 5,300 |
| TOTAL | 11,000,000 | 24,332,000>e | 24,800,000 | 26,000,000 | 32,000,000 | 29,000 |

>c Subsequently this order was cancelled.

>d Subsequently AID/Washington reports show that \$128,000 has been deobligated from central procurement.

>e \$569,813.46 of pills for SMP program provided from existing AID/W stock.

APPENDIX E

USAID/BANGLADESH FPSP
SUMMARY OF PROJECT ACHIEVEMENTS

APPENDIX E

USAID/Bangladesh FPSP

Summary of Project Achievements

ORIGINAL PROJECT
(FY 81 - 83)

| <u>PROJECT COMPONENT</u> | <u>PLANNED</u> | <u>ACHIEVEMENT</u> | <u>ACTUAL (AS OF JULY, 1984)</u> |
|--|---|--------------------|--|
| <u>Purpose</u> Raise over CPR from 13% to 25% by | | | |
| <u>Outputs</u> | | | |
| 1. <u>Service Expansion</u> | 1. <u>Service Expansion</u> | | 1. <u>Service Expansion</u> |
| a. Commodities | a. Contraceptive supplies are made available to all categories of fieldworkers; medical kits to physicians and paramedics. | | a. MOPHC and SMP's needs met for oral pills and condoms, CuT's and foam. Instead of medical kits, at the request of GOB an emergency supply of drugs and supplies for VS program purchased. |
| b.. Voluntary Sterilization Reimbursements | b. At least 400 GOB sterilization centers operating year around; a total of 1,625,000 sterilization performed by end of project. | | b. More than 400 GOB centers are operating year round. Between April 1981, when reimbursement began and June 1983. 725,510 sterilizations performed. Informed Consent forms printed. Sterilization surveillance team operating as of 17 Nov. 1982. Chartered accountant auditing quarterly as of April 1983. |
| c. Local Family Planning Project | c. Swanirvar villages receive small grants to incorporate family planning into village activities. TPPOs receive small grants to sponsor local level improvements in service. | | c. Due to inappropriate locus of authority, project bureaucratically unable to proceed. |

1983

2. Demand Creation

- a. IUD Reimbursements
- b. Mass Media Campaign
- c. Feasibility Studies and Small Scale Experiments/Projects

3. Training

- a. TPPO academic and professional

2. Demand Creation

- a. Activities to create demand within the family planning sector.
- b. To increase frequency and quality of radio programs designed to motivate married couples to reduce their fertility.
- c. At least 5 feasibility studies and/or small scale experiments undertaken relating to increasing demand for family planning.

3. Training

- a. 360 TPPOs trained in supervisory and community organizational skills; three mid-level GOB managers receive masters degree academic training; 10 senior and mid-level managers from GOB and private sector receive short term professional training in US or Asian countries.

2. Demand Creation

- a. IUD reimbursement funded initiated in October 1982 retroactive to July 1982..
- b. PSI contracted with Manoff International to develop mass media campaign. Based on sophisticated market research, messages been developed, pretested and are now on the radio. Newspaper ads, TV spots and short films are now being developed and tested.
- c. Population sector assessment on beyond family planning initiatives
 - Female Secondary Education Assessment
 - Experiment to transfer innovations in Matlab to GOB program and to test whether MCH enhances FP in Matlab.
 - Blindness prevalence survey funded as prelude to more demand creating MCH activities.

3. Training

- a. TPPO training program in Indonesia cancelled in March 1982. No TPPOs trained under these funds. Three GOB officers currently receiving masters level training and one completed. Four persons received short term training, including two GOB logistics officers who were trained at USAID and in US observational tours).

b. MCH & FP Materials

b. MCH and FP training and field-work materials and manuals available for use by PWVs, FWAs, TBAs, and other field-workers.

b. 55,000 copies of Better Child Care Manual for PWVs and FWAs printed. Compromise version of Growth Chart being field tested. Motivational kits found to be unacceptable. NIPORT, IEM Unit currently reviewing.

c. Printing

c. Not mentioned in project paper

c. 2,000 copies of Population Growth in Bangladesh printed; IUD Manual submitted and in process of being revised. VS manual printed.

