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**MIDTERM EVALUATION OF THE  
BANGLADESH FAMILY PLANNING  
AND HEALTH SERVICES DELIVERY  
PROJECT  
(388-0071)**

by

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## Glossary

AGR	annual growth rate
A.I.D.	United States Agency for International Development
AVSC	Association for Voluntary Surgical Contraception
BAVS	Bangladesh Association for Voluntary Sterilization
BDG	Government of Bangladesh
BFRP	Bangladesh Fertility Research Program
BFS	Bangladesh Fertility Survey
CA	Cooperating Agency
CBD	community-based distribution
CBR	crude birth rate
CBS	Community-Based Sales (program)
CCC	Cambridge Consulting Corporation
CIDA	Canadian International Development Agency
CMR	child mortality rate
CPR	contraceptive prevalence rate
CPS	Contraceptive Prevalence Survey
CYP	couple year of protection
DFP	Directorate of Family Planning (MOHFW)
DHS	Demographic and Health Surveys
EEC	European Economic Community
ELCO	eligible couple
EPI	Expanded Program on Immunization
FHI	Family Health International
FPAB	Family Planning Association of Bangladesh
FPCVO	Family Planning Council of Voluntary Organizations
FPHSP	Family Planning and Health Services Project
FPIA	Family Planning International Assistance
FPLM	Family Planning Logistics Management (project)
FPMD	Family Planning Management Development (project)
FPSTC	Family Planning Services and Training Center
FWA	family welfare assistant
FY	fiscal year
GTZ	Association for Technical Cooperation (Germany)
ICDDR,B	International Center for Diarrheal Disease Research, Bangladesh
IEC	information, education, and communication
IEM	Information, Education, and Motivation Unit (MOHFW)
IMR	infant mortality rate
IUD	intrauterine device
JHU/PCS	Johns Hopkins University/Population Communications Services (project)
JSI	John Snow, Inc.
LEB	life expectancy at birth
LMIS	Logistics Management Information System
MCH	maternal and child health
MIS	management information system
MILGRD	Ministry of Local Government, Rural Development and Cooperatives
MMR	maternal mortality rate

<b>MOHFW</b>	<b>Ministry of Health and Family Welfare</b>
<b>NGO</b>	<b>non-governmental organization</b>
<b>NORAD</b>	<b>Norwegian Agency for Development Cooperation</b>
<b>NIPORT</b>	<b>National Institute for Population Research and Training</b>
<b>Norplant®</b>	<b>a method of contraception which releases the synthetic hormone levonorgestrel through capsules inserted beneath the skin of the upper arm</b>
<b>NPI</b>	<b>National Physical Inventory</b>
<b>ODA</b>	<b>Overseas Development Administration (British)</b>
<b>OPH</b>	<b>Office of Population and Health (USAID)</b>
<b>OR</b>	<b>operations research</b>
<b>ORS</b>	<b>oral rehydration salts</b>
<b>ORT</b>	<b>oral rehydration therapy</b>
<b>PIL</b>	<b>project implementation letter</b>
<b>PSI</b>	<b>Population Services International</b>
<b>REACH</b>	<b>Resources for Child Health Project (project)</b>
<b>SMC</b>	<b>Social Marketing Company</b>
<b>SMP</b>	<b>Social Marketing Project</b>
<b>TAF</b>	<b>The Asia Foundation</b>
<b>TFR</b>	<b>total fertility rate</b>
<b>TFYP</b>	<b>Third Five Year Plan</b>
<b>Tk.</b>	<b>Taka</b>
<b>UNFPA</b>	<b>United Nations Population Fund</b>
<b>UNICEF</b>	<b>United Nations Children's Fund</b>
<b>USAID</b>	<b>United States Agency for International Development (mission)</b>
<b>VS</b>	<b>voluntary sterilization</b>
<b>WHO</b>	<b>World Health Organization</b>

# Executive Summary

## 1. Background

The Government of Bangladesh views reduction in the rate of population growth as its highest development priority and remains committed to achieving this objective through a public and private sector family planning and maternal and child health (MCH) program. The United States Agency for International Development (USAID) has been providing assistance for family planning in Bangladesh for most of the past 20 years. Although the first and once the largest donor in the field of population assistance in Bangladesh, USAID is now beginning to phase down some of its assistance and is being replaced by other donors. Nonetheless, USAID's history of sustained project support and strong, flexible technical assistance has been unmatched by any donor.

The shape of the program has remained fairly consistent over the past 20 years. Support activities have consisted primarily of provision of contraceptive commodities, technical assistance in nearly all technical fields, and research associated with fertility and service delivery. Assistance has been channeled through the Government of Bangladesh (BDG) national program implemented by the Ministry of Health and Family Welfare (MOHFW) and two private sector activities — non-governmental organizations (NGO) and the Social Marketing Project (SMP). USAID remains essentially the sole donor supporting private sector activities. Family planning service delivery has received precedence over all other interventions.

## 2. The Family Planning and Health Services Project: Goals and Strategy

The goals of the five-year, \$176 million Family Planning and Health Services Project (FPHSP), which is receiving a mid-term evaluation in this report, are to assist Bangladesh efforts to reduce fertility and the rate of population growth and to reduce current high levels of infant, child and maternal morbidity and mortality associated with closely spaced and other high risk births, immunizable childhood diseases and dehydration due to diarrhea. The project purpose is to improve the coverage and quality of family planning and MCH services in Bangladesh. The project's goal and purpose are almost perfectly congruent with the intent of the Third Five Year Plan (TFYP, 1985-1990).

Between 1986 and 1989, measurable progress was made toward achieving the family planning and MCH goals of the project and the BDG. The total fertility rate (TFR) fell from 5.6 to 5, the infant mortality rate (IMR) from 128 to 120, and the child mortality rate from 24 to 19. If the TFR continues its downward trend and is validated in the 1991 Contraceptive Prevalence Survey, the TFR target of 4.8 will very likely be reached in 1991. Similarly, if the IMR is sustained, the FPHSP target of 125 has already been reached.

Three of the four project strategies are being successfully implemented. USAID's support of family planning service delivery has helped increase the contraceptive prevalence rate (CPR) from 21.7 percent in 1983 to 32.8 percent in 1989. Likewise, a full range of contraceptives is available, with increasing numbers of women choosing oral contraceptives and female voluntary sterilization (together, these accounted for 55 percent of the 1989 CPR). Progress is also being made

toward decentralization of services, most notably in a project not evaluated in this report (the *Upazila* Family Planning Initiatives Project), but also through non-governmental organizations' recent ruralization of their efforts and the *Upazila* Communication Project, which attempts to address the relatively low level of media penetration in the rural areas. The strategy for improving quality of care cannot be assessed because activities for improvement have been minimally implemented.

### 3. Project Components

The project has five functional components: technical assistance to the three major channels of family planning service delivery in Bangladesh: the government program, the Social Marketing Company (SMC), and the NGOs, and two types of supporting assistance that goes to all three service delivery channels: commodities and related technical assistance in logistics and research. Slightly under half of the total funding is obligated for technical assistance and slightly over half is expected to go toward commodities and research. Together, these five elements comprise a comprehensive and integrated approach to solving one of Bangladesh's major developmental, economic, and social problems.

**Total Project Obligations, Arranged Functionally**

Function	Planned Obligations (millions)	Percent
BDG	\$ 31.23	18
NGO	\$ 44.85	25
SMC	\$ 19.47	11
Commodities/Logistics	\$ 64.92	37
Research	<u>\$ 15.53</u>	<u>9</u>
<b>Total</b>	<b>\$176.00</b>	<b>100</b>

It is possible to identify USAID's contribution to the overall successes of the Bangladesh family planning effort since USAID provides sole donor support for several activities in the program. With regard to the three service delivery channels, it has been the only supporter for nearly all NGO service delivery and for the Social Marketing Project. In this project, other donors have shared support for the government program. Three USAID-supported BDG activities are evaluated in this report: provision of all technical assistance in information, education, and communication (IEC) to the Information, Education, and Motivation (IEM) Unit of the MOHFW, support to the urban component of the national Expanded Program on Immunization (EPI), and some participant training (not including the *Upazila* Family Planning Initiatives Project, which was given a positive evaluation earlier). With respect to the supporting activities, USAID's role in commodity support has been very important: it has provided all the condoms and IUDs distributed through the government and NGO programs and all condoms and orals for the SMC. (Other donors provide oral contraceptives and injectables for the BDG and NGOs.) USAID also provides most technical assistance in commodities and logistics and has also supported most family planning research activities.

## 4. Achievements

### 4.1 USAID Contribution to Prevalence

USAID's contribution to the NGOs and the SMP has been of major importance in the overall picture of contraceptive prevalence in Bangladesh. Together, the NGOs and the SMC account for over 40 percent of Bangladesh contraceptors. The NGO sector, in particular, has made gains over the past decade, increasing its contribution to the national CYP from 11 percent in 1981 to 24 percent in 1988. The SMP, although its share of national prevalence is lower, having varied between 13 and 18 percent during the 1980s, accounted for an estimated 60 percent of the national family planning program's condom protection in 1989 and 20 percent of oral contraceptive protection. Moreover, the access and perceived access represented by the huge volume of SMC contraceptives moving through the program's extended distribution network contributes substantially to effective and continuing use by providing an emergency backup source to government and NGO sources when their supplies are disrupted. In addition, the SMC pricing and merchandising of family planning commodities has made them affordable to a segment of the general population which might intentionally avoid using BDG outlets and which might have no easy access to NGO services.

**Active Users/Couple Years of Protection  
Attributable to Provider  
1981 - 1985\* and 1986 - 1988\*\***

Percent of Users/CYPs by Provider				
Year	BDG	SMC	NGOs	Total
1981	71	18	11	100
1982	70	17	13	100
1983	65	16	19	100
1984	65	14	22	100
1985	65	13	25	100
1986	65	14	21	100
1987	65	14	22	100
1988	58	18	24	100

\* USAID Mission, Dhaka, Bangladesh.

\*\* Program Review Team, February 1990.

Commodity support has been an essential component of the U.S. contribution to contraceptive prevalence, and, for the BDG, the most valued aspect of USAID assistance. This phase of project support is now declining rapidly, however: A.I.D. assistance for BDG and NGO condoms ended in 1989 (the World Bank is taking over) and the plan is for A.I.D. also to phase out its support for SMC condoms in the near future.

## **4.2 Other USAID Contributions**

### **4.2.1 NGOs**

Through the NGO component, USAID provides support to six Cooperating Agencies (CA) which work with indigenous NGOs to carry out programs which collectively include community-based distribution projects in both urban and rural areas, high quality clinical service programs, training, institutional development, research, IEC, and logistics support. The BDG depends on NGO efforts, having assigned the NGOs responsibility for certain urban and rural areas of service delivery (and included their performance in the countrywide MIS). It supplies them with contraceptive commodities and utilizes their unique resources at both local and national levels of the program.

In addition to the contributions to prevalence through their 119 subprojects in 320 sites, the NGOs have provided a unique resource to the BDG program. Their approach to family planning is dynamic; they address sensitive issues, work with underserved populations, and in the process have developed a comparative advantage when it comes to introducing new ideas and innovations into other parts of the Bangladesh family planning program. This facet of their work is appreciated by the government, which has helped introduce NGO-originated improvements into its own program. Among the innovations adopted by the government are the decrease of the worker to client ratio to 1 to 750; the adoption of the NGO-developed Field Guide, which is now being used by fieldworkers in motivating and counseling clients; a record book and improved work plans and record-keeping mechanisms for fieldworkers; and the introduction of contraceptive prevalence rate calculation by field personnel. In addition, NGOs collaborate with the BDG to provide training to various cadres of BDG personnel and assist with its efforts to decentralize the program by facilitating conferences and workshops at the district, *upazila*, and union levels.

Another important contribution is that NGOs are moving towards technical sustainability, i.e., they are taking steps that will leave the technical know-how and technical benefits of the family planning intervention in community hands after NGO withdrawal. Specific steps in this direction include strengthening indigenous, community-based NGOs through training and technical assistance to enable them to implement family planning and development programs more effectively; promoting community contributions (donation of land and/or office space) and mobilizing local level resources in support of the NGO's family planning program (businesses, influential citizens, opinion leaders, and volunteers); and establishing mutually beneficial linkages with the national family planning program.

### **4.2.2 SMC**

In addition to its direct contributions to prevalence, the SMC is also contributing to maternal and child health, as its oral rehydration therapy product in 1987 was used in 20 percent of the cases treated by oral rehydration solution (ORS). Of greater significance, the SMC is increasing its technical or institutional sustainability — its ability to operate with little or no technical support. It has developed human resources, using its own staff, rather than external staff, to increase activities, product lines and services. Its large distribution effort means that there is now in place a large cohort of trained distributors and distribution specialists. At the same time, USAID has allowed for the development of private sector research capability and has fostered a network of individuals who have had experience in developing a communications strategy, designing campaigns, targeting messages, and evaluating audience response. Now, there are several research firms in operation, competitive

procurement has become the normal procedure for making project awards, and all the firms are doing work for organizations other than A.I.D. If A.I.D. were to withdraw assistance from Bangladesh tomorrow, there would be some failures, but the more established research firms would continue to operate. Finally, now that the SMC has become a private indigenous organization, other donors may be more willing to provide support for its operations. The government and NGOs could learn much from the SMC's success in gaining technical sustainability.

#### **4.2.3 Research**

The research activities supported by USAID include three very successful efforts. Since 1979, Contraceptive Prevalence Surveys have provided an incomparable history of program achievements. The International Center for Diarrheal Disease Research, Bangladesh (ICDDR,B) has identified many issues of relevance to population policy in Bangladesh and can be credited with several important changes in the government's service delivery approach. The Bangladesh Fertility Research Program (BFRP), part of Family Health International's network of national contraceptive research institutions, does quality work in reproductive health research and in testing standard and new contraceptives. The pattern of using private sector research firms established by the SMC has held true for these research efforts as well, with similar felicitous results.

#### **4.2.4 Technical Assistance to the Government Program**

- **Assistance to IEC**

More effective IEC continues to be needed, and USAID's technical assistance in IEC has helped in the production of a wide variety of good quality materials. The *Upazila* Communication Project should help develop local information networks and indigenous media that could support the service delivery systems of the NGOs, the BDG, and perhaps the SMC.

- **Municipal Immunization**

USAID provides support for the urban component of the UNICEF-supported, rurally based EPI. This assistance has filled a gap in an impressive BDG national effort, contributing to the solution of a national MCH problem of great importance. In addition, it has provided training for program-related personnel which would otherwise quite likely not have taken place, provided targeted commodity support of an appropriate and useful nature, and has been very well received by UNICEF and the BDG.

- **Training**

Training activities (other than the *Upazila* Family Planning Initiatives Project) represent a minor effort under the project (involving to date only 54 individuals, selected on an *ad hoc* basis mostly from the private sector, for short-term training).

#### **4.2.5 Logistics Support**

USAID's technical assistance, most recently (since 1988) provided through the Family Planning Logistics Management (FPLM) project, is designed to assist procurement activities and monitor distribution of A.I.D.-supplied commodities. It also aims to improve the logistics distribution

system of the government, the NGOs and the SMC. Among specific activities, some 2,850 MOHFW staff members have been trained, with resulting improved job performance and better compliance with reporting instructions; and a logistics management information system (LMIS) has been designed and implemented, to help monitoring and procurement.

## **5. Issues**

### **5.1 Institution Building**

Both USAID and the larger donor community agree on the difficult nature of implementing development programs with the BDG. It may be unprecedented to find that a country that has accorded fertility regulation top governmental priority and then has failed repeatedly to remove obstacles that impede implementation. The recent history of the USAID's efforts is studded with examples of bureaucratic impediments to project activities. The IEM Unit has many unfilled slots, no counterpart relationships have been developed with USAID technical assistance, and little interest has been shown by Unit staff in producing materials. Significant numbers of persons who have been given training in family planning have been transferred to other BDG ministries or agencies with no family planning agenda. Likewise, although many trained family planning staff are nearing retirement, the BDG has not addressed manpower needs, developed a long-term training plan, or accorded a high priority to external training. Long and inexplicably difficult negotiations marked the creation of the private sector SMC. Attempts to have the National Institute for Population Research and Training (NIPORT) take responsibility for logistics training were even more complicated, marred by the unexplained refusal to use trainers of trainers for agreed-upon purposes and not providing replacements, failure to provide training space and time at NIPORT, and cancellation of agreed upon training courses. Acquiring BDG agreement for the PIL to extend the FPLM cooperative agreement required crisis intervention and retroactive funding. Critical BDG posts have remained unfilled for excessive periods in the logistics system. There has been a chronic inability to keep in-country contraceptive pipelines filled and inability to establish a family planning management information system useful for rational and timely logistics management decision making.