Management Information

4. Management Information

4. Management Information

a. Contraceptive Prevalence Surveys

a. National level prevalence of contraceptive use data available yearly.

a. Determined that bi-annual frequency were appropriate. Secondary analysis project of 1981 CPS funded, but report not submitted. 1983 CPS contracted to a private firm; field work began in October 1983.

b. Operations Research

b. At least 20 evaluation studies on different components of the program are completed

b. New RFP procedures introduced; one RFP topic cancelled due to change in Government. Unanticipated delays in the research topic approval process. One Bibliography funded and completed; Three studies on-going and three pending concurrence with USAID.

c. Sterilization Surveillance System

c. Surveillance system monitors all aspects of the sterilization program

c. Serious delay in implementing system. Four Bangladeshi doctors in place as of 17 November 1982. Three expatriate doctors in place as of early 1983. In September 1983, USAID finally received copies of the monthly reports of the team.

d. Evaluation

d. At least six months before the end of project an in-depth depth external evaluation will be conducted

d. An in-depth mid-term evaluation conducted in August 1982. Final report received March 1983 and results incorporated into design on follow-on project.

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5. Social Marketing Project

5. Social Marketing Project

Contraceptive products available universally in urban and rural commercial outlets. CYP increased from 400,000 to 809,000.

5. Social Marketing Project

Retail outlets increased to over 85,000; major expansion into rural area achieved. Sales to wholesalers and retailers consistently exceeded targets, due particularly to condom sales. The Mis system did not permit accurate CYP estimates.

6. Non-Governmental Organizations

6. Non-Governmental Organizations

a. IPAVS/BAVS

a. Number of DAVS clinics doubled from 24 to 48; at least 150,000 sterilizations performed

Training activities increased; quality of sterilization services improved in GOB and private organizations.

6. Non-Governmental Organizations

a. - 28 clinics in place; 6 additional clinics in process of establishment; 133,072 sterilization performed.

- Refresher training program for 600 GOB physicians approved and under implementation.

- 56 GOB physicians attended BAVS Regional Medical Workshops.

- Consultant completed needs assessment for initial VS training for GOB physicians.

(In addition, under its central grant funds, BAVS provided VS training to 118 GOB and 103 NGO physicians, as well as 47 NGO paramedics/health auxiliaries involved in VS service delivery)

b. FPSTC

b. At least 20 indigenous Bangladeshi PVOs delivering family planning services; increased use of contraceptives, and community support for family planning.

b. 18 indigenous PVOs delivery family planning services with community involvements.

c. BFPA

c. Clinical services, I&E programs, youth and women's programs and community-based family planning services made available; increased community development in family planning.

c. 500 traditional healers and 100 local level clubs and PVOs provide community-based services.

- Production of one 20 minute, color, family planning motivational film.

- 20 seminars on family planning held for 2000 local level opinion leaders.

d. Pathfinder Fund

d. Family Planning Services made available in factories, jute mills; District and Sub-Divisional towns; increased use of contraceptives.

d. 18 subprojects providing family planning services to urban and industrial populations.

January - June 1983 do not include clinical referrals.

e. Asia Foundation

e. Community-Based family planning services integrated into other development efforts of indigenous PVOs; increased contraceptive distribution and use.

e. 18 local and national PVOs providing community based family planning services.

f. Care-FWV Faculty Training

f. Faculty in all 12 FWVTIs (80-80 trainers) trained to train FWV in clinical family planning and MCH care.

f. Slow start up due to prolonged negotiation with GOB. 18 trainers from first batch completed and posted and 18 trainers are currently completing their training.

g. NGO Technical Assistance, Research and Training

g. Not mentioned in project Paper.

g. Commencing September 1983, a PSC has been hired to develop a MIS for USAID-funded

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APPENDIX F
THE BANGLADESHI CONTEXT

Appendix F

THE BANGLADESHI CONTEXT

Bangladesh is one of the poorest countries of the world. In an area similar to the state of Wisconsin (55,000 square miles) live 100 million people. The population density (1,800 per square mile) is exceeded only by the city-states of Hong Kong and Singapore. The old section of Dhaka is the most densely populated area of the world--200,000 people/square mile.

Most of Bangladesh is a flat, wet, alluvial plain formed by three major rivers (the Ganges, the Brahmaputra and the Meghna), which mingle in a maze of waterways that ultimately empties into the Bay of Bengal. The land is fertile and intensively cultivated for rice, jute and wheat. Natural resources are limited to some low-quality coal and moderately large reserves of natural gas.

The monsoons from June to October provide rain for the crops but also put large parts of the land under water, intensifying problems of ground travel, which even in the dry season is difficult. There are about 5,000 miles of perennial and an additional 2,000 miles seasonal waterways, and approximately 6,000 miles of road. During the dry season an auto drive of less than 250 miles (Dhaka to Khulna) takes about eight hours and involves two major ferry crossings.

Bangladesh has one of the largest Muslim populations in the world. Ethnically, 98 percent of the people are Bengali and speak Bangla, the common language.

The current doubling time of 24.6 years, if unchanged, would result in a population of 200 million by the year 2010. Under the standard projection used by the World Bank, the population would reach nearly 360 million by the year 2050.

Following the bloody struggle for liberation (1971), Bangladesh has sought to constitute itself as a democratically ruled country. Its first leader and liberation hero, Sheikh Mujib, was killed in 1975. In 1982, his successor, President Ziaur Rahman, was also assassinated. Currently ruling under a relaxed form of martial law is General Hussain Muhammed Ershad.

Administratively, the country is divided into four divisions (Dhaka, Khulna, Rajshahi, and Chittagong) which are subdivided into 64 districts. These in turn are divided into a total of 464 upazilas (equivalent to US counties with populations of 100,000-250,000) which are subdivided into 4,500 unions, approximately 13,500 wards, and then into 68,000 villages.

As part of a move to decentralize government one year ago, upazila chairmen were elected to head Upazila Parishads (committees). At the national level more than 20 political parties are engaged in forming various coalitions to exert the power that the splintered factions need to obtain a significant constituency. As this is being written, it has been stated by General Ershad that parliamentary elections are planned and that martial law will be dismantled.

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APPENDIX G
CONTRIBUTION OF SPECIFIC PROJECT COMPONENTS

Appendix G

CONTRIBUTION OF SPECIFIC PROJECT COMPONENTS

Between mid-1981 and year-end 1985, the CPR (modern methods) rose approximately 8 percentage points according to the CPS--from 10.9 to 18.7 based on the conventional sample of married women in reproductive ages (see Table 2). Although the CPS can provide some insights into the relative importance of the three separate project components (GOB, SMP, and NGOs) in this rise, it does not permit a precise attribution of the contribution of each component. The USAID mission, however, produces estimates of "active users" for each component based on service statistics reported by the MIS unit of the Population Directorate. These data are provided in a format that permits determination of the contribution of each component to changes in overall prevalence.

Table 6 summarizes the USAID-calculated "active user" rates for each of the major Project components for the years 1981-1985. According to these results, estimated prevalence of program methods rose from 12.2 percent of eligible couples in 1981 to 23.4 percent in 1985 or by a total of 11.2 percentage points. GOB prevalence increased by 6.1 percentage points (8.6-14.7) during this period, NGO prevalence by 4.4 percentage points (1.4-5.8) and SMP prevalence by 0.7 percentage points (2.2-2.9). Thus, of the total 11.2 percent increase, the GOB can be credited for 54 percent; NGOs for 39 percent and the SMP for 6 percent. This would suggest a very impressive role NGOs particularly considering how small their total operation is compared to the GOB's, and only a very modest SMP role. It is difficult to judge how much credence should be given the results, however, once careful consideration is given to how the "active user" rates are determined.