The implication of these repeated instances may be that A.I.D.'s standard strategy of targeting resources toward government institution building should be accorded a lower priority in the Bangladesh context. The government has demonstrated limited absorptive capacity in its infrastructure and has demonstrated limited ability to develop the institutional capability required for the smooth functioning of necessary systems.

### **5.2 Sustainability**

Given the heavily donor subsidized nature of the BDG and the very low potential for a significant or dramatic economic turnaround in the Bangladesh economy, it is unrealistic to hope that any social development, the family planning program or any specific service delivery component thereof, can sustain itself financially independent of donor support within the next two decades. Some project elements lend themselves more readily to varying degrees of cost recovery than others, e.g., the SMC and some fee-generating activities of the NGOs. For example, the SMC may be able to increase its recovery of total costs (commodities plus operating costs), as mandated, from 10 to 20 percent, but only if it continues to receive subsidized branded condoms. If the SMC is to continue to operate as a social marketing project, it will continue to require a subsidy in the form of branded commodities for at least the next five years and likely for the rest of the century. For the NGOs,

also, self-sustainability is an unrealistic expectation within the next several decades. Furthermore, any efforts to pursue sustainability in these organizations must be made cautiously, since overly zealous pursuit of cost recovery might do injury to the much more important objective of providing family planning services and reaching institutional sustainability.

### 5.3 USAID Role

In addition to the constraints inherent in the BDG environment, USAID is facing internal changes that may make it more difficult for it to operate during the coming decade.

The first consideration is that the assistance that is most valued by the BDG, commodities, is being significantly reduced within USAID's portfolio. USAID demands a higher standard of accountability than is required by other donors, but with diminishing USAID resources may come loss of advisory leverage, with the further result that USAID's strong technical expertise and sound family planning experience may become less influential. The final result may be a reduction in the effectiveness of Bangladesh's population program.

USAID is a major but no longer the largest donor; other donor inputs for family planning and MCH are substantial and increasing. Moreover, funding levels for the follow-on project will most likely be lower than present levels. The degree of donor coordination and cooperation is unusually good, and USAID has established and maintains excellent working relationships with the entire donor community. The World Bank and European Economic Community (EEC) have already shown willingness to take over A.I.D.'s commodity role, other donors may be interested in assuming more responsibility for support of the IEM Unit, and additional ways may be found to shift the burden of support from USAID to other donors without injuring the Bangladesh program.

The prospect of reduced influence faces USAID at a time that the management load for the mission continues to be extremely burdensome. The wide-ranging scope of the Office of Population and Health's portfolio would present a management challenge in the best of circumstances. The complications of dealing with the Bangladesh bureaucracy mean that circumstances in Bangladesh are far from the best. In addition, USAID/Bangladesh has been unduly isolated from the technical and policy developments of the globally oriented, centrally funded contracts. The reason has been that the size of the bilateral program has made A.I.D./Washington reluctant to become involved in any centrally funded activities in Bangladesh other than through buy-ins. The result, however, is a lack of flow of information that could be of help to the Bangladesh program.

The repeated difficulties that the BDG program has experienced in absorbing USAID assistance in recent years, coupled with the expectation that USAID may have less leverage in future, suggests that USAID should reexamine its level of involvement in BDG institution-building activities. Likewise, considerations of management burdens for the mission should affect the emphasis of future programming efforts.

One final overriding consideration should also guide planning for future activities: The government-sponsored family planning program, even with its deficiencies, has established itself as an institution with strong support from the central authority in a traditional Islamic society. It has enjoyed generous donor support, but as an institution is highly vulnerable to political, religious, economic and traditionalist attacks. A large degree of its strength has stemmed from its being perceived as a provider of desirable social services. The donor community should cooperate to

nurture and strengthen this perception and not too vigorously insist that a government institution pursue a course of action that will result in its risking serious setbacks to its family planning activities.

## **6. Recommendations**

Two issues demand immediate attention, both related to supplies and logistics. The first is that there remains a lack of a three-month pipeline of contraceptives beyond the Division level in spite of adequate amounts having been supplied by donors. The second issue is the lack of a guarantee of sufficient, subsidized branded condoms for the SMC beyond 1992, when USAID plans no longer to provide them.

The three recommendations below should help address the problems.

1. **USAID should organize and participate in an intensive, coordinated collaboration of donors and the BDG to insist that the MOHFW use all its available government- and donor-provided resources to implement its own policies of maintaining a three-month contraceptive commodity pipeline at all Division and below supply points, including those of the NGOs.**
2. **USAID immediately should bring pressure to bear to the extent necessary to assure that the Central Warehouse provides and maintains the required stock levels for a three-month pipeline for the NGOs.**
3. **USAID should continue to negotiate with the EEC and other donors to ensure a plan for continued provision of subsidized, branded condoms to the SMC beyond 1992. If these negotiations do not bear fruit, USAID should make contingency plans to provide them beyond 1992.**

The following list contains the recommendations of principal importance to USAID. A listing of all the recommendations made in the report is provided in Chapter 8.

### **6.1 BDG**

#### **IEC**

1. **USAID should continue support of IEC activities throughout this and successive projects.**
2. **USAID and JHU/PCS immediately should explore and implement mechanisms for expanding IEC technical assistance to CAs and contractors supported by USAID, and to other interested non-governmental entities.**
3. **USAID involvement with IEM headquarters activities should be limited to coordination, with discrete technical assistance that responds only to direct requests and that concentrates on policy formulation and planning. JHU/PCS or future CAs should maintain strong liaison with the IEM Unit and provide it with high level technical assistance on matters of strategy and policy.**
4. **The *Upazila* Communication Project should be continued.**

5. Because of continued non-supervision by government and failure to demonstrate programmatic impact, USAID should no longer support the National Folk Singing Project.

#### **Urban Immunization**

1. USAID should review project documentation and its contract with the Cambridge Consulting Company (CCC) and consider revising them to be more explicit in quantitative terms and to provide time lines for specific components.
2. The workplan of the contractor should be presented in a format to be agreed upon by USAID and approved preceding the period that it is to cover.
3. Until urban EPI coverage reaches or exceeds the level of the national program and is BDG-sustainable with minimal UNICEF or other donor assistance, USAID assistance to this segment of the national program should continue, presuming the continuation of sufficient USAID funding and management staff.

#### **Training**

1. USAID should continue its current low-intensity participant training activity instead of a developing a more costly and labor-intensive program until an information needs assessment has been conducted, a BDG training plan developed to respond to identified need, and until the BDG has accorded higher priority for external training needs.
2. The mainstay of USAID's Office of Population and Health (OPH) training for government personnel should remain the *Upazila* Family Planning Initiatives Project.
3. USAID should not participate in the British Overseas Development Administration (ODA)-coordinated development of a project designed to improve MOHFW manpower planning capability unless a needs assessment is included as part of the undertaking.

### **6.2 NGO Component**

1. In efforts to strengthen clinical activities and quality assurance, USAID and the CAs should broaden the focus of these initiatives beyond clinical staff to include field staff. Future planning and implementation of this project should stress the linkages between the clinical and paramedical cadres of family planning workers and the fieldworkers.
2. USAID should encourage CAs and NGOs to integrate EPI and ORT into ongoing programs.
3. USAID and the CAs should maintain only realistic and modest expectations of gains in achieving financial sustainability. In considering possible cost-recovery schemes, NGOs should favor interventions that are related to and support their programming and organizational objectives; that are low maintenance and require minimal levels of management; and that are not directly competitive with private enterprise. Feasibility

studies and sound business plans should be required prerequisites to implementation and regular monitoring and evaluation will be necessary from the outset to ensure the success of the program.

4. USAID should support technical assistance from international organizations to assist the CAs to expand and strengthen their knowledge and resource bases with reference to the principles of sustainability and cost recovery in general and specifically in the Bangladesh context.
5. USAID and the CAs should promote the process of developing community ownership of NGO programs and objectives and linkages at the local government level in order to achieve technical sustainability.

**6.3 Social Marketing Company Component** (The principal recommendation for this component is found at the start of Section 6.)

1. USAID should encourage a gradual SMC market shift from condoms to more effective, less costly methods such as orals.
2. USAID should encourage cooperation in research development between all USAID-supported organizations, including the SMC, in order to achieve the maximum use from the outputs of each group's efforts.
3. The SMC should focus research efforts on new, not existing, products and attempt to coordinate with other research efforts to obtain data on current products and baseline uses.
4. USAID and the SMC should obtain market research technical assistance to allow for development of an overall research strategy and plan for product research.

**6.4 Commodities and Logistics Component** (The two principal recommendations for this activity are found at the start of Section 6.)

1. The recent MOHFW decision to eliminate the logistics monitor positions that were being sponsored by UNFPA and CIDA should be addressed by USAID and other donors whose commodity supplies are disrupted by the loss of these positions. The donors should insist that the positions be maintained and new positions added so that from four to six monitors would be stationed at each Division and would report to the top family planning officials in each Division. The purpose should be to ensure that a reliable monitoring system is operating effectively.
2. USAID/FPLM should increase logistics technical assistance to all CAs and serve as the official liaison between the NGOs and the Central Warehouse. Technical assistance to CAs should include areas such as standardization of the Family Planning Association of Bangladesh (FPAB) logistics system with that of MOHFW, facilitating flow of information to the MIS and LMIS, warehousing, and participation in ongoing logistics management training activities.

3. If the scheduled review of the MIS and the LMIS indicates the desirability of continuing the LMIS, BDG/FPLM should develop and implement a plan to institutionalize the LMIS within the BDG. BDG managers and decision-makers should be required to receive training in data analysis, report interpretation, planning and evaluation through the FPLM project.
4. The current practice of the Chittagong Regional Warehouse of dividing each shipment of contraceptive commodities received into five equal allotments should be replaced by a method in which allocations to each Division and to the NGOs correspond to the calculated projections of need.
5. USAID should consider seriously whether it or some other source should provide obviously necessary assistance in logistics management, but should be assured the BDG receives (and uses) it from some source.

## **6.5 Research Component**

### **Contraceptive Prevalence Surveys**

1. Because of their importance as an integral part of the program planning process, CPSs, regardless of the form, should be continued.
2. USAID should continue to work towards moving the CPS to NIPORT, while maintaining other options and contingency plans.
3. DHS should be encouraged to provide technical support to the next round of the CPS regardless of whether it is a full-scale CPS or an abbreviated one. DHS should be asked to provide technical assistance in the areas of sampling, questionnaire format, interviewer training, data processing, analysis and report presentation.
4. USAID should coordinate closely with the German Association for Technical Cooperation (GTZ) with regard to technical assistance needs and should informally assist in strengthening NIPORT's research capability by offering it access to the demographic and research technical skills within the mission and within the various projects.
5. USAID should provide for more secondary analysis of CPS data.
6. USAID should work with the BDG to develop a policy to archive the CPS data and to service would-be users. If the BDG is not responsive, the International Statistical Institute's survey archive or the DHS project should be considered.

### **ICDDR,B Extension**

1. In developing the follow-on to the project, USAID should put emphasis on maintaining the strong research capability of the Extension Project and expanding the utilization of research findings.

2. The Office of Population should provide funding support from central resources for family planning operations research (OR) for some parts of the Extension Project and use the project's findings as part of its dissemination of lessons learned.

### **BFRP**

1. FHI and USAID should continue core or non-earmarked project support to allow BFRP to respond to the family planning research needs of Bangladesh, respond immediately to changing research needs, and develop programs or activities in advance of project funding.
2. USAID should consider providing resident technical assistance for BFRP in research methodology (two years), management systems (six months), and program development (six months).
3. USAID should encourage BFRP to continue its focus on family planning clinical research. FHI may wish to increase documentation on research protocols and recognize that BFRP is not yet a technically "graduated" institution, and donors must recognize that there are limits in both technical and managerial areas and must act accordingly in their dealings with BFRP.
4. USAID should encourage BFRP to prepare a long-term staff development plan and make every attempt to encourage staff participation in training and professional activities that will increase its skills, including practicums, participation in consulting teams, internships, etc.

## **6.6 Follow-On Project**

1. USAID should reexamine, and reduce, its degree of involvement with BDG institution building.
2. USAID should continue cost-recovery efforts, but recognize that financial self-sustainability of the family planning program is an unrealistic expectation for at least the next two decades.
3. Technical support should be sustained or increased to continue the process of achieving technical or institutional sustainability of the private sector.
4. Given probable future funding constraints and fixed or reduced personnel levels, future project design should support non-governmental activities in preference to governmental institution building, family planning over non-population MCH activities, preserving family planning service delivery activities over supporting activities, maintaining well-established activities in preference to newer activities, and reducing the number of subprojects and activities rather than attempting to maintain the current number under conditions of management overload.
5. A.I.D. should fund increased participation of centrally funded projects. The activities should supplement, not tax, mission technical and management resources.

# Bangladesh Population and Health Indicators

(Data for 1989 unless otherwise stated)

<b>Total Population</b>	110,000,000 <sup>1</sup>	<b>Average Age of Female at Marriage</b>	18 yrs.
<b>Number of Eligible Couples</b>	20,400,000 <sup>1</sup>	<b>EPI Coverage</b>	
<b>Total Fertility Rate</b>	4.9 <sup>2</sup>	<b>(Complete series of DPT/Polio)</b>	30% <sup>3</sup>
<b>Infant Mortality Rate (est.)</b>	120/1,000 <sup>3</sup>	<b>ORT Treatment Rate (1987)</b>	23.2% - Urban <sup>5</sup>
<b>Under Five Mortality Rate (est.)</b>	188/1,000 <sup>3</sup>		25.0% - Rural <sup>5</sup>
<b>Maternal Mortality Rate (est.)</b>	6/1,000 <sup>3</sup>	<b>Mean Duration of Breastfeeding</b>	28.6 months <sup>1</sup>

## Contraceptive Prevalence Rate<sup>1</sup> by Method

	<u>Percent</u>	<u>No. Users</u>
Oral Pill	9.1	1,860,000
Tubectomy	9.0	1,840,000
Condom	3.1	630,000
IUD	1.7	350,000
Vasectomy	1.6	330,000
Injection	1.1	220,000
<u>Vaginal Foam</u>	<u>0.2</u>	<u>40,000</u>
All Modern Methods	25.8	5,270,000
Safe Period	3.8	800,000
Withdrawal	1.2	240,000
Abstinence	0.5	80,000
<u>Other</u>	<u>1.5</u>	<u>310,000</u>
All Traditional Methods	7.0	6,430,000
All Methods	32.8	6,700,000

## Historical Trends in CPR and TFR

<u>Year</u>	<u>CPR</u>	<u>TFR (est.)</u>
1975	7.7%	7.0
1979	12.7%	--
1981	18.6%	--
1983	21.7%	--
1986	25.3%	--
1989	32.8%	4.9

## Source of Supply for Current Users of Non-Clinical Methods (Pills, Condoms, Vaginal Foam)

Commercial outlets	40%
Doctors/clinics	13%
Field workers	42%
Other/don't know	5%

<sup>1</sup>1989 Contraceptive Prevalence Survey and 1989 Bangladesh Fertility Survey

<sup>2</sup>1989 Bangladesh Fertility Survey

<sup>3</sup>UNICEF

<sup>4</sup>1987 Diarrheal Morbidity and Treatment Survey

# 1. Project Description

## 1.1 Background on Project

### 1.1.1 Historic Overview

The United States Agency for International Development (USAID) has been providing assistance for family planning activities in Bangladesh for most of the approximately 20 years since the country's independence. The shape of the program has remained fairly consistent over these years. Support activities have consisted primarily of provision of contraceptive commodities, technical assistance in nearly all technical fields, and research associated with fertility and service delivery. Assistance has been channeled through the Government of Bangladesh (BDG) national program and two private sector activities — non-governmental organizations (NGO) and the Social Marketing Project (SMP). USAID remains essentially the sole donor supporting private sector activities. Family planning service delivery has received precedence over all other interventions.

The program has been marked by exemplary attention to documentation, needs assessment, and evaluation. The current program design and activities reflect not only long experience but also a commitment by the USAID mission to put that experience to work.

A.I.D.'s assistance has been of longer duration and in greater amounts than that of any other bilateral or multilateral donor. Recently, however, the decision has been made to phase down the level of USAID's support and other donors are beginning to take its place in some areas.

### 1.1.2 Project Goals and Strategy

#### Goals

The goals of the Family Planning and Health Services Project (FPHSP), which is receiving a mid-term evaluation in this report (see Appendix A), are to assist Bangladesh efforts to reduce fertility and the rate of population growth, and to reduce current high levels of infant, child and maternal morbidity and mortality associated with closely spaced and other high risk births, immunizable childhood diseases and dehydration due to diarrhea. The project purpose is to improve the coverage and quality of family planning and maternal and child health (MCH) services in Bangladesh.

The project's goal and purpose are almost perfectly congruent with the intent of the Third Five Year Plan (TFYP, 1985-1990). The goals of the TFYP were included in the project paper, with the comment that, although the BDG targets were optimistic, the emphases on family planning, oral rehydration therapy (ORT), an Expanded Program on Immunization (EPI), and safe birth practices were sound (see Table 2 below for targets).

Also, as affirmed in the project paper, the Government of Bangladesh continues to view reduction in the rate of population growth as its highest development priority and remains committed to achieving this objective through a public and private sector family planning and MCH program.

## **Strategy**

The essential elements of the project strategy as listed in the project paper were

- supporting both public and private sector family planning and MCH services;
- enhancing the range of contraceptive choice to make a full range of contraceptive methods readily available;
- improving the quality of care to affect the initial adoption and continued use of family planning services; and
- decentralizing service delivery by encouraging *upazila* level involvement in provision of family planning and MCH services.<sup>1</sup>

In short, the primary project strategy is one of promoting greater coverage and continued use of family planning and MCH services utilizing public and private sector mechanisms to improve service delivery.

The project has deliberately chosen a family planning service delivery strategy over other strategies such as improving literacy, increasing family income, improving nutritional status and other non-family planning MCH measures, etc. The rationale is that, given the resources available and existing demand for fertility control by couples, this is the most rapid and direct route to alleviating the constraints to economic and social development stemming from unregulated fertility. Relatively modest and discrete MCH project interventions (EPI and ORT) are included, but are complementary to the major family planning service delivery thrust, which is considered to be the most important child survival intervention.<sup>2</sup>

The strategy is applied through a "three-pronged approach" focused primarily on the three channels of service delivery. Activities within these three channels that will be reviewed in this evaluation are as follows:<sup>3</sup>

### **Component 1: Support for the Ministry of Health and Family Welfare (MOHFW)**

- Information, Education, and Communication (IEC) Services
- Urban Immunization Program<sup>4</sup>
- Training

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<sup>1</sup>The *upazila* is a geographic and political entity; there are 9-10 *upazilas* in each of 64 districts.

<sup>2</sup>The mission process of strategy selection is discussed more fully in the Country Development Strategy Statement (CDSS).

<sup>3</sup>The project paper contained a fourth component: Support for MCH Activities. This contained three activities: ORT Social Marketing, which is discussed in Chapter 3; the Municipal Immunization Program, discussed in Chapter 2; and Innovative MCH activities, of which the training portion is covered within the training section in Chapter 2. Appendix B provides a complete listing of project components as they appeared in the project paper.

<sup>4</sup>As noted in footnote 3, this was included under the fourth project component — Support for MCH Activities — in the project paper.

## **Component 2: Support for Social Marketing**

- Social Marketing Project (Company)

## **Component 3: NGO Family Planning Activities**

- Family Planning Association of Bangladesh (FPAB)
- Bangladesh Association For Voluntary Sterilization (BAVS)
- Family Planning Service and Training Center (FPSTC)
- Family Planning International Assistance (FPIA)
- The Pathfinder Fund
- The Asia Foundation (TAF)

Each channel contributes significantly to contraceptive prevalence, so each merits consideration for support. In 1988, the government was providing 58 percent of the total couple years of protection (CYP); the Social Marketing Project, 18 percent, and the NGO family planning activities, 24 percent (see Table 8 in Chapter 4).

The portfolio mix provides technical assistance to the three major channels listed above. It also contains technical assistance and support for contraceptive commodities and logistics and for research that were included in the project paper under components of the BDG program but that benefit all three service delivery channels (see Chapters 5 and 6). Accordingly, these will be treated as components and be evaluated as well. The full spectrum of activities reflects a comprehensive and integrated approach to solving one of Bangladesh's major developmental, economic, and social problems.

### **1.1.4 Project Funding**

Life-of-project funding totals \$176 million. This can be broken down approximately as follows: contraceptives, approximately one-third (33.8 percent); BDG, nearly another third (29.4 percent); NGOs, about one quarter (25.7 percent); and SMP, just over one-tenth (11.1 percent). Omitting the contraceptive component (which supports all three service delivery channels), the remaining \$116 million obligations to the channels themselves breaks down as follows: 44 percent to the BDG program, 39 percent to the NGOs, and 17 percent to Social Marketing Company (SMC). Table 1 shows current status by component, planned and actual obligations. A more detailed breakdown of the status of obligations by component and sub-component appears as Appendix C.

Project funding can also be broken down functionally to reflect obligations to the three delivery channels and the two supporting activities — commodities and research. As seen in Table 2, the totals differ from those in Table 1. Whereas commodities continue to receive the largest proportion (still in the one-third range), the next highest recipient becomes the NGO effort (again about one-quarter). The BDG, which receives most of the research and a good proportion of the commodity allocations, drops to third place, receiving just under one-fifth of the total obligations, and the SMC portion drops to just over one-tenth.

Table 1

**Planned and Actual FY 1987-1992 Project Obligations  
(in millions)**

Component	Obligated to Date	Total Planned	Percent Obligated to Date
1. BDG	\$ 44.560	\$ 51.720	29.4
2. SMC	\$ 16.076	\$ 19.470	11.1
3. NGOs	\$ 33.300	\$ 45.280	25.7
4. Contraceptives	<u>\$ 50.204</u>	<u>\$ 59.530</u>	<u>33.8</u>
Total	\$144.140	\$176.000	100.0

Table 2

**Total Project Obligations, Arranged Functionally**

Function	Planned Obligations (millions)	Percent
BDG	\$ 31.23	18
NGO	\$ 44.85	25
SMC	\$ 19.47	11
Commodities/Logistics	\$ 64.92	37
Research	<u>\$ 15.53</u>	<u>9</u>
Total	\$176.00	100

## 1.2 Progress toward Goal Achievement

### 1.2.1 Indicators of Progress

The indicators selected in the project paper as measures of goal achievement were total fertility rate (TFR), infant mortality rate (IMR), child mortality rate (CMR), crude birth rate (CBR), crude death rate (CDR), annual growth rate (AGR), and life expectancy at birth (LEB). Of these indicators, the most useful and measurable for monitoring trends in fertility and mortality are the TFR, IMR and (less accurately) the CMR.<sup>5</sup> All three are widely used.

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<sup>5</sup>TFR, IMR, and CMR can be calculated through the use of two well-designed and ably conducted surveys -- the Bangladesh Contraceptive Prevalence Survey (CPS) and the Bangladesh Fertility Survey (BFS), both of which yield relatively precise numerator and denominator information. Both, in addition, enjoy demographic and international acceptability and a degree of validation for internal consistency by computer models based on data from developing countries (see Chapter 6 for additional information on surveys). The other indicators, CBD, CDR, AGR and LEB, are less useful as indicators as they are difficult to measure with any accuracy. Because both numerator and denominator data required for CBR and CDR are highly suspect in Bangladesh, the margin of error for indirect estimation of these from survey data is high. Furthermore, because both rates are dependent on the age structure of the population (which the project cannot influence), they are of little use as indicators of either rate. The AGR is derived from the previous two approximations, correcting for net migration

Achievement of the demographic goals would be realized, according to the TFYP, through the family planning efforts that would increase overall national contraceptive prevalence to 40 percent (from 29.8 percent in 1985) by the year 1990. Achievement of the health goals would involve the EPI, ORT, and Safe Birth Practices. The program objectives established were 90 percent of the infant and child population provided with ORT services; basic immunization (for diphtheria, pertussis, tetanus, measles, tuberculosis and polio) to 80 percent or more of all children; 65 percent of the population covered with primary health care services; and 50 percent of expectant mothers provided with ante-natal examinations and delivery by a trained birth attendant. The TFYP goals for 1990 and for the FPHSP targets for 1992, together with achievements for these indicators as of 1989, are set forth in Table 3.

Table 3

Indicators of Progress toward Achievement of BDG and FPHSP Goals

	1986	1989	BDG Goals by 1990	FPHSP Goals by 1992
TFR	5.6	5.0 (CPS) 4.9 (BFS)		4.8
CBR	38.9	35.5 <sup>3</sup>	31.0 <sup>1</sup>	
CDR	14.6	13.5 <sup>3</sup>	13.0 <sup>1</sup>	
AGR	2.4		1.8 <sup>1</sup>	2.2
IMR	128.0	120.0 (CPS est.) 120.0 (BFS est.)	100.0 <sup>2</sup>	125.0
CMR	24.0	19.0 (BFS)	12.0 <sup>2</sup>	21.0
MMR	6.0		4.0 <sup>2</sup>	4.0
LEB	52.0		54.0 <sup>2</sup>	53.0

CPS = Bangladesh Contraceptive Prevalence Survey, 1989.

BFS = Bangladesh Fertility Survey, 1989.

<sup>1</sup>In TFYP, for 1990.

<sup>2</sup>In "National Strategy for a Comprehensive MCH Programme," developed by the BDG MCH Task Force and accepted by the Ministry of Health and Family Welfare (MOHFW) in 1985.

<sup>3</sup>The English translation of the Fourth Five Year Plan presented 1989 values for these indicators but sources could not be determined.

Note: The FPHSP indicators for the measures of goal achievement and end-of-project status were the same as the goals and health targets of the TFYP, but the magnitude of the indicators for the FPHSP were scaled back to the level that was considered more realistically achievable. When the project was amended to extend project activities through FY 1992, neither the indicators nor the magnitudes were changed.

For the year 1989, the Contraceptive Prevalence Survey (CPS) and the BFS, using differing sampling techniques covering approximately the same time period, arrived at nearly identical

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(considered to be very low in Bangladesh), and therefore also has little immediate use as an indicator. The values for CBR, CDR and AGR for 1986 appear to have been official BDG estimates, which in turn likely were derived from projections from the 1981 census. The project paper is not clear on this point, nor on derivation of the figure for maternal mortality. The latter is notoriously difficult to estimate accurately even in countries with more dependable death registration systems and sophisticated methods of attributing death. LEB is calculated from life table models which are highly insensitive to variables in populations. The life table used for LEB calculation for 1986 is from a model for South Asia and not specific for Bangladesh.

estimates of TFR and IMR — 5 and 4.9 respectively for TFR and 120 for IMR.<sup>6</sup> If the TFR continues the downward trend and is validated in the 1991 CPS, the TFR target of 4.8 will very likely be reached in 1991. Similarly, if the IMR is sustained, the FPHSP target of 125 has already been reached.

### 1.2.2 Success of Strategy

The strategies selected for achieving the project purposes are appropriate, comprehensive, and valid for achieving accomplishments to date.

The success of strategies for increasing coverage through the public and private sectors by family planning service delivery is attested to by increases in coverage data between the 1986 and 1989 CPS as shown below in Table 4.

**Table 4**  
**Contraceptive Prevalence Rates by Method**  
**1986 and 1989**

Contraceptive Prevalence Rate	1986	1989
<b>Modern Methods (total)</b>	<b>22.9</b>	<b>25.8</b>
Oral Pill	5.1	9.1
Condom	4.0	3.1
Vaginal Method	0.2	0.2
Injectables	0.5	1.1
IUD	1.4	1.7
Tubectomy	7.9	9.0
Vasectomy	3.8	1.6
<b>Traditional Methods (total)</b>	<b>6.9</b>	<b>7.0</b>
Safe Period	3.8	3.8
Withdrawal	0.9	1.2
Abstinence	0.5	0.5
Others	1.7	1.5
<b>All Methods</b>	<b>29.8</b>	<b>32.8</b>

Source: 1989 CPS.

Likewise, the strategy to enhance the range of contraceptive choice by making a full range of contraceptive measures readily available is succeeding. Table 4 shows increases particularly in the use of the oral pill and female sterilization. There were also declines: a fall in the use of condoms and of vasectomies.

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<sup>6</sup>The BFS was unclear as to whether the CMR was calculated for children 0-5 or 1-5 years of age. If calculated by the method used in the 1986 CPS, it would appear that the target has been achieved.

The strategy of improving quality of care, particularly in use of clinical methods, is not possible to evaluate as planned efforts have yet to be implemented.<sup>7</sup>

Decentralization to the *upazila* level is being implemented primarily through the *Upazila* Family Planning Initiatives Project, a project that was recently given a favorable evaluation (see Section 4.1.3). Project NGO and SMC components are also fully supporting this announced BDG policy.

### 1.3 Other Donors

With current obligations of US \$176 million, USAID is the largest single bilateral donor to the Bangladesh family planning effort. Particularly significant, USAID is the only donor for a considerable portion of the overall program: for nearly all NGO service delivery, the Social Marketing Project, provision of condoms and intrauterine devices (IUD) for the government and NGO program, all condoms and orals to SMC, provision of Norplant® (for clinical trials), the Municipal Immunization Project, most research activities, most technical assistance in commodities and logistics, and all IEC technical assistance. In view of diminished USAID funding availability, a move to increase other donor involvement in all these areas is under way.

Current donor inputs for family planning and MCH are in the following areas:

- The World Bank, with \$250 million allocated over a five-year period for construction, salary provision for female field workers, equipment and monitoring funds for the sterilization program, transportation and transportation costs, operating costs of the Management Development Unit, and salaries and operating costs for the National Institute for Population Research and Training (NIPORT). The NIPORT support was provided through the German Association for Technical Cooperation (GTZ).
- United Nations Population Fund (UNFPA), with \$20 million for the TFYP for injectables (all), salaries and operating costs of the Information, Education and Motivation (IEM) Unit, medications and equipment for voluntary sterilization (VS) and technical assistance in logistics and statistics.
- Federal Republic of Germany (FRG), with a five-year commitment of 50 million DM (about \$25 million) for the government training program for all levels of family planning staff. This funding, through GTZ, has provided salary support and operating costs associated with the entire training program of family welfare visitors (FWV), family welfare assistants (FWA) and family planning assistants (FPA), all front-line government service providers. In addition, another German entity, the Credit Institution for Reconstruction (KfW) has provided approximately half of the oral contraceptives for the government and NGO programs.

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<sup>7</sup>These are efforts to be carried out primarily through Cooperating Agencies' NGO projects and annual IUD monitoring evaluations. A proposed subproject intervention to improve counseling and monitoring capabilities in satellite clinics has not yet been implemented.

- Canadian International Development Agency (CIDA) has provided about \$20 million for government and NGO oral contraceptives, supported the ICDDR,B (International Center for Diarrheal Disease Research, Bangladesh) Demographic Surveillance System through 1989, and has provided other limited support to ICDDR,B Matlab MCH-family planning and MCH-family planning Extension Projects.
- United Nations Children's Fund (UNICEF), with approximately \$60 million for nearly all equipment, salaries and operating costs of the EPI, funds for upgrading local production of oral rehydration salts and major support for the National Diarrheal Disease Program, and traditional birth attendant (TBA) training.

The degree of donor coordination and cooperation is unusually good, particularly when the scope and scale of total assistance is considered, and the FPHSP project is non-duplicative of other efforts. USAID has established and maintains excellent working relationships with the entire donor community, not only according to USAID, but to all donor agencies interviewed. Differences in agendas and areas of desired emphasis are inevitable, but they are addressed frankly and settled.