In assessing the validity of the active user results, it is instructive to compare the CPR derived from service statistics with CPR determined by the CPS. The two sets of data are not necessarily consistent with each other (see Table 5). There are two reasons for this. The first is that the CPS includes prevalence from non-SMP commercial sales (mainly for oral pills) which are not included in the MIS service statistics. In Table 5, therefore, the contribution of the non-SMP commercial sector has been deducted from the CPS rate. According to the 1983 CPS final report, about 40 percent of the 3.3 percent prevalence of pill use is due to non-SMP commercially purchased pills (see page 213 of CPS report). Thus the comparable CPS working rate of 16.2 has been reduced by 1.3 percentage points (.40 x 3.3) yielding a rate of 14.9 percent. This is somewhat below the active user prevalence rate of 16.7 percent.

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Second, a number of assumptions are necessary to convert data on service statistics to active users before they can be expressed in terms of prevalence. The validity of these assumptions must be taken into account in assessing the amount of confidence that can be placed in the accuracy of the judgment of the relative contribution of each project component to the increase in prevalence between 1981 and 1985.

Specifically, the contribution of the SMP may have been understated. Condoms are the major method provided by SMP--64 percent of its active users use condoms (compared to 7 percent for the NGOs and 4 percent for the GOB). The "condom gap"--the term used to describe the phenomenon that the number of condoms distributed far exceeds the numbers that would be needed for those who appear to be using condoms according to CPS results--makes it extremely difficult to determine with confidence the number of active users of condoms.

Converting data on service statistics into active user prevalence or couple years of protection (CYP) requires using CYP assumptions as to the number of condoms needed per couple to provide one CYP. When USAID used the standard conversion factor to determine active user prevalence for condoms, increasingly unrealistically high rates were implied, at least when judged against the low and virtually constant prevalence levels reported from survey results.

USAID decided therefore to assume that condom prevalence remained constant between 1981-1985 at 2.7 percent of eligible couples, as reported by the CPS working rate. This assumption required that a different conversion factor be used for each year (see Table 6).

By keeping overall condom prevalence constant, however, USAID has ensured that none of the increase in numbers of condoms distributed by SMP translates into increased prevalence being attributed to SMP, and therefore, SMP does not appear to a major contributor to any rise in overall active user prevalence. Unfortunately it is difficult to judge the extent to which the assumption of constant condom prevalence is justified and hence to know whether the SMP contribution is understated in the active user results.

On the other hand, the contribution of the NGO to the rise in active user prevalence may be overstated. Pill distribution is far more important for NGOs than is condom distribution; 28 percent of their active users are pill users (compared to 16 percent of the active users credited to GOB using pills and 31 percent for SMP). Furthermore, NGO distribution of pills has increased sharply in recent years. As with condoms, when these distribution figures are translated into active user prevalence,

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the prevalence is far above what the CPS found--3.8 percent compared with 2.0 percent (see Table 5). In contrast to the figures for condoms, however, there has been no attempt to deal with the "pill gap" when converting distribution figures into active users. Again, the question remains as to the relative trustworthiness of the two sets of figures and therefore as to the real level of the contribution of the NGOs.

The 1983 CPS provides other data that are relevant to assessing the contribution of the Project components. Current users of both oral pills and condoms were asked to show the packages to the interviewer in order to determine the brand or if that failed, to identify the brand of pill or condom from samples displayed by the interviewer. Since both SMP and the GOB have distinct brands (NGOs use GOB supplies), it is possible to verify physically the source of pill or condom supply. Results based on the conventional sample of eligible women as well as the special couple and husband samples are shown in Table F. There are some differences in reporting according to the type of sample. Most likely, reports by women are more accurate for pills and reports by men are more accurate for condoms. An interesting sidelight is that a high proportion use private brands and thus presumably pay a market price for their supply. (GOB brands are given out free and SMP brands are sold at subsidized prices.) It is also clear that SMP is the major supplier of condoms, providing over 70 percent according to responses from male respondents. Thus whatever the level or trend in condom use may be, SMP is responsible for most of it.