#### **1.4 Conclusion**

The FPSHP project was extremely well designed and enviable in the degree of match with host government plans and objectives. It is contributing strongly to the national program, and is very well coordinated with and non-duplicative of the activities of other donors.

The four strategies selected for achieving the project purpose were appropriate, comprehensive, and valid and at least three appear to be meeting with success.

The portfolio mix, which provides major technical assistance to all major channels of family planning service delivery and vital supporting assistance via commodities/logistics and research, reflects a comprehensive and integrated approach.

## 2. Ministry of Health and Family Welfare

### 2.1 Overview

The government-sponsored family planning program has established itself as an institution with strong support from the central authority in a traditional Islamic society, a large degree of which has stemmed from its being perceived as a provider of desirable social services. As an institution, however, the program is highly vulnerable to political, religious, economic, and traditionalist attacks.

Within this complex setting, USAID is providing support to a variety of Ministry of Health and Family Welfare (MOHFW) activities. The most prized of these are the centrally procured commodities (plus nearly \$5.4 million in related technical assistance) supplied to the MOHFW program through the commodity and logistics component of the project. Like research, this is a cross-cutting activity that supports the BDG, NGO, and SMC components.

In addition to support for commodities/logistics and research, USAID has obligated an estimated total of \$31.53 million in support of seven discrete BDG activities. Three, representing about one-third of the total planned obligations, are discussed in this section. These are

- **Information, Education and Communication Services (\$3.51 million)**

In 1988, USAID executed a buy-in with Johns Hopkins University/Population Communication Services (JHU/PCS) for technical assistance, support of some activities of the MOHFW Information, Education and Motivation (IEM) Unit, and a *Upazila* Communication Project.

- **Municipal Immunization Project (\$6.5 million)<sup>8</sup>**

With a 1988 buy-in to the central Resources for Child Health (REACH) project followed by a 1990 contract with the Cambridge Consulting Group, USAID has supported a national urban immunization program targeted at women and children that supplements the rural program supported by UNICEF. Support includes technical assistance and training, production of IEC materials and programs, and funding of some municipal staff and of vehicles and computers. UNICEF is responsible for vaccines and the cold chain.

- **Training (estimated \$.3 million)**

The only training discussed below concerns the 54 trainees who have been supported directly by the BDG component of this project, two-thirds for less than 30 days.

The four other BDG activities supported by USAID were excluded from the scope of work for this evaluation. They include

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<sup>8</sup>In the project paper, this is categorized as one of three activities under the Support for MCH Activities component (see Appendix B).

- **Upazila Family Planning Initiatives Project (\$3.57 million)**

This received a separate evaluation recently and is therefore excluded from this evaluation.

- **Support for Fieldworker Mobility/Clinical and Community-Based Family Planning Services (\$10.15 million)**

This activity, initially intended to enhance quality of clinical services through the provision of transport, has been revised to support satellite clinics throughout the country. The revised activity is still undergoing internal mission and BDG review.

- **National Family Planning Headquarters (\$5.0 million)**

This is intended to consolidate the widely separated headquarters of the national program. There have been no expenditures for this activity, primarily because of BDG failure to meet conditions precedent. Depending on the current level of USAID and BDG interest and commitment, this might better be funded by another donor.

- **Innovative MCH Activities (\$2.5 million)<sup>9</sup>**

Small amounts of training have been provided with this funding, but the MOHFW has requested no assistance for innovative MCH activities.

## **2.2 Information, Education, and Communication Services**

### **2.2.1 IEM Unit**

The IEM Unit was established within the MOHFW in 1977 as a coordination and production unit. Its work is supplemented by three other government efforts: the population program cells of national radio and television provides significant programming time, and the Health Directorate's Health Education Bureau and the EPI program each has IEC activities. The two other project components (NGO and SMC) each also carries out IEC activities. The Unit has had little success to date in coordinating the efforts of these various groups.

Since its inception, the Unit has depended heavily upon a variety of donor inputs for support, including GTZ through the mid-eighties, primarily for salary support, UNFPA continually from 1981 until the present providing staff salary support, and USAID since 1988. Donor support, however, has been uneven, resulting in breaks in continuity, unsustainable initiatives and donor-related changes in emphasis. Although government support of the Unit gradually has increased, only 35 out of the 94 filled (and 139 slotted) positions at the Unit's headquarters are government funded, the rest being funded by donors, particularly UNFPA.

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<sup>9</sup>In the project paper, this was included under the Support for MCH Activities component.

## 2.2.2 Need for IEC Activities

Although many research studies have shown that there is an extremely high level of awareness of contraception in Bangladesh, there is also a huge gap between that awareness and acceptance and/or continuation of contraception. Two-thirds of eligible couples still are not using any method of family planning, and at least one study indicated that knowledge of choice-enabling multiple methods is thin. Additionally, interpersonal communication and motivational skills are weak throughout the delivery system, particularly at the periphery where they are most needed. On the plus side, there is no organized religious opposition to family planning in the country and the growing body of satisfied users represents a ground swell of potential support for the program.

In addition to its role as a coordinating body, the IEM Unit was expected to produce IEC materials. Although the Unit began operations in 1979, nearly 10 years later, very little communication expertise has been introduced either into the Unit or at the field level, and the materials that are being produced are ineffective — tedious and non-targeted.<sup>10</sup>

In 1988, given the need for efforts to increase demand for family planning, the government asked USAID to increase the modest assistance efforts that were then under way under the previous USAID umbrella population project (Project No. 388-0050 - Project Implementation Letter [PIL] #102). The new initiative would capitalize on existing strengths (also identified in the JHU/PCS needs assessment — see footnote 10 below) — an established IEM unit, a large health and population rural field infrastructure, and NGO capabilities for increased involvement in IEC activities.

## 2.2.3 USAID Assistance

Current USAID assistance to the BDG in IEC began in April 1988 (PIL #15). The five-year assistance effort included initial inputs of \$3,510,000 directed into three project components: technical assistance, support of some activities of the MOHFW IEM Unit, and a Communication Test subproject (subsequently renamed the *Upazila* Communication Project). The effort is being implemented through a buy-in with the Johns Hopkins University/Population Communication Services (JHU/PCS) project.

Efforts were to take place at three levels: in the unit, by improving delivery of integrated family planning/MCH messages; at the field level, by better management and training of

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<sup>10</sup>According to a needs assessment undertaken by JHU/PCS, principal problems were as follows:

- There was no long-term IEC plan or strategy;
- Communication messages were literacy dependent and didactic;
- Target populations were not segmented and audiences not carefully studied;
- Program and field IEC activities were routine and tedious;
- Communication flows were top down and one way;
- Family planning/MCH messages were not integrated;
- An acute shortage of effective IEC materials existed;
- Modern communication technology was not being used;
- Well-trained communication staff and fieldworkers were insufficient;
- Well-designed communication skills training programs and curriculum materials were lacking;
- Interagency and intersectoral collaboration was weak; and,
- Useful IEC research and evaluation was virtually non-existent.

field workers and by stimulating community participation; and among other agencies, by improving interagency communication.<sup>11</sup>

The three components were to be carried out as follows:

1) A 13-person technical assistance team established an office and in conjunction with IEM staff, drew up a work plan that laid the basis of subsequent activities. With skills in management, audience segmentation, message targeting, audiovisual technology, IEC training, and field research, team members are providing technical assistance in materials development, interpersonal communications, IEC program management and coordination, training of personnel, and field trials and evaluations to the IEM Unit, its contractors, and to other agencies (EPI, NGOs, USAID) with which it has a working relationship. As appropriate, local and international consultants have been utilized to provide assistance to a number of specific activities.

2) Efforts to improve operations of the IEM Unit were described in a 12-month workplan, approved by the IEM Unit and USAID in April 1990, which listed IEC outputs for which the technical assistance team would provide assistance (see Appendix D for details). Work on some of these materials had begun prior to the project and others were new.

3) The objective of the *Upazila* Communication Project is to develop and field test a package of practical and effective communication interventions to strengthen and extend the service delivery systems at the *upazila* level and below. This is an applied research endeavor which will develop and test how IEC interventions in one *upazila* affect contraceptive use by local populations. Interventions would include improving interpersonal contact between fieldworkers and clients and developing and testing local information networks and indigenous media and would be designed to be locally sustainable. Results of research in this activity should benefit the service delivery systems of the NGOs, BDG, and perhaps the SMC.

## 2.2.4 Performance

### Achievements

A variety of quality IEC products geared both to fieldworkers or to users or to potential users have been created (e.g., posters, TV spots, films, newsletters, a fieldworker's guide, a newsletter), and these have been well received by the IEM Unit. Plans were overambitious, however, and in many cases, only a small proportion of planned activities were completed in the anticipated time frame. The technical assistance provided to the MOHFW, NGOs and others was found to be highly professional and fully appropriate.

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<sup>11</sup>The purposes as described in the PIL were set out as follows:

- improving quality and effectiveness of IEC at field level;
- better management of IEC programs at Upazila level and below;
- improving communication skills and knowledge for fieldworkers;
- stimulating community participation and social mobilization;
- improving delivery of integrated family planning/MCH messages; and,
- improving interagency coordination.

The *Upazila* Communication Project has good potential for useful accomplishment, although definitive results must await preparation, training and refinement of methodologies, field testing and fine tuning. A promising start, however, has been made on establishment of this field laboratory for study of rural IEC realities. NGOs will most likely benefit first, and in time they may assist in transfer of useful findings to the government. In view of the time needed for this activity to prove itself, USAID's plans to withdraw its support from IEC in 1992 after currently approved IEC funds are expended may be ill-advised.

### Issues

Despite the many achievements, a considerable amount of dissatisfaction has been expressed by both the IEM Unit and JHU/PCS on implementation of this activity. Overall, levels of performance by the IEM Unit have been disappointing, and, even after a decade of heavy donor inputs, there is a lack of a cohesive, comprehensive, and sustainable strategy.

A major issue is the level of interest in, and capability of, the IEM unit to produce its own materials. The government has demonstrated neither high initiative nor great innovation in IEC matters and until now, most of the IEC materials produced with JHU/PCS technical assistance and funding have been contracted out to private firms. The IEM Unit has played a minor role, limited primarily to approving the materials suggested by JHU and to distributing the materials produced through its channels. JHU/PCS has made all the administrative and contractual arrangements with private firms for production, acting as a middleman in a series of commercial operations rather than providing technical assistance, as anticipated.

An ostensible reason for this *modus operandi* relates to production equipment: Heavy presses received from UNFPA in the early 1980s have only recently become operable and the Unit reportedly has other unused audiovisual production equipment that has not been installed, because operating funds and technical assistance either have not been provided or have not been utilized. Additionally, the nature of the bureaucracy inhibits the ability of others to accept or adopt innovations. Dismayed by the difficulties in following BDG procurement and production procedures and impressed by JHU success in using contractors, the IEM unit requested permission from the BDG to use private contractors during the Fourth Five Year Plan period. Thus, it appears that the IEM unit has no intention of taking a more active role in producing materials in the near future.

JHU/PCS has ready access to the IEM Unit, but no clear counterpart relationships have been formally established. This, plus the unit's apparent lack of interest in creating its own materials, suggests that institution building of the IEM Unit may be a poor option as the primary approach.

On the other hand, the current arrangement has some advantages and the opportunity exists for improvements. On the plus side, the materials that have been developed are of high quality, and the current approach has also allowed for stimulating and developing the local private sector. It is not clear that much is to be gained by making the IEM Unit a strong producer of population-related IEC materials. There is room, nonetheless, for an organization that coordinates the various government family planning IEC activities and develops a defined IEC role and strategy. This role could legitimately be filled by the IEM unit. In addition, the unit could be responsible for in-house production of internal MOHFW materials, such as invitations and simple informational and motivational printed materials. Other more complex printed and all audiovisual IEC materials would continue to be contracted out.

A lesser issue, but one that nonetheless has resulted in some friction, relates to funding procedures. Unlike arrangements for UNFPA funds, project funds are channeled through JHU/PCS, rather than through the IEM Unit, and the IEM Unit must adhere to strict A.I.D. accountability regulations.

On the program level, one questionable activity is the National Folk Singing Program. After 14 years of donor support, there has been no assessment of its impact. While suggesting the ripe potential of this medium as a rural communications tool, a recent evaluation also identified many problems with the project. USAID and JHU/PCS will decide whether to continue support depending upon the degree to which remedial measures are taken by the BDG in response to the recommendations of the evaluation.

### **2.2.5 Future Strategies**

It is possible that the mechanical problems alluded to above will gradually be alleviated over time as the Unit and JHU/PCS get to know each other better. The larger issue, however, is the wisdom of USAID's recent strategy program assessment recommendation to decrease USAID support for IEC. Given that most of the IEC needs identified in the earlier needs assessment still pertain, it is clear that the need still exists for activities in IEC. Any long-term commitment to population in Bangladesh should therefore include assurance that IEC issues will be adequately addressed, whether it be USAID or some other donor agency that supports them.

As suggested above, institution building of the Unit should not be the primary emphasis. Despite high-quality technical assistance, the IEM unit is not absorbing this assistance well, proving instead to be somewhat unreceptive to efforts to institutionalize IEC skills. On the other hand, USAID-funded CAs and the NGOs they support are more open in accepting IEC materials and ideas, and most likely would welcome high-quality IEC technical assistance. Additionally, IEC materials developed and tested largely by the NGOs do find themselves into the national program, as witness recent adoption and distribution of the Field Worker's Guide, which was a CA initiative.

With respect to donor involvement, the U.S. has a comparative advantage in population communication and is well positioned to address many of the needs identified in the needs assessment, including strengthening interpersonal communications skills, developing training manuals, segmenting and targeting audiences, improving IEC field activities, integrating family planning and MCH messages, training of communications and field staff, designing and implementing skills training programs, and developing IEC monitoring and evaluation. UNFPA remains willing to continue efforts to develop the institutional capacity of the IEM Unit. Proposed UNFPA and World Bank assistance (1991-1995) includes formulating an IEC strategy, program planning, some research regarding segmentation, and supporting the merger of the Health Education Bureau and the IEM Unit.

### **Recommendations**

1. USAID should continue support of IEC activities throughout this and successive projects.

2. USAID and JHU/PCS immediately should explore and implement mechanisms for expanding IEC technical assistance to CAs and contractors supported by USAID and to other interested non-governmental entities.
3. USAID involvement with IEM headquarters activities should be limited to coordination, with discrete technical assistance that responds only to direct requests and that concentrates on policy formulation and planning. JHU/PCS or future CAs should maintain strong liaison with the IEM Unit and provide high level technical assistance to the IEM Unit on matters of strategy and policy.
4. The *Upazila* Communication Project should be continued.
5. Based on experience to date, JHU/PCS should scale down its workplan for 1991 to less ambitious targets (see Appendix D for specific recommendations).
6. Because of continued non-supervision by government and failure to demonstrate programmatic impact, USAID should no longer support the National Folk Singing Project.

## **2.3 Municipal Immunization Project**

### **2.3.1 Background**

#### **Government Rural Program**

Of an estimated 830,000 annual deaths in Bangladesh of children under five, about 30 percent are caused by vaccine preventable deaths, particularly neonatal tetanus and measles.<sup>12</sup> To address this serious problem, the MOHFW began an expanded program for immunization (EPI) in 1979 soon after the Alma Ata Conference. By the mid-1980s, however, less than two percent of Bangladesh children had been fully immunized.

In 1986, the MOHFW undertook an intensified national immunization program to cover the country's rural areas. Prime support came from the United Nations Children's Fund (UNICEF), with the participation of the World Health Organization (WHO), the World Bank, the Swedish International Development Agency (SIDA), CARE and the Bangladesh Rural Advancement Committee (BRAC). With this assistance, coverage throughout most of the country has been impressive and has progressed relatively rapidly. According to the national EPI in 1990, full coverage in children under one in the rural areas currently is about 70 percent (UNICEF figures for 1989, combining both rural and urban areas, show a much lower coverage: only 30 percent).

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<sup>12</sup>Source: Municipal EPI Design, USAID/Dhaka. K. Olivola, M. Pollack and M. Wilson, January 1988.