Also of interest are data collected on the source of supply of contraceptive methods. These suggests that the NGOs may be less important than the active user statistics imply. The CPS results for 1983 on the source of supply of non-clinical methods (pill, condom, foam) are reproduced in Table G. They show very low percentages of respondents indicating an NGO source. It should be noted that despite a number of steps taken in the CPS to ensure proper identification of type of field workers, there may have been some NGO workers identified as GOB workers, especially in the urban sample spots (see CPS 1983 Final Report, pp. 201 and 235). Nevertheless, even if all home delivery of non-clinical methods in urban areas attributed to GOB workers were actually provided by NGO fieldworkers, they would still account for only 17 percent of non-clinical methods. According to the active user statistics, in 1983 NGOs supplied 16 percent of non-clinical methods nationally (rural and urban combined). Considering that NGOs operated primarily in urban areas at the time of the 1983 CPS, their share in terms of supplying urban users should be far in excess of 16 percent. Hence the CPS results are inconsistent with the active users statistics and suggest a lesser contribution of NGOs. While it might be tempting to assume that the dramatic increase in

prevalence between 1983 and 1985 indicated for urban areas by the preliminary CPS results (see Table 2) was attributable to NGO activity (since they still operate mainly in urban areas), this would be a premature judgment. Before conclusions are drawn, the new CPS data in conjunction with information from other sources need to be analyzed in some detail. In particular, careful attention should be given to the 1985 CPS results on reported source of method in urban areas. Presumably the increased NGO activity since 1983 should be reflected in an increased share of reported sources in the new CPS data.

USAID collects monthly service statistics from all NGO subprojects receiving FPSP support. An explicit set of instructions has been issued on how to determine active users. Together with information provided about the number of eligible couples in the area being served by the subproject, these data are used to calculate the CPR for the subproject target populations. Many of these subproject CPRs are impressive. A rough tally of the latest CPRs reported for close to 100 of the subprojects indicates that almost 30 percent report CPRs of 50 percent or above and only about a third reported CPRs of 50 percent or above and only about a third report CPRs under 30 percent. This would imply impressive performance, if correct. Unfortunately, there is little systematic evidence for assessing the accuracy of the rates for the group of subprojects as a whole.

For a number of subprojects the reported CPR based on active users fluctuates substantially over the duration of the project. In some cases this may be due to expansion or redefinition of the project area to be covered but this is unlikely to explain all the erratic results. Discussions with one NGO director indicated that there had been a problem in the past in accurately communicating USAID's definition of an active user to the field-level worker although he believed that presently the reporting system was better understood and implemented. One critical problem mentioned in discussions about validity of the active user CPR reported for NGO subprojects was that of defining accurately the number of eligible couples to use as the denominator for calculating the rates.

Although no systematic attempt has been made to assess the impact of NGOs, USAID is making progress in improving and standardizing collection of data on active users. Mini-CPSs have been carried out for at least nine subprojects. In some cases these were done because the director of the cooperating agency was suspicious of the very high CPRs that were being reported. The results, however, are often far different from the CPR based on service statistics (see Table H).

The major conclusion to be drawn from this comparison

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is that there is considerable uncertainty in the accuracy of prevalence rates derived from the NGO subprojects' service statistics. While the overall impression that many NGO subprojects have made impressive contributions to increasing contraceptive use in their areas may be valid, it is not easy to identify which specific ones genuinely have achieved an unusually high CPR.

Conclusions

Results from the national CPS provide adequate information for judging the extent to which the Project is meeting its goal defined in terms of increased CPRs. The CPS data also provide some information on the contribution of each major Project component, although a precise assessment of the separate contributions of each is not possible from CPS data. Service statistics collected by MIS and analyzed by USAID provide estimates of the separate contribution of each component, but their validity for this purpose can be called into question because of their heavy dependence on assumptions. Moreover, evidence from the CPS about the performance of the difference components is often inconsistent.

There is an impression by many observers that the NGOs are performing very well and are contributing to relatively high levels of contraceptive prevalence in the areas they serve. So far no systematic attempts has been made to assess their impact. USAID is making progress in improving and standardizing collection of data on active users. Some mini-CPSs done in several subproject areas suggest that prevalence rates based on active user statistics can over- or understate prevalence by a large margin.

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APPENDIX H
FEMALE SECONDARY EDUCATION PROJECT

Appendix H

FEMALE SECONDARY EDUCATION PROJECT

1. Questionable Conclusions in the Martin et al. Report

The assessment of the demographic impact and cost effectiveness of the Female Secondary Education project presented in the report by Martin et al. is potentially misleading and may seriously underestimate the cost of lowering fertility through the project. The basic problem is that before the demographic effectiveness of the project can be assessed, the educational impact needs to be established and this had yet to be adequately done at the time of the evaluation.

There are two ways in which the project would have an educational impact: (1) by permitting students who would otherwise terminate their education at the primary level to enter secondary school; (2) by permitting already enrolled students who would otherwise drop out to continue. The way the project operated was to provide scholarships to all girls enrolled in the participating secondary schools, regardless of the likelihood that they would attend without receiving a scholarship. Thus, an unknown, but potentially large, proportion of scholarship recipients would have started or continued secondary education in the absence of the project. The crucial task in assessing the educational impact is to estimate how much of an increase in the number of girls starting secondary school and how much a decrease in the number who drop out occurred that can be attributed to the scholarship program.

According to the Martin report, the fertility impact of starting secondary school (as opposed to stopping at elementary school) is far greater than of finishing once entered. In other words, preventing a girl from dropping out is relatively trivial in terms of her future fertility, while permitting a girl to start secondary school has a much larger impact. This is important to note because the Martin report does provide some information on the extent to which the drop-out rate was improved by the scholarship program, but provides no adequate assessment of the impact on the number of girls who entered secondary school as a result of the program.

The Martin report potentially seriously overstates the demographic impact of the scholarship project by attributing to the project the reduced future fertility of all scholarship recipients rather than only that of those recipients who would either have not started or would have dropped out had scholarships not been available. As a result, the number of

births averted due to the project is overestimated, possibly by a very large extent. Moreover, the estimated cost of each birth averted is underestimated, perhaps quite considerably, since when the cost of the project is divided by a smaller number of births averted, the cost per birth averted will rise.

In justifying their assessments, the Martin team note that the cost per acceptor in family planning programs typically ignores the fact that some "substitution" takes place, i.e., that some acceptors would have used contraception even in the absence of the program. Therefore, they argue, the fact that some scholarship recipients would have gone to school anyway can likewise be ignored. The extent of substitution, however, is probably very different between the two situations. In the case of the secondary school projects, the schools were already operating before the project began and hence already had an established clientele, unlike family programs which typically start in the absence of equivalent services. Thus the potential substitution effect is far greater in the case of the secondary school project.

2. Suggestions for Collection of Data on Educational Impact

Minimum information that should be collected for BACE and SGS schools in AID Scholarship Program to evaluate educational impact of current program follows:

Let y = Year scholarship program begins. Then, collect data for each year $y-3, y-2, y-1, y, y+1, y+2$ up to the present for each school in program.