### Need in Urban Areas

Assistance for coverage of the municipalities was not provided in the National EPI Program, primarily because the MOHFW has no responsibility for health in the country's 88 municipalities (although, by default, the Ministry normally provides curative services under the district Civil Surgeon).

Bangladesh's urban population accounted for 17 to 20 percent of the total population in 1988 and will approximate 33 percent in 2000. Forty-five percent of the urban populace is concentrated in the two largest cities, Dhaka, which accounts for four percent of the national population, and Chittagong. The 88 entities identified as municipalities include the 5 largest cities, 64 District headquarters, and 19 larger *upazila* towns.

Technically, "municipality" status is granted by the Ministry of Local Government, Rural Development and Cooperatives (MLGRD) and permits the entity to collect its own taxes. With the MOHFW having no official responsibility for health activities in urban areas, the MLGRD is charged certain health responsibilities, including EPI, food inspection, and garbage collection. In practice, the responsibility for EPI devolves to each mayor, and each city must take responsibility for its own preventive services or make its arrangements with the MOHFW for inclusion in national programs such as EPI.

As a result, preventive coverage by the government is inadequate in most urban areas, and coverage surveys indicate up to 30 percent of immunizations in urban areas are delivered by NGOs or private practitioners.

### **2.3.2 Project Goals and Objectives**

The municipal immunization component of the FPHSP complements the national EPI, whose focus is immunization of children and women in rural areas. The project's goal and objectives are to expand and improve accelerated EPI activities<sup>13</sup> in all urban areas, and to assist the government to achieve its 1990 target of 85 percent coverage of children under one year of age with the four childhood vaccines for six diseases,<sup>14</sup> and 85 percent of women of child-bearing age (15 to 45 years of age) with two doses of tetanus toxoid. The project also aims to reinforce the EPI delivery system so that these coverage rates can be sustained into the future.

Launched in 1988, the USAID effort was designed technically to follow the international model for rural areas set by UNICEF, WHO and the MOHFW. It was expected to be carried out in two phases:

- During the first year of activity (the intensification campaign), children under two would be given all four vaccines and women 15 to 45 years old would be given tetanus toxoid (two doses). After the backlog has been cleared, the emphasis would be on children less than one year old and on pregnant women.

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<sup>13</sup>As stated in the USAID buy-in to the Resources for Child Health (REACH) project and USAID's subsequent contract with the Cambridge Consulting Corporation (CCC).

<sup>14</sup>DPT, which protects against diphtheria, pertussis, tetanus; BCG, which protects against tuberculosis; and vaccines for measles and polio.

- After this "catch-up" stage, the target population would become newborns and 15-year old females (new entrants to the child-bearing cohort), as well as pregnant women for boosters of tetanus toxoid.

The goal, by the end of 1990, was that all municipalities would have completed at least one year of intensified activities, and each municipality minimally would have one fixed facility providing vaccination services every week.

### Implementation

The five-year project began in October 1988 and is being implemented through three U.S.-based entities:

- Early activities were carried out through a buy-in to the central Resources for Child Health (REACH) project. Two REACH resident EPI advisors remain in place.
- In April 1990, USAID signed a contract with the Cambridge Consulting Corporation (CCC) of Reston, Va. and its subcontractor, John Snow, Inc. (JSI) of Boston, Mass. for the final four years of the project. This became operational in July of that year.

Total funding is \$6.5 million which funds technical assistance at a level of \$4.822 million through a REACH buy-in and contract with CCC and support of local currency costs of \$1.678 million mediated through PIL 25.

### 2.3.3 Performance

#### Achievements

USAID assistance to the Bangladesh EPI program has contributed to the solution of a national MCH problem of great importance by filling a major gap in an impressive BDG national effort. By eventually reducing child mortality, this assistance should enhance the population-related thrust of the larger USAID effort.

Specific accomplishments include technical assistance in launching intensification campaigns in all municipalities in the country, hiring of seven Urban Operations Officers to assist and monitor EPI efforts throughout the country and of 41 vaccinators (all in Chittagong — mayors and health authorities are covering costs for the rest), training for program-related personnel which would otherwise quite likely not have been provided, and vehicles and some computers (see Appendix E for additional details). These efforts have been very well received by UNICEF and the BDG.

Both REACH and CCC have consistently urged the BDG to establish a program that is capable of producing sustainable results rather than short-lived "campaign" achievements. Both have encouraged the BDG to use its own underutilized resources more effectively, i.e., to involve more government staff and to activate additional immunization sites. They have also attempted to avoid grafting on more efficient, (perhaps) temporary components to the BDG program that will disappear without continuing donor support.

From a technical perspective, the project appears to have operated in exemplary fashion. It has benefitted from a wealth of technical recommendations made by a number of internationally recognized EPI technical experts and appears to value and give consideration to those recommendations and incorporate them insofar as possible, considering operational and financial constraints.

### Issues

**Project Design.** One concern relates to the project design — namely, that the project paper, the REACH agreement, and the CCC contract, are all set forth in qualitative terms, making it difficult to quantitatively evaluate project performance. Goals and purposes for the technical assistance are set forth, but there is no mention of end-of-project status, no quantification of outputs, no listing of verifiable indicators, no means of verification, and no assumptions. In short, the project has no logical framework. Instead, some activities are listed, some levels of inputs identified, and some products specified, but no real time lines are indicated (see Appendix E). The implementing documentation is more in the nature of a level-of-effort category similar to some cooperative agreements, lacking the quantitative specificity of the usual A.I.D. contract. (Other subactivities of the FPHSP also may lack a logical framework, but are better described in quantitative terms.)

Although the project documentation is somewhat vague, REACH has produced annual workplans to guide activities. REACH produced an annual workplan for 1989 in its strategy paper, although it was not clear how much importance USAID attached to it. Most of the activities in that detailed workplan were accomplished, albeit in 21 months rather than the planned 12. The annual workplan submitted in June for calendar year 1990 restates the goals of the urban immunization portion of the national program, rather than using as its frame-of-reference activities specified in the contract. Given the lack of clearly defined outputs and time lines in the CCC contract, project management might be facilitated if workplans contained quantification of effort and were developed not only for each year but perhaps for shorter terms as well — three- or six-month periods.

**Duration of USAID Involvement and Prospect for Institutionalization.** Another issue relates to the long-term relationship between USAID, the government, and UNICEF for national immunization efforts.

For the time being, the current arrangement (with UNICEF in rural areas and USAID in urban) is well adapted to Bangladesh needs and also serves USAID's overall program goals. UNICEF's approach, which tends to use the same programmatic formula in every circumstance, is suitable for the rural areas, whereas municipal implementation, given the different health structures, funding bases, and personnel levels in different municipalities, requires the more tailored approach that USAID is offering. The immunization program also serves to strengthen A.I.D.'s overall focus on family planning. In contrast to UNICEF, the CCC project team is well positioned and "mandated" to identify stronger linkages between EPI and family planning activities in urban areas. This should benefit both initiatives, particularly given the high levels of concern accorded each program by government leadership. Finally, being identified with a high-quality, high-yield MCH intervention can only enhance USAID's image.

The likelihood that USAID can successfully shift responsibility for urban programs either to UNICEF or the government is not great. Although USAID's assistance could be subsumed by UNICEF, this might involve some risk as there are questions regarding UNICEF's willingness and ability to provide urban-oriented technical assistance. In addition, UNICEF, which normally prefers

to work only with ministries of health, would need to work out complicated arrangements with each of the 88 municipalities.

Even less auspicious is the outlook for institutionalization of the immunization of the program within the government. The magnitude of the national problem is so great that UNICEF (presuming its continuing involvement) will be taxed to institutionalize even the rural program within the BDG after the current (denied but real) campaign strategy wanes. For urban programs, there is the complicating factor of which ministry ultimately will assume responsibility for providing preventive services in urban areas. Neither the MLGRD nor the MOHFW has the resources or technical and administrative capabilities to assume overall responsibility for urban EPI. The lack of clarity on this issue will continue to leave unanswered questions about the sustainability of the urban EPI program. With respect to cost recovery, there seem no viable prospects other than the obvious, and marginal, possibilities through NGO cost-recovery schemes.

### **Recommendations**

1. USAID should review project documentation and its contract with CCC and consider revising them to be more explicit in quantitative terms and to provide time lines for specific components.
2. The workplan of the contractor should be presented in a format to be agreed upon by USAID and approved preceding the period that it is to cover.
3. Until urban EPI coverage reaches or exceeds the level of the national program and is BDG-sustainable with minimal UNICEF or other donor assistance, USAID assistance to this segment of the national program should continue, presuming the continuation of sufficient USAID funding and management staff.

## **2.4 Training**

### **2.4.1 Project Performance**

This section discusses the project training efforts of USAID's Office of Population and Health (OPH), apart from the *Upazila* Family Planning Initiatives Project (the mainstay of USAID participant training) and training activities supported through other project components (see Appendix F).

The training discussed below is a relatively low-intensity activity, with a total of 54 participants having been trained to date, including about 44 from the private sector and 10 from government. (This compares with some 213 participants funded to date through the *Upazila* Family Planning Initiatives Project, or nearly four times as many, almost all of whom were from the government.) Nearly all of the 54 participants were trained in family planning activities. Two-thirds of the participants have been sponsored for training of 30 days or fewer, with 19 percent for 10 days or fewer. Observation tours, seminars, conferences and workshops, rather than formal courses, have predominated (see Table 5 on next page).

The major portion of this training has resulted from discrete project activities and has been generated by the CAs or contractors, with the rest largely having resulted in response to *ad hoc*

requests from the BDG. The high proportion that has resulted from outside requests reflects the lack of a systematic health/population manpower needs assessment or formal training plan done by the BDG.

## 2.4.2 Issues

Given the relatively modest level of participant training provided under the project against what may be assumed to be a large need, the question is whether USAID should plan to step up its efforts in this area. The choice is difficult: whether to undertake a significant but costly and labor-intensive training effort or to continue the current *ad hoc* approach in response to clearly defined need. Strong arguments can be made on both sides.

Table 5  
USAID-Sponsored Training, 1988-1990

Year/ Project No.	Participants			Duration in Days			
	U.S.	TC*	Upazila	<10	11-30	31-60	61-180
<b>1988</b>							
0050	—	—	(77)	—	—	—	—
0071	6	1	—	—	—	5	2
<b>1989</b>							
0050	—	10	—	10	—	—	—
0071	11	2	(91)	—	7	6	—
<b>1990</b>							
0050	—	3	—	—	2	—	1
0071**	6	15	(45)	—	17	3	1
<b>Totals</b>	<b>23</b>	<b>31</b>	<b>(213)</b>	<b>10</b>	<b>26</b>	<b>14</b>	<b>4</b>

Source: Compiled from USAID data.

\* TC = Third Country

\*\* Does not include one long-term (1 year) trainee.

Note: Some of this training was funded by the predecessor Family Planning Services project (388-0050).

On the pro side, the cohort of experienced family planning officials who were trained through large donor inputs (particularly through large central A.I.D. funding) during the 1970s is nearing retirement, and its successors, as a group, are said not to have received the same degree of formal family planning training. Due to the lack of a systematic needs assessment, the magnitude of this apparent problem is unknown by the BDG or by donors. Nonetheless, there exists a felt (although undocumented) need for training now for family planning leadership later, most recently expressed in a recommendation from the Population Sector Review, which called for the BDG and

USAID to "take advantage of every opportunity to provide training and other support necessary" to improve the management skills of the upper-level leadership of the MOHFW.

On the other hand, a number of factors suggest that it may be impractical or unwise to increase resources devoted to participant training. Centrally provided A.I.D. training funds are in short supply and USAID faces possible future lower levels of resources. Added to this are the management requirements to the mission for a large training component. Participant training activities are highly labor intensive and, in Bangladesh, have been made more time-consuming due to the absence of a needs assessment, problems in obtaining appropriate and qualified BDG nominees (in time or at all), and difficulties in persuading trainees to return to Bangladesh. The long-term usefulness of these training efforts is also in question: There has been a history of loss to the family planning program of significant numbers of returnees by transfer to other BDG ministries or agencies with no family planning agenda and to the private sector. Those who are retained by the Ministry may be assigned positions in which their training is not particularly relevant. These problems exist to some degree in most participant training programs, but USAID and other donors agree the problems have been more severe in Bangladesh.

Also significant, formal external training has been awarded a relatively low priority by the BDG. In its proposed program for the Fourth Five Year Plan, the MOHFW requested training assistance only for in-country development of BDG institutions except for one \$50,000 item calling for external study for staff of the Management Development Unit and the Family Planning Clinical Surveillance Team. This was given priority B, out of A,B, and C.

A needs assessment on manpower needs would assist the mission in assessing an appropriate priority for future training activities. Two efforts may feed into this effort. The first is an initiative by the British Overseas Development Administration (ODA) to establish an MOHFW manpower planning capability, for which it is reportedly attempting to enlist donor support. It is unclear whether an extensive training needs assessment would precede this effort, although such an assessment clearly should precede the long development of an institutional capacity for manpower planning. A second effort is taking place at a private level. The director of a local firm, Technical Assistance, Inc., has begun development of a computerized database which might be capable of documenting and categorizing formal family planning training that MOHFW personnel have received. To date, the director has found no market for this activity.

### Recommendations

1. USAID should continue its current low-intensity participant training activity instead of a developing a more costly and labor-intensive program until an information needs assessment has been conducted, a BDG training plan developed to respond to identified need, and until the BDG has accorded higher priority for external training needs.
2. The mainstay of OPH external training for government personnel should remain the *Upazila* Family Planning Initiatives Project.
3. USAID should not participate in the ODA-coordinated development of a project designed to improve MOHFW manpower planning capability unless a needs assessment is included as part of the undertaking.

### **3. Non-Governmental Organizations**

### 3. Non-Governmental Organizations

#### 3.1 Overview

##### 3.1.1 Background

Non-governmental organization (NGO) activity in family planning in Bangladesh began in 1953 through the Family Planning Association of Bangladesh (FPAB). Initial objectives focused on addressing acceptance of and decreasing resistance to family planning and on making the government aware of the need for family planning. By 1965 the government had become involved in the family planning movement. Initially, NGOs focused on urban IEC and service delivery but were asked by the BDG in 1986 to extend programs to rural areas.

A.I.D. has supported NGO family planning activities in Bangladesh since the 1970s, initially through centrally funded grants and contracts to the CAs that fund the Bangladesh-based activities. In 1981, under the Family Planning Services Project, USAID began providing bilateral funding to a number of NGOs implementing programs in training and family planning service delivery. Major emphasis was on programs for community-based distribution (CBD) of contraceptives and clinical activities focused on provision of high quality voluntary sterilization (VS) services. Additional funds were provided to CARE for development of a curriculum for BDG staff training, operations research (OR) on the transfer of findings from International Center for Diarrheal Disease Research, Bangladesh (ICDDR,B)/Matlab's program to the BDG program, a pilot project by The Asia Foundation (TAF) to encourage late marriage and reduced fertility through female education, and contraceptive-related research through the Bangladesh Fertility Research Program (BFRP).

##### 3.1.2 The NGOs and CAs

Under the present FPHSP, USAID provides support to six CAs which carry out programs that collectively include CBD projects in both urban and rural areas, high-quality clinical service programs, training, institutional development, research, IEC, and logistics support. (It has also continued its support to ICDDR,B and BFRP, discussed in Chapter 6.) The NGOs currently support over 100 projects with 320 project sites (see Table 6 on next page).

A summary description of each of the six NGOs follows (see Appendix G for further details).

1. The Asia Foundation. In implementing its program, TAF has emphasized improving management of subprojects through fine-tuning monitoring and supervisory systems; developing manuals for standardized program and clinic operations; refining workplans, reporting and management information system (MIS); and utilizing its OR and evaluations to increase effectiveness of programs and procedures. Today TAF is supporting 31 projects in 75 rural and urban sites. Since 1985, the organization has also supported a pilot effort, through five NGOs in six *upazilas*, to lower fertility while improving the educational status of females.

Table 6

USAID-Funded Family Planning NGOs by Number of Projects and Sites  
June 1990

NGO	No. of Projects	No. of Sites
AVSC	1	25
TAF*	31	75
FPAB	2	40
FPIA**	5	64
FPSTC	49	49
PF	31	67
Total	119	320 (142 urban and 178 rural sites)

Source: USAID-Funded NGO Family Planning Projects Report, 1990.

\* Includes five female education projects.

\*\* One project with 33 sites included here was terminated July 31, 1990.

2. Association for Voluntary Surgical Contraception. AVSC is known for its high technical quality and its expertise in the field of surgical contraception, as well as its long history of operation in Bangladesh. Coupled with its effectiveness in both government and NGO sectors, this makes it a resource for transfer of technologies, training, and innovations to improve the national program. AVSC supports service delivery and training activities in Bangladesh through the Bangladesh Association for Voluntary Sterilization (BAVS), a local NGO established in 1974, which presently has 25 clinics.
3. Family Planning Association of Bangladesh. FPAB's programs are implemented through the community using volunteers, youth and women, with attention being given to promoting self-reliance and institutionalization of services and benefits. Since 1981, FPAB has been implementing two innovative service delivery projects: a) Use of Voluntary Agencies in Population Activities, which has utilized 225 of the more than 5,000 small, local-level voluntary agencies that provide family planning motivation and services in rural areas; and b) Utilization of Traditional Healers in Family Planning, which involves provision of family planning motivation and service delivery by traditional healers, a group whose members are considered to be influential persons in the community and which provides health services to between 60 and 70 percent of the rural population. FPAB also plays a role in coordinating the logistics and supply of commodities for itself and three other CAs (FPIA, TAF and The Pathfinder Fund — see Section 5.3 below for full discussion).
4. Family Planning International Assistance. FPIA's subprojects are mainly in rural areas, utilize a CBD approach, and implement innovative strategies for tapping different groups of the community as motivators-cum-educators. During the period under evaluation, FPIA supported five subprojects which operated in 64 sites and served about 150,000 acceptors annually. FPIA has focused on improved project

management through continuous project staff development and training. Cost recovery and sustainability are being encouraged through income-generating models and community involvement. (In October 1990, all FPIA activities except one, which FPIA will continue with its own funds, were transferred to TAF. The cooperative agreement with A.I.D. expired on October 31, 1990.)

5. Family Planning Services and Training Center. FPSTC, established by the MOHFW in 1978, serves as the secretariat for the Family Planning Council of Voluntary Agencies (see Section 3.1.3 below) and as an umbrella resource organization providing financial and technical assistance to local NGOs active in family planning. Currently, FPSTC funds 49 service delivery projects (43 urban and 6 rural); provides basic and refresher management training for management, supervisory and office staff of its sub-grantees and other NGOs; and disseminates family planning information through seminars, workshops, and a monthly newsletter. As an organization created by the government with many typically NGO functions, FPSTC falls into a unique category somewhere between a government and a non-governmental organization.
6. The Pathfinder Fund. Currently Pathfinder activities focus on the following six major themes: 1) service delivery; 2) decentralization and development of local leadership; 3) coordination among NGOs and between NGOs and the government; 4) technical assistance in training and development of training materials; 5) support to promote the small family norm; and 6) sustainability of family planning program activities. Pathfinder supports 29 CBD projects with 30 urban and 33 rural sites as well as two clinical projects at five sites. During Pathfinder's years of operations in Bangladesh, a close relationship has developed with the government. As a result, Pathfinder has assisted in providing orientation and training to district, *upazila*, and union level officials in support of Bangladesh's population program.

Despite the diversity of their approaches, each NGO has unique strengths that have allowed it to play a leadership role for the others in a specific area. For example, organizations that have linkages with the government such as FPSTC and Pathfinder serve as a liaison for other NGOs; AVSC is a resource for clinical methods; TAF is a resource in the area of institutional development; FPIA is a resource for innovative models in rural areas; and FPAB coordinates commodities logistics for a large portion of the NGO community.

### 3.1.3 Coordination of NGO Activities

Coordination of the NGOs has been a concern both of the Bangladesh government and of the NGOs themselves, and each has made an effort to develop mechanisms to avoid excessive overlap and to capitalize on its individual skills.

The government took the first steps in this direction in 1978, when it created the Family Planning Council of Voluntary Organizations (FPCVO) and its secretariat, the FPSTC. To date, FPCVO has met sporadically. During the period from October 1988 to September 1989, only one meeting was held and no meetings were held during the first three quarters of FY 1990. A meeting was held during the month of August 1990, at which issues related to area demarcation and solutions to this problem were discussed. Very recently, in June 1990, the BDG established the NGO Affairs Bureau as part of the President's Secretariat. This Bureau is headed by a Director General and will function as the contact point between government and foreign NGOs and Bangladesh NGOs

receiving foreign funds. The Bureau, which will be dealing with NGOs in all sectors, was established with a view to streamlining NGO procedures, providing one-stop service to NGOs for registration and project processing, and achieving better coordination and effective use of resources. As the NGO Affairs Bureau becomes increasingly operational, the roles of FPCVO and FPSTC may become altered. It is still too early to judge the effectiveness of the Bureau. A BDG requirement for a project approval fee caused considerable donor concern until it was subsequently abolished.

The NGOs took their first steps toward better coordination in 1986, with the establishment of an NGO Coordinating Committee. This move came in response to the 1986 evaluation,<sup>15</sup> together with subsequent recommendations from USAID. The Committee meets monthly to coordinate activities, address issues, share experiences, focus on areas for improvement, and foster relationships between the government and NGOs. This body was recognized by the FPCVO through a resolution passed in November 1986.

The Committee has succeeded in fostering a coordinated approach in a number of areas. Through its committee on training, curricula were updated and improved and a plan for training NGO management and field personnel was developed. The Coordinating Committee has also addressed issues of area demarcation through sponsorship of conferences and workshops and is taking a lead in cost recovery and institutionalization of programs. The coordination effort includes not only the USAID-sponsored CAs, but also Concerned Women for Family Planning, a national NGO active in family planning since 1974; ODA, which supports integrated health and limited family planning activities through its NGO project; and ICDDR,B, which facilitates the transfer of innovative technologies to the government program.

In addition, the CAs have worked toward improving and coordinating their MISs, NGOs rely on each other in areas in which one or another has expertise, and they are cooperating to improve overall management of clinical service delivery and the clinical and counseling skills of project staff.

#### **3.1.4 USAID NGO Strategy**

USAID and the NGOs have collaboratively developed strategy papers since the beginning of their association. Three separate strategies have been developed encompassing the periods 1981-84, 1985-88, and the present strategy for 1987-91. The first strategy emphasized the replication and expansion of existing urban service models (CBD and quality clinical programs for VS) and NGO/BDG collaboration at local and national levels to improve motivation and productivity in the national program. The second strategy gave priority to consolidation and improvement of existing models with selective and innovative expansion to rural areas and improvement of management, evaluation, and training. The present strategy concentrates on 1) increasing quality services and the contraceptive prevalence rates (CPR) in urban areas and expansion of rural projects through collaboration with the BDG; 2) strengthening NGO project management, planning, and implementation through workshops, conferences, and training committee activities; 3) undertaking innovative activities and targeting younger, low parity clients; 4) introducing MCH components into mature projects; and 5) ensuring efficient systems for logistics and commodities. A fourth strategy presently is being developed for the USAID follow-on project.

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<sup>15</sup>*An Overall Evaluation of the USAID/Bangladesh Family Planning Services Project (388-0050) Key Issues, and Future Assistance* (ISTI, March 1986).

USAID, the single largest donor to the NGOs, is supporting over 90 percent of NGO costs in family planning. Since 1981, USAID support to NGOs has totaled more than \$61 million. Under the current FPHSP, approximately \$44.85 million, or 25.5 percent of the total project costs of \$176 million, has been budgeted for the NGO component. Current levels of CA funding are as follows: AVSC — \$4.41 million; TAF — \$17.5 million; FPAB — \$2.62 million; FPIA — \$3.82 million; FPSTC — \$ 7 million; and Pathfinder — \$9.50 million (see Appendix C).

The long association of the CAs and USAID with population programs in Bangladesh gives both a comparative advantage which enhances individual strengths and makes coordinated efforts more effective. The length of time that USAID has been involved and the continuity of its programming efforts are two of the most positive aspects of A.I.D.'s assistance.

## **3.2 NGO Contributions to National Family Planning Program**

### **3.2.1 Contribution to Contraceptive Prevalence**

NGO programs play an important role in the Bangladesh national family planning program, accounting for approximately 21 percent of the active users in the country. This includes approximately 20 percent of the eligible couple (ELCO) coverage and 22 percent of the active users nationwide.<sup>16</sup>

During the first six months of 1990, it was estimated that NGOs supplied contraceptives to nearly two-thirds of the active users who were visited by NGO staff in the 320 USAID-funded NGO project areas. NGOs were the predominant source for pills and condoms, whereas other sources provided a larger proportion of clinical methods (IUDs and VS), many presumably through NGO referrals (see Table 7 on next page).

Traditionally, the NGOs have made a particularly important contribution in urban areas. The 1989 Bangladesh Fertility Survey attributed 32.7 percent of all urban users being supplied by home delivery almost exclusively to the service of NGOs. This high percentage attests to the importance of home delivery in a culture in which it is difficult for women to appear in public. The BDG program cannot as easily provide door-to-door services.

As management in the individual NGO programs has evolved and experience increased, many of the projects can claim CPRs in the 50 to 60 percent range, with others registering a lower, but still strong, 40 percent.

The BDG is aware that NGO activities complement and supplement its national program, a fact it has most saliently demonstrated by having regularized the NGO role in national service delivery activities. Specifically, the BDG has made the NGOs responsible for certain urban and rural areas of service delivery (and included their performance in the countrywide MIS); supplies them with contraceptive commodities; and utilizes their unique resources at both local and national levels of the program. For example, NGOs collaborate with the BDG to provide training to various cadres of BDG personnel and assist with its efforts to decentralize the program by facilitating

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<sup>16</sup>These figures are based on 1989 CPS estimates of eligible couples and active users and the USAID NGO Quarterly Performance Report, April - June 1990.

Table 7

**Total Number of Active Users in USAID-Funded  
NGO Project Areas, by Method  
(Cumulative as of End of Quarter)**

Methods	No. Users Visited and Supplied by NGO	No. Users Visited but Supplied by Other Sources	Total Active Users
Pill	663,989	156,193	820,182
Condom	254,826	52,008	306,834
Foam	225	3,757	3,982
IUD	43,254	65,130	108,384
Injectable	58,723	30,143	88,866
Vasectomy	37,719	65,990	103,709
Tubectomy	40,714	234,522	275,236
Research/Norplant*	544	146	690
<b>Total</b>	<b>1,099,994</b>	<b>607,889</b>	<b>1,707,883</b>
<b>Percent</b>	<b>64.41</b>	<b>35.59</b>	<b>100</b>

Source: USAID NGO Quarterly Performance Report, April - June 1990.

conferences and workshops at the district, *upazila*, and union levels. The BDG most recently (in 1989) signaled its recognition of the contribution of the NGOs by honoring several NGOs with the President's Award for Excellence in Family Planning Services.

### 3.2.2 Innovations in Service Delivery

Perhaps the most significant characteristic of the NGO program is its dynamism. CAs and NGOs are constantly learning from their experiences and adapting their programs accordingly. They are addressing sensitive areas such as the relationship of religion to family planning and adolescent education as well as targeting programs for newly married couples and underserved populations in rural areas. The USAID NGO involvement over the last 15 years has contributed significantly to an evolving population program and should continue to do so in the future.

By dint of their long-term exposure in these difficult program areas, NGOs have developed a comparative advantage when it comes to introducing new ideas and innovations into other parts of the Bangladesh family planning program. This facet of their work is appreciated by the government, which has helped introduce NGO-originated improvements into its own program.

Notable among these improvements is the BDG's decision to decrease the worker to ELCO ratio to 1 to 750 by planning to hire 10,000 new FWAs. This decision was based on the finding by the NGOs, together with ICDDR,B, that a reduced ratio of worker to ELCOs was of critical importance in increasing the effectiveness of service delivery programs. A second contribution has been the development of the Field Guide, which was created through the activities of the NGO Training Committee as a tool for fieldworkers to use in motivating and counseling clients. The BDG, after making minimal adaptations, printed 40,000 copies of the Guide for its personnel. Other contributions are a record book and improved work plans and record-keeping mechanisms for

fieldworkers and the introduction of CPR calculation by field personnel. Through these activities and their contribution to prevalence, the NGOs have provided tangible support to BDG policies supporting small family norms.

The potential exists for greater contributions to the government in helping improve their service delivery. The concept of using depot holders (i.e., sales agents who make contraceptive sales from their homes), for example, to cut costs of programs and introduce an alternate mechanism of supplying commodities is one intervention that merits attention. Through the implementation of its Utilization of Traditional Healers in Family Planning project, FPAB has gained experience using depot holders for provision of contraceptive commodities as well as linking with government programs as it withdraws from mature project areas. Introducing this mechanism in high prevalence areas may be a first step in weaning highly subsidized projects that are dependent on large numbers of fieldworkers. At this point, although few projects have introduced this concept and there is little knowledge of the effects this strategy might have on contraceptive prevalence in urban and rural areas, the concept may have considerable potential.

Similarly, NGO flexibility has an advantage in starting family planning projects in such traditional and conservative areas as Chittagong Division. Both FPAB and Pathfinder have experience in dealing with programs relating religion and family planning. TAF has experience in strengthening local organizations. NGO approaches such as these may serve to help bring underserved areas into the national program.

### **3.3 Issues**

#### **3.3.1 Service Delivery vs. Innovation**

As described above, the NGO program represents a good mix between standard efforts to contribute to the nation's CPR and more innovative programs that are catalysts for new approaches to service delivery. Together, these approaches represent the strength of the NGO program.

Theoretically, there may be an issue of emphasis, a question whether too great an effort in the area of innovative activities will detract from service delivery, or vice versa, whether too great a stress on service delivery will vitiate the program's efforts to forge new ground. An important factor in this equation is that the NGOs have greater skills in breaking new ground than do the government or the commercial sector, and thus, they are needed to initiate a process that will gradually bring underserved areas into the national program. Innovative activities by NGOs should be encouraged for the improvements they may be able to introduce to their own programs in the short run and to the government program over the long term. These strengths notwithstanding, however, the overall NGO project goal must remain to reduce fertility.

#### **3.3.2 Coordination at the Local Level**

Originally, the BDG provided family planning services in the rural areas while NGOs were limited to urban programs. As part of its efforts to provide better coverage in rural areas, the BDG changed its policy in 1986, requesting the NGOs to expand their programming to rural areas. NGOs were assigned specific locations of operation by local government. NGOs have now expanded

the scope of their activities into rural areas and are working in conjunction with local-level government programs to expand coverage in underserved locales. Of the 320 projects supported through the CAs, 178 are rural and 142 are urban. This change marks a significant contribution to the government's decentralization policy.

The demarcation into NGO and BDG project areas was designed to utilize scarce resources by expanding coverage and reducing duplication. A complicating factor, however, has been the government's decision to hire 10,000 new FWAs in an effort to improve services. To date, approximately 7,500 new FWAs have been posted in *upazilas* throughout the country, sometimes in wards and locations that had previously been assigned to the NGOs. This situation has caused some confusion and overlap resulting in conflict and, in some areas, negative effects on service delivery. It is particularly difficult for NGOs that have invested time and energy to start programs in one area to be told a short time later to relocate to a new area. The nature and magnitude of the problem varies from *upazila* to *upazila*, with some areas experiencing no difficulties at all.

Directing NGO energies into rural areas is part of a larger BDG move to increase program concentration outside urban centers. Other efforts in this direction include the *upazila* Family Planning Initiatives Project and Social Marketing (SMC) community-based distributors (see Section 5.3 below).

Since this is an issue that will affect all CAs working in an *upazila*, a coordinated effort to find a solution will provide the greatest benefit in the long run. To address ways in which NGO fieldworkers and FWAs can be supportive, not duplicative, of each others efforts, the CAs should hold workshops during which they carry out a systematic review of the problems faced by their subgrantees and develop a set of solutions. Capitalizing on the pluralistic approach can only serve to strengthen the overall family planning program in the long run.