(1) Total number of students by sex (number of boy students, number of girl students) enrolled in each class (6, 7, 8, 9, 10) during the school year:

Students enrolled during school year

| Class | Year y-3 | | Year y-2 | | Year y-1 | | Year y | | Year y+1 | | Year y+2 etc. | |
|-------|-------------|-------|-------------|-------|-------------|-------|-----------|-------|-------------|-------|------------------|-------|
| | Boys | Girls | Boys | Girls | Boys | Girls | Boys | Girls | Boys | Girls | Boys | Girls |
| VI | | | | | | | | | | | | |
| VII | | | | | | | | | | | | |
| VIII | | | | | | | | | | | | |
| IX | | | | | | | | | | | | |

X

(2) Collect the number of dropouts for same years for each school

Number of dropouts

| | Year | | | |
|-------|------|-------|------|-------|------|-------|------|-------|------|-------|----------|-------|
| | y-3 | | y-2 | | y-1 | | y | | y+1 | | y+2 etc. | |
| Class | Boys | Girls | Boys | Girls |

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VII

VIII

IX

X

(3) Collect data on (a) average attendance and (b) number of students achieving different grades according to the same format (i.e., by sex and class) for the same year.

(4) Also collect for each year from y-3 until present:

- Number of teachers by sex
- Number of classrooms
- Number of Aysas
- Existence of tubewell

Comments: The information under (1) and (2) will permit estimation of the impact of the program on (1) enrollment trends for boys and girls (2) dropout rates for boys and girls. By establishing the trend for years y-3 to y-1 and extrapolating it, the extrapolated trend for years y thru the most recent years can be compared to the actual trend and the difference would indicate the impact of the scholarship program. By having the data for both sexes, we can see if increased girl enrollment affected enrollment for boys.

Note: This is the minimum information needed and should be collected as soon as possible. It should not require a major effort to get this information, which presumably is available in the school records. More elaborate data involving other variables and primary school enrollment trends, possibly involving a control area, might also be collected. Collection of

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these data would probably entail considerably more effort and cost, and should be given careful consideration by the Mission before moving ahead.

APPENDIX I

EVIDENCE OF RELIGIOUS OBJECTIONS AS BARRIER
TO CONTRACEPTIVE USE

Appendix I

EVIDENCE OF RELIGIOUS OBJECTIONS AS BARRIER
TO CONTRACEPTIVE USE

There is substantial evidence from a variety of research findings that religious objections are an important barrier to contraceptive use among significant subgroups of the Bangladeshi population. There is also some suggestions that objections are stronger against permanent methods than against others.

Focus group research conducted by PIACT, Bangladesh for example, found that religious objections (see Table J1-4) were clearly the dominant reason for not accepting contraception. As shown in these tables, religion was cited as the main obstacle to contraceptive use by males and females from both poor and middle class interviewees.

Another qualitative study, prepared for the SMP by MCRB Ltd., yielded similar findings. With specific reference to religion, the authors stated "This was the most widely mentioned reason for not adopting family planning among all segments of the population".

These findings are further supported by data analyzed from the 1983 CPS as shown in Tables J5 and J6. Table J5 shows that among non-users who do not intend to use family planning, nearly 50 percent say that it is for religious reasons. A comparison of Muslim and Hindu respondents shows marked differences in current contraceptive use, with the exception of those with more than a primary school education. The differences are particularly notable for permanent methods, with use levels for Hindus which are almost twice that for Muslims (see Table J6).