### **3.3.3 Method Mix, Use Effectiveness, and Quality Assurance**

About 60 to 70 percent of active users in the NGO sector rely on pills and condoms. In an effort to increase the use of more effective long-term clinical methods, USAID took the lead in carrying out a clinical services needs assessment in June 1989. The assessment found that clinical supervision, monitoring, client care, and counseling would have to be improved before use of clinical methods would increase and major changes could be made in the method mix. To this end, USAID and Pathfinder developed a Quality Assurance Manual which addresses such topics as clinic management and maintenance, client care, counseling and informed choice, appropriate screening for method selection, and management of side effects and follow-up.

The CAs presently are developing a coordinated strategy to upgrade and maintain the skills of NGO clinicians and managers to enhance the quality of care in clinical family planning services. A group of clinical master trainers, to be drawn, most likely, from the CAs and the large NGOs, will become a professional team which can provide training, monitoring, evaluation, and supervision of clinical activities for the family planning NGOs.

One issue is that present plans do not include training of NGO fieldworkers, although they are the primary contact point with clients. It is the fieldworkers who must promote these methods and respond to side effects as they arise. Constant feedback between the fieldworkers and clinicians is imperative for a balanced approach. Unless fieldworker involvement is included as part of the training, the project may falter.

### **3.3.4 Integration of MCH Services**

Integration of MCH and family planning is a stated policy of the BDG, but to date, most of USAID's population activities with the NGOs has been rather narrowly focused on family planning service delivery. On the other hand, practically all of the NGOs are offering some type of MCH health services in their programs, in response to the expressed needs of the community. TAF has integrated MCH services in its field projects using private funds and establishing project linkages with ODA. It is collecting information from its sub-grantees on child survival indicators and is utilizing traditional birth attendants in some projects. AVSC has recently initiated a comprehensive MCH and family planning training program for medical interns. Most FPSTC subprojects include supportive activities including MCH services. All Pathfinder's CBD projects are staffed by women and offer some MCH services. In addition, a number of NGOs strengthen their own services and enhance the nationwide EPI program by expanding immunization coverage.

This positive aspect of NGO programming ultimately facilitates family planning activities rather than detracts from them. By supporting targeted MCH interventions through the NGO sector, a relatively low-cost investment can enhance the success of individual family planning programs and may provide models and linkages that can be used in future government programs. In particular, such targeted interventions as immunization and ORT should have a beneficial effect on child survival and ultimately on reducing fertility.

### **3.3.5 Cost Recovery and Sustainability**

Even if USAID is able to continue to fund NGO activities at current levels, the rate of growth for the NGOs will necessarily slow because more accessible areas and receptive people have been mined and it will be more difficult to maintain the rate of growth of services to these areas and people. This prospect represents a challenge to the NGOs: To increase operating revenues, they will need to find ways to increase efficiency, transfer responsibility for services and funding to the community ("graduate"), obtain funding from other donors, or increase cost recovery. The following discussion focuses on the prospects for increasing revenues by initiating cost recovery activities.

The CAs have exhibited an overall positive response to A.I.D.'s requests for greater efforts toward cost recovery, having sponsored workshops on the subject and introduced some cost recovery schemes. This process needs to continue; the NGOs should take every opportunity to share their successes and failures so that cost recovery interventions can be of optimal benefit to all programs. To play an effective role in this overall process, the CAs should expand and strengthen their own knowledge and resource base with reference to the principles of sustainability and cost recovery in general and specifically in the Bangladesh context. In this manner, they will be able to serve as an effective resource to the NGOs and provide a continuing forum for the exchange of ideas.

In resource-poor Bangladesh, however, expectations of the degree to which NGOs will be successful in family planning cost recovery should be kept very low. NGOs are not equipped to compete in private enterprise-type efforts, and experience from NGO programs in other countries indicates that NGOs rarely are successful in entering and sustaining viable enterprises in the competitive private sector. Moreover, such activities, often totally unrelated to ongoing programs, may divert NGOs' time and resources. A review of the levels of cost recovery in a current Pathfinder project suggests a realistic perspective of the potential for such efforts. In this project, revenue generation initiatives began in November of 1989 through sales of contraceptives, selected FWA/doctor service charges, and sharing operational costs by the grantee organization and local

community. As of June 1990, Tk. 60,682 (\$1,725) had been generated in 28 urban projects from the sales of contraceptives; a total of Tk. 16,740 (\$975) had been realized from service fees of 23 projects; and local contributions of 22 projects had amounted to Tk. 39,418 (\$1,125).

The conclusion is that financial self-sufficiency of NGO family planning programs in Bangladesh, although desirable, likely will not be achieved within the next several decades. This does not mean, however, that NGOs are, or should be considered as being, totally dependent upon donor funds. Rather, some CAs and NGOs are already involved in efforts that are moving towards technical sustainability, i.e., NGOs are moving toward leaving the technical know-how and technical benefits of the family planning intervention in community hands after NGO withdrawal. Specific steps in this direction include strengthening indigenous, community-based NGOs through training and technical assistance to enable them to implement family planning and development programs more effectively; promoting community contributions (donation of land and/or office space) and mobilizing local level resources in support of the NGO's family planning program (businesses, influential citizens, opinion leaders, and volunteers); and establishing mutually beneficial linkages with the national family planning program.

Technical sustainability, by increasing integration of services and benefits within the local community, is, in the long run, a more significant goal than achieving financial self-sufficiency. The end result, for the NGO, will be to place the ownership and responsibility for the intervention fully in community hands. The focus on "community ownership" of a project and the concept of family planning as a social movement promote this aspect of sustainability.

**Recommendations** (Recommendations relating to individual NGOs are contained in Appendix G.)

1. In efforts to strengthen clinical activities and quality assurance, USAID and the CAs should broaden the focus of these activities beyond clinical staff to include field staff. Future planning and implementation of this project should stress the linkages between the clinical and paramedical cadres of family planning workers and the fieldworkers.
2. USAID should encourage CAs and NGOs to integrate EPI and ORT into ongoing programs.
3. USAID and the CAs should maintain only realistic and modest expectations of gains in achieving financial sustainability. In considering possible cost-recovery schemes, NGOs should favor interventions that are related to and support their programming and organizational objectives; that are low maintenance and require minimal levels of management; and that are not directly competitive with private enterprise. Feasibility studies and sound business plans should be required prerequisites to implementation and regular monitoring and evaluation will be necessary from the outset to ensure the success of the program.
4. USAID should support technical assistance from international organizations to assist the CAs to expand and strengthen their knowledge and resource bases with reference to the principles of sustainability and cost recovery in general and specifically in the Bangladesh context.

5. **USAID and the CAs should promote the process of developing community ownership of NGO programs and objectives and linkages at the local government level in order to achieve technical sustainability.**

#### **4. The Social Marketing Project**

## 4. The Social Marketing Project

### 4.1 Background

#### 4.1.1 Overview

The Social Marketing Project (SMP) in Bangladesh was initiated in 1974 to sell contraceptives at subsidized prices through private commercial outlets using modern marketing techniques. The SMP established its own nationwide distribution system, using the large existing marketing sector, and aimed sales at low-income, largely rural consumers.

From its start, the project has repeatedly confounded those who doubted that poor Bangladeshis would pay for contraceptives. Throughout the 1980s, SMP contraceptives annually have been estimated to account for between 13 and 18 percent of total couple years of protection (CYP) to the national program annually. According to the 1989 CPS, by 1989 SMP accounted for an estimated 60 percent of the national family planning program's condom protection and 21 percent of oral contraceptive protection.

Over the years, the SMP has concentrated on promotion, marketing and sales of branded pills, condoms and, for a period, foaming tablets. In 1986, the product line was expanded to include packaged oral rehydration salts (ORS) bearing the brand name Orsaline.

The SMP nationwide distribution network, with its estimated 130,000 sales outlets, utilizes wholesalers (stockists) and retailers, including pharmacies, grocers, kiosks, private physicians and rural medical practitioners. SMP has supported generic advertising campaigns that promote family planning in general as well as product-specific advertising campaigns.

#### 4.1.2 Transition to an Independent Private Sector Enterprise

In January 1990, the SMP was officially dissolved and replaced by the private Social Marketing Company, Ltd. (SMC). This change came about after the project had operated for 16 years under a written agreement between Population Services International (PSI), which provided technical support, and the BDG, represented by MOHFW. Now, the social marketing activity is officially designated as a private organization and is governed by a board of directors composed of representatives from the private sector. PSI support has continued, but the agreement now is between PSI and the SMC, rather than between PSI and the government. USAID continues to fund PSI through a cooperative agreement (an arrangement that replaced central funding in 1981).

Although officially under government support, during the 1980s, the SMP attained a *de facto* independent legal status. The official change to private status was set in motion in October 1988, when a number of management and operational problems led the mission to make a strong formal move to establish SMP as a fully private sector enterprise. In January 1989, the mission informed the MOHFW that three issues needed resolution in order for USAID to continue SMP support: 1) a formal subagreement between PSI and the SMP clearly establishing SMP's management rights and responsibilities; 2) written agreement on a mechanism for designating the SMP a *de jure* fully private sector enterprise; and, 3) agreement that the composition of the SMP board of directors would provide majority private participation and control.

Negotiations over this issue were protracted, lasting about some 15 months (October 1988 to January 1990). Early on in the process, the BDG-PSI agreement expired, the MOHFW established a purely governmental council to govern the SMP, USAID suspended funding for local costs of the SMP (resumed later), and operations were reduced. The major issue was the reluctance of government officials on the SMP council to "subordinate" themselves to a private foreign organization.

This impasse ended in December 1989 when MOHFW officials proposed an unexpected alternative — dissolution of the government controlled council and establishment of a new body composed entirely of representatives from the private sector. USAID immediately agreed to this new formula, remaining issues were rapidly resolved, and the SMC has resumed operations and reestablished its status as a major source of family planning supplies. Throughout the rest of this document, only the term "SMC" will be used to refer to the social marketing activity.

Thus was completed a difficult and demanding 16-year effort to establish social marketing as a fully sanctioned private sector enterprise. The conversion from a quasi-governmental body to a non-profit company clarifies the legal status of the organization, establishing it clearly as an indigenous organization and thus opening the door to support from other donors. The clarified legal status and private-oriented Board of Directors will also permit the SMC to utilize entrepreneurial business methods while encountering fewer governmental bureaucratic constraints.

## **4.2            Contribution of SMC to the National Family Planning Program**

### **4.2.1        SMC Contribution to Contraceptive Prevalence**

The SMC has consistently played a significant role in the national family planning program, in terms both of its contribution to contraceptive prevalence and to CYPs. In both 1981 and 1988, the SMC was estimated to have provided 18 percent of the active users and CYPs, although this percentage fluctuated during the intervening years, falling to as low as 13 percent in 1985. The SMC played a smaller role during this period than did the national program (which fell from 71 to 58 percent) or the NGOs (which rose from 11 to 24 percent). SMC's contribution to CYPs must be reviewed in the context of its role, which is to provide temporary methods and which translate into lower CYPs than do the VS and IUDs offered through the government and, in some cases, NGO programs (see Table 8 on next page).

According to two Contraceptive Prevalence Surveys (1986 and 1989), the SMC had a significant market share of all condoms sold in Bangladesh: Its brands (Raja, Panther, and Majestic) represented nearly three-quarters of all condoms sold in 1986, dropping in 1989 to about three-fifths. Its market share of oral contraceptives was less substantial but was nonetheless important: Its brands (Maya and Ovacon) represented about one-quarter of all pills sold in 1986, dropping to one-fifth in 1989 (see Table 9 on next page). Interestingly, the upper end of the SMC product line (Majestic) was much less subject to erosion of market share than were Raja and Panther. This suggests some market segmentation based on price, with competition from the government program commodities at the lower end of the product line.

Table 8

**Active Users/Couple Years of Protection  
Attributable to Provider  
1981-1985\* and 1986-1988\*\***

Percent of Users/CYPs by Provider				
Year	BDG	SMC	NGOs	Total
1981	71	18	11	100
1982	70	17	13	100
1983	65	16	19	100
1984	65	14	22	100
1985	65	13	25	100
1986	65	14	21	100
1987	65	14	22	100
1988	58	18	24	100

\* USAID Mission, Dhaka, Bangladesh.

\*\* Population Sector Review Team, February 1990.

Note: Active users were converted into CYPs, by the Population Sector Review Team.

Table 9

**SMC Share of Orals and Condoms Used by Bangladesh Acceptors  
Percent of Current Users  
with Verified Brand**

Pills	1986	1989
Maya	15.5	6.1
Ovacon	<u>10.1</u>	<u>14.6</u>
Total Pill Share	25.6	20.7
Condoms	1986	1989
Raja	50.9	41.3
Panther	12.5	9.5
Majestic	<u>9.5</u>	<u>9.4</u>
Total Condom Share	72.9	60.2

Source: Contraceptive Prevalence Surveys for 1986 and 1989.

The erosion in market share noted for 1989 appears to have continued through the first six months of 1990, according to data on monthly sales to stockists and retailers for 1990 provided by the SMC (see Table 10). Raja sales had dropped by half between January and June, and drops in Panther, Maya and Ovacon sales were nearly as great. In spite of diminished sales to retailers and stockists, the SMC provided a potential 700,000 CYP during the first six months of 1990.<sup>17</sup> Nonetheless, it is evident that the SMC must regain momentum if it is to reestablish its market share.

<sup>17</sup>USAID and SMC calculated the CYPs, using standard international conversion factors.

Table 10

## SMC Contraceptive Sales to Stockists and Retailers, First Six Months of 1990

Number Sold				
	Pieces		Cycles	
1990	Raja (000)	Panther (000)	Maya (000)	Ovacon (000)
January	10,846	930	269	453
February	13,482	794	335	378
March	—*	—*	—*	—*
April	4,937	416	330	263
May	6,390	625	247	390
June	5,277	555	166	262

Source: SMC monthly data on sales to stockists and retailers.

\*No sales to stockists and retailers in March to allow them to draw on inventories.

The drop in the SMC market share in 1989 and in actual sales in 1990 reflects the program's inactivity when negotiations between USAID and the BDG were stalemated. (Information for the 1989 CPS was gathered between March and August 1990, when program activities were at a low.) The steep decline in actual sales in April reflects a second factor: a 40 percent increase in the recommended retail prices for SMC products in April 1990. Significantly, this decline was followed by a slight recovery in May. Sales have continued to fluctuate and likely will take months to stabilize.

The recent fall in the SMC's contribution to national pill and condom sales must be viewed in the longer-term context of the vast increases in numbers of contraceptors and the success of the SMC in meeting the challenge of supplying these new users. The number of contraceptors doubled between 1983 and 1989, from 3.6 million in 1983 to 7.1 million in 1989. To keep pace with this increase, sales of SMC pills have quadrupled (99,000 married women using SMC branded oral contraceptives in 1986 to 406,200 in 1989) and couples using SMC condoms have grown by about 43 percent (from 280,500 in 1986 to 402,500 in 1989). Likewise, the contribution to the national CPR of both program orals and condoms showed an increase during this period. Prevalence traceable to SMC pills increased from .6 percent to 1.9 percent, contributing to the national increase of prevalence due to pills from 3.3 percent to 9 percent. The increased prevalence due to condoms was less impressive — from 2.7 percent CPR due to condoms in 1983 to 3.1 percent in 1989, with SMC condoms, whose share rose from 1.7 percent to 1.9 percent, contributing about half (see Table 11 on next page).

Table 11

**Estimates of the Family Planning Target Population, Current Contraceptors,  
and Users of Selected Methods and Supply Channels**

	1983	1986	1989
Women aged 15-49 <sup>1</sup>	20,428.4	22,748.0	27,617.5
% of above currently married <sup>2</sup>	80.8	78.3	78.1
Currently married women 15-49 <sup>3</sup>	16,502.1	17,819.5	21,569.3
Contraceptive Prevalence Rate (% of above using contraceptives)	21.7	29.8	32.8
Number of contraceptors	3,580.9	5,310.2	7,074.7
<b>Contraceptive Prevalence Rate According to Method (orals and condoms)</b>			
Oral contraceptives <sup>4</sup>	3.3	5.1	9.1
SMC brands	0.6	1.3	1.9
Other brands	2.7	3.8	7.2
Condoms <sup>4</sup>	2.7	4.0	3.1
SMC brands	1.7	1.1	1.9
Other brands	1.0	2.9	1.2
<b>Methods and Supply Source Used Expressed as Number of Married Women</b>			
Oral Contraceptives <sup>4,5</sup>	544.6	908.8	1,962.8
SMC brands	99.0	231.7	406.3
Other brands	445.6	677.1	1,556.5
Condoms <sup>4,5</sup>	445.6	712.8	668.6
SMC brands	280.5	516.8	402.5
Other brands	165.0	196.0	266.1

<sup>1</sup>USAID population (in 000s) projections based on Bangladesh Bureau of Statistics adjusted totals of the 1981 census.