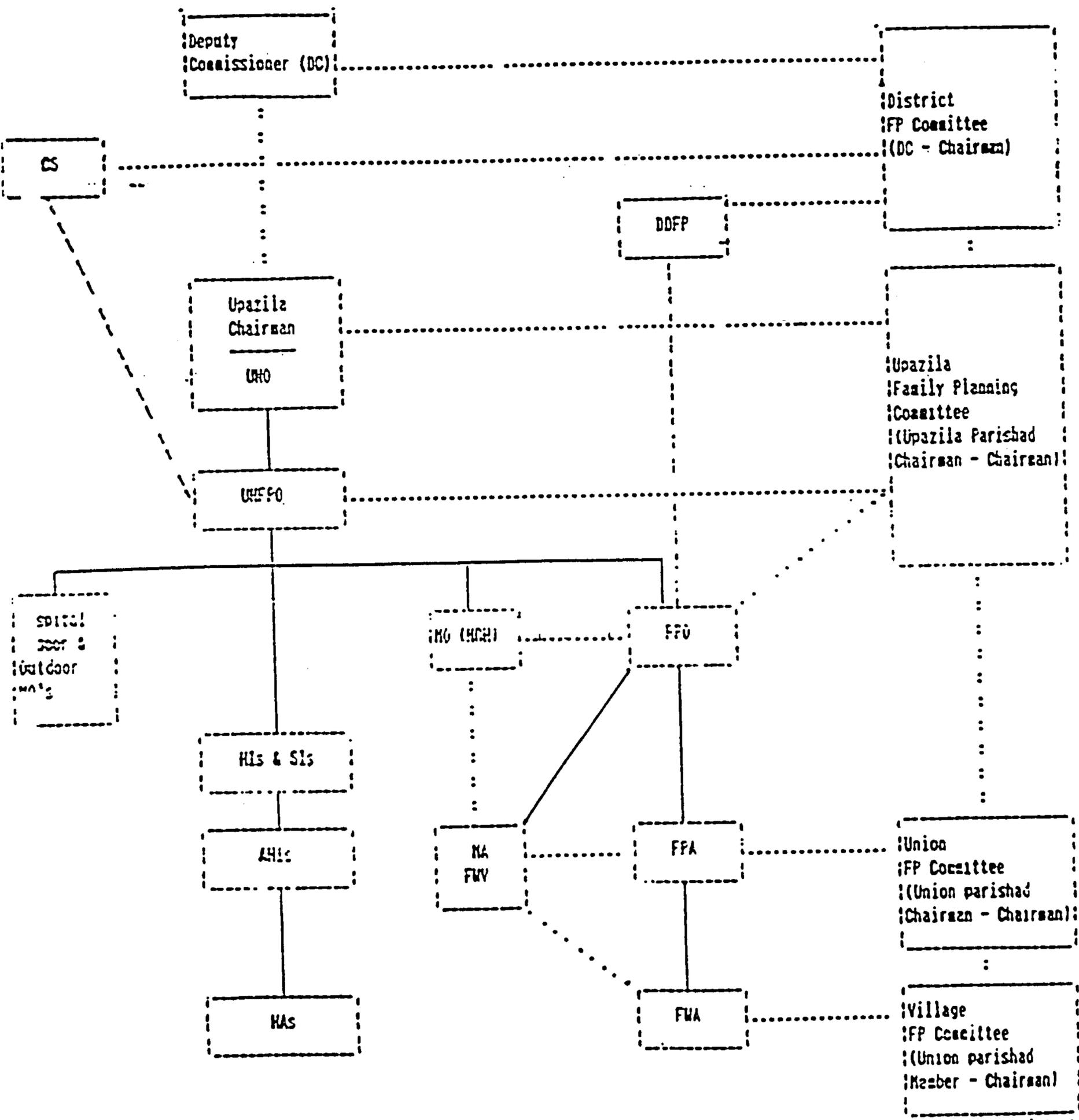
In sum, while there has often been a tendency to play down the importance of religion as a barrier to family planning in Bangladesh, these data suggest that this may not be the case. Moreover, the data also show a marked preference among Muslim users for temporary methods. This issue deserves further study and perhaps some special programmatic initiatives to address these concerns.

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APPENDIX J

FLOW CHART OF HEALTH AND FAMILY PLANNING AT
DISTRICT AND UPAZILA LEVEL

Flow Chart of Health and Family Planning Program
At District and Upazila Level



- Line of Command
- - Line of Coordination & Support with some commands
- - - Line of Coordination & Support
- C.S. - Civil Surgeon
- DDFP - Deputy Director, Family Planning
- UHO - Upazila Nirbahi Officer
- UHFPO - Upazila Health & Family Planning Officer
- MO - Medical Officer
- FPO - Family Planning Officer
- FWV - Family Welfare Visitor
- HI - Health Inspector
- AHI - Assistant Health Inspector
- HA - Health Assistant
- MA - Medical Assistant
- FPA - Family Planning Assistant
- FWA - Family Welfare Assistant

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