<sup>2</sup>1983, 1986, and 1989 Contraceptive Prevalence Surveys.

<sup>3</sup>Sum of use rates for condoms and vasectomies reported by husbands in the CPS couple samples and use rates reported by females from the principal samples of the CPSs.

<sup>4</sup>The CPSs asked current users of pills and condoms to show the interviewers a sample. If none was available, the interviewers displayed samples of all brands obtainable in Bangladesh and asked women which one they used.

<sup>5</sup>Condom use rates from husband's reports, but the percentage of condom users who use SMC brands are as reported by women in the principal sample who said their husbands are currently using condoms.

In short, the fall in the SMC's market share is not surprising, viewed in the context of the overall growth in numbers of contraceptors. Moreover, both the government and NGOs have been stepping up their efforts to expand pill distribution in the public sector, cutting into SMC's share of a *bigger* market, and cut by about 25 percent the market share served by all commercial non-SMC brands. Moreover, the BDG, the NGOs, and the SMC are in reality partners, not competitors, in the overall effort to increase prevalence. Thus, the increase in market share by the BDG and NGOs should be viewed as a healthy development, and not reflect negatively on the SMC program.

**Conclusions.** The SMC has been and should continue to be a major contributor to the success achieved in the Bangladesh family planning program. The protection provided by the contraceptives distributed is the success indicator easiest to measure. Less measurable contributions also have contributed to increased prevalence. For example, the impact on prevalence resulting from the SMC generic family planning promotional campaigns (including the only campaigns targeted at males) cannot be measured, but it can be inferred: Significant rises in contraceptive knowledge occurred during the period that SMC was engaged in its extensive and intensive family planning mass media information program, no doubt the largest such effort in Bangladesh experience. Likewise, although it is not possible to draw a direct measurable relationship between availability and prevalence, the access and perceived access represented by the huge volume of SMC contraceptives moving through the program's extended distribution network contributes substantially to effective and continuing use by providing an emergency backup source to government and NGO sources when their supplies are disrupted. For example, the SMC backup may mean the difference between a successful long-term user and an unwanted pregnancy when the FWA is late with resupply. In addition, the SMC pricing and merchandising of family planning commodities has made them affordable and economically valuable to a segment of the general population which might intentionally avoid using BDG outlets and which might have no easy access to NGO services.

#### 4.2.2 SMC Contribution to ORS Sales

In addition to the contraceptive commodities it distributes, the SMC is also active in the area of child survival through the non-subsidized distribution of Orsaline, the branded ORS packet. Data from the Diarrhea Morbidity and Treatment Survey, a comprehensive nationwide study carried out in 1987-1988, showed that about 20 percent of children who were treated for diarrhea with ORT received the SMC Orsaline product, the largest market share of commercially sold ORS. Table 12 shows ORS sales during the first half of 1990.

Although the ORS volume was impressive, because of disruptions in operations it fell far short of the volume SMC expected to distribute. SMC management states it expects to increase sales five times above current levels when its current educational programs and promotion campaigns take effect. How it will do this unclear, since local production already is below amounts needed, and the BDG gets first priority on available ORS supplies for its outlets.

Table 12

#### SMC Sales of ORS to Retailers and Stockists, First Six Months of 1990

Month	Packets
January	329,960
February	459,200
March	353,640
April	367,170
May	1,109,340
June	648,000
<b>Total</b>	<b>3,267,370</b>

## **4.3 SMC Research**

### **4.3.1 Research Topics**

All social marketing projects use commercial marketing techniques to promote and deliver their products. Market research can help identify strategies in any number of areas.<sup>18</sup> The 11 major studies undertaken by the SMC to date, however, and the 4 planned suggest that more innovative approaches could have been used which would have been more useful for future project planning. Studies have focused on existing products (e.g., the Panther and the Majestic condoms) and have also included two baseline studies (one completed and one planned). These studies have served primarily to assist the SMC in problem solving and monitoring performance. For example, they have helped guide the project in the areas of packaging, pricing, scheduling advertising, and modifying message content and delivery in advertising campaigns. Although these are all useful contributions, at this point the SMC's current products have a solid share of the market and the products themselves do not need additional research unless there is a major change in use patterns that requires investigation. Similarly, little investment needs be made for yet more baseline data. A broadened approach to research could have identified unsuspected constraints to market expansion (e.g., price) or new approaches to service delivery (e.g., community-based sales — see Appendix H for further information on the SMC research activities).

One area that has been rightly overlooked has been the monitoring of SMC cost effectiveness, a topic recommended in the 1986 evaluation report. Although a cost study of the overall family planning program is in process, the SMC has not produced any related analysis and it is questionable whether it should. The proposed methodology of using prevalence rates (from surveys) divided by total expenditures is extremely crude, useful only in a comparative analysis (which is not being done by other service delivery approaches), and is subject to a wide variety of biases having nothing to do with the SMC (e.g., government pricing policies). If cost effectiveness studies are appropriate, they should be done externally for all sectors of the service delivery program.

### **4.3.2 Research Methodologies**

The main research technique employed by the SMC has been the use of survey techniques, including mini-surveys, intercept surveys, household surveys, retail audits, and qualitative in-depth interviews. The project, however, has done very little qualitative research of the sort used widely in the commercial market research sector that depends on such techniques as focus groups, observation, in-depth interviews and case studies.

### **4.3.3 Private and In-House Research Capabilities**

In conducting its research activities, the SMC has relied primarily on a variety of private external data collection organizations, although it also maintains a limited in-house capability to collect and utilize data.

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<sup>18</sup>Marketing research is used to identify market needs, pricing structures, demand creation strategies, packaging, product substitution effect (new vs. substituting consumption), market segmenting and targeting strategies, market preparation, market penetration, media preferences, advertising approaches, and educational efforts required to ensure demand and utilization of the product.

Its efforts to recruit private sector research organizations have been very fruitful. Mitra and Associates, PIACT-Bangladesh, Market Research Consultants of Bangladesh, and Research Services Limited have all undertaken research contracts for SMC. The benefits of this approach are many: It widens capability to do research; increases private sector involvement in what traditionally has been an area of intense government involvement; can reduce staff and overhead for the SMC; allows the SMC to benefit from the broad range of experiences of these firms; and ensures use of a wider variety of data collection methodologies.

On the negative side, some studies may be more expensive if done outside the SMC, the SMC cannot always control scheduling of studies, and quality control can be more difficult for the SMC if it is not managing fieldwork. On the whole, the SMC has benefitted from the use of outside research firms. Use of these firms represents a real contribution to private sector initiatives being made by A.I.D. and USAID. The development of a broad base of research firms also should ensure sustainability of quality services available to the public, quasi-public, and private sectors.

The SMC also has maintained some in-house research capacity for small or *ad hoc* studies, but suffers from having no in-house research director, a position vacant for over a year, and no overall research strategy or plan. Its in-house capability increases flexibility, helps keep research skills current, and provides the opportunity to do quality control checks on externally implemented studies. The strategy of maintaining limited in-house capability while relying on the private sector for most research services is a good one for the SMC now and for the foreseeable future; however, the SMC should develop its own research strategy and mechanisms to achieve that strategy through its own efforts or through accessing other research vehicles such as the CPS.

Recent SMC studies reflect need for improvement in the areas of analytical reasoning, computer processing, qualitative research methods, computer assisted analysis, data presentation and report writing. USAID may wish to facilitate their development, possibly through requesting centrally funded private sector development resources.

#### **4.3.4 Use of Research Efforts of Others**

Another issue is the SMC's tendency not to use the research efforts of others. Bangladesh has an unusually large quantity of country-wide family planning research that SMC and other research organizations could monitor. SMC has used data from the recurring CPSs, but more data could be collected if SMC had more input in the design of the questionnaire. Similarly, the Bangladesh Fertility Survey apparently had no inputs from SMC. Likewise, the ICDDR,B Extension Project could provide useful research data to SMC at minimal cost. As the most non-traditional source of family planning services, the SMC would profit if it were more aggressive in seeking externally supplied information to enable it to maintain its hard-won edge as a major source of contraceptive supplies.

#### **4.3.5 Utilization of Research Results**

SMC has made very little effort to assure maximum dissemination and utilization of the results of its research. SMC studies are done for and by SMC for its own planning purposes. The SMC's documentation consists mainly of tabulations and limited analysis for internal consumption. A notable exception to this process was the Diarrheal Morbidity and Treatment Survey Report, which was done with support from Johns Hopkins University. Although this internalized approach meets the SMC's needs, it fails to serve the wider audience of the BDG, USAID, donors

and the international family planning community. The lack of documentation also makes it difficult to evaluate the quality of the data or the effectiveness of the utilization.

More extensive documentation would ensure maximum utilization both inside and outside the country. It would allow peer review, which would give greater credibility to the research results, increase recognition of the social marketing program, and facilitate historical and trend analysis. SMC should make greater efforts to put research findings in report formats, produce a larger number of copies, distribute the reports widely within Bangladesh and internationally, and promote secondary analysis by others.

#### **4.4 Community-Based Sales**

At the request of USAID, SMC is developing a community-based sales (CBS) program to use women sales agents in rural areas to sell oral contraceptives door-to-door or to make sales from their homes (a depot system). The program was getting under way at the time of the evaluation, with the first group of agents having been trained in September 1990. This effort is being implemented as a pilot activity designed to resolve a number of questions about the feasibility of this approach, rather than as a major new service delivery strategy.

The CBS program is a variation of the standard CBD schemes used worldwide, the only difference being the focus on profit/cost recovery as a factor in motivation. Standard CBD efforts are in the hands of volunteers who are not motivated by profit whereas CBS relies on women distributors who receive proceeds from the sales. In this CBS program, the sales agents will also distribute ORS and provide the counseling necessary for its appropriate use.

Although USAID has launched the CBS program as a pilot effort, no formal set of questions has yet been drawn up defining the issues that need answering before it is expanded into a national program. At this point, the purpose is to test generally whether prevalence can be raised using commercial methods in rural areas where women have less mobility and are accessible only to other women and where prevalence is still low. It is also assumed that, like other CBD programs, CBS will have a role in improving effectiveness of contraceptive use because community-based agents, by virtue of their status in the community and their recurring contacts with clients, have motivational and educational opportunities not generally available to retail or clinical service delivery approaches.

As a mechanism for contraceptive distribution, there is little reason to doubt that CBS will be successful. International CBD experience repeatedly has demonstrated the effectiveness of the concept, as a means both to increasing the use of contraception and to increasing availability of contraceptives. International experience has also shown that this approach is particularly effective when alternative sources of family planning services are not available or available only at great cost (time, expense, social perceptions, family attitudes). It is likely that, in Bangladesh, this approach will enjoy high levels of community satisfaction and that volunteers will continue to serve for several years. That, at least, appears to have been the experience to date in a similar approach — the Urban Volunteer Project (a separate USAID-funded project) which uses volunteers to motivate women for family planning and distribute ORS. (That project has not yet been evaluated.)

USAID understands that the conclusions above do not represent adequate grounds on which to launch a national effort and has contracted with PSI to develop an implementation plan and monitoring scheme that will meet its own and SMC's informational needs with regard to program

expansion. A number of issues that warrant further exploration are suggested below. It is possible to offer an opinion on some, but most will need further study and clarification.

- **Cost Effectiveness**

Would CBS outputs justify the operating costs (cost effectiveness)? Since no data have been generated for CBS in Bangladesh, it is impossible at this point to judge; however, comment based on international experience suggests they would not. CBD programs generally are found to be an expensive way to deliver services. Although distribution labor costs are low, the costs for management, recruitment, training, retraining, supervision, record keeping, and resupply/distribution quickly add up. This increases the cost per unit output for what is already generally the low level of productivity associated with CBD-type agents.

For example, in the CBS activity, in order to generate 10 CYPs from oral contraceptives per month, the volunteer will have to sell 130 cycles per month. To sell 130 cycles, she will have to make 45 sales of three cycles per sale (or 130 sales of one cycle). In order to make that many sales at current prevalence levels, unless serving as a depot holder proves to be effective, she may have to visit 450 households per month or 22 per day — hardly a part-time job. As her route gets established, she eventually should need fewer visits to generate the same sales, and these visits may also generate outputs in condoms and ORS sales. The point remains that international experience has shown that single-purpose CBD agents rarely or ever are an inexpensive or cost-effective approach to reducing national level fertility. CBD schemes usually are an interim measure until other more cost-effective approaches can be developed.

- **Effectiveness in Adding to Prevalence**

Will CBS generate new prevalence or merely provide an alternate source of supply? There will be no final answer to this question until project experience provides them. It is likely, however, that CBS will be more effective in adding to prevalence in rural areas than in urban ones. In the above example, for instance, making the numbers of contacts required would certainly be easier in urban areas of high population density, but it is unlikely that urban-based CBS would result in significant net gains in contraceptive prevalence due to the existence of other kinds of services. On the other hand, in low prevalence rural areas where services from NGO, government or commercial sources are not easily available or accessible, CBS efforts are more likely to generate new prevalence, but at significantly greater cost because of the less densely populated nature of these rural areas.

- **Economic Feasibility**

Do clients have the financial resources on hand to make purchases during random contacts? Or will some of these low prevalence areas be unwilling or economically unable to participate in fee-for-service family planning?

- **Mobility of Women**

Can women move around enough to have a "sales route" in Bangladesh? Alternatively, if the depot holder concept is implemented, will potential clients be able to avail themselves of the services? Or will local custom restrain movement of providers or clients to the extent that CBS does not represent a major improvement in either access or availability?

- **Reliance on Unsalaried Sales Agents**

Although it is assumed that using village-based sales agents will allow for excellent communication with rural women, other aspects of their involvement raise questions. For example, what is the optimum level of supervision for these women to achieve maximum outputs? How long will they hold their positions and what structures for recruitment and training are optimal? What effective system for clinical referrals can be developed, and will the agents make appropriate clinical referrals when they may lose income as a result?

- **Effect on Larger SMC system**

Although the SMC is the logical site for the CBS program, more thought should be given to how adding this activity will affect the larger operation. For example, can SMC manage the additional logistics burden without damaging the outlet distribution system? What will be the effect of CBS on retail sales and retailers' attitudes toward the SMC? How does CBS affect service delivery activities when it overlaps other program areas?

## **4.5 Sustainability**

### **4.5.1 Financial Sustainability**

At the macro-level, donors, A.I.D. in particular, are increasingly looking for ways to reach long-term sustainability of population projects. In Bangladesh, the prospects that local resources can cover some of the costs of providing services now covered by international funding sources are particularly slim. Moreover, even if funding levels were to remain stable (not a given), increasing demand will result in the projected contraceptive commodity requirements outstripping funding levels in the next five years.

The SMC, particularly now that it has been privatized, would appear to be able to recoup an increasing amount of its costs. There is, however, a serious question whether the program can do this and still maintain or increase contraceptive prevalence. A.I.D. has challenged the SMC to increase its cost recovery of operating costs from 20 to 40 percent and of its total costs (commodities plus operating costs) to 20 percent from 10 percent by the end of the project period. The expectation that the SMC can accomplish this appears reasonable as long as it continues to receive subsidized branded condoms.

Options for increasing cost recovery include increasing prices of contraceptives and adding other, more lucrative, product lines. Neither option, however, is very promising in the resource-poor environment of Bangladesh if SMC is to continue to be an important contributor to the family planning effort in that country.

The experience with price hikes to date is that, after temporary declines, sales have gradually returned to former levels at rates depending on the size of the price hike. Unknown is whether, when not purchasing SMC contraceptives, users shift to other sources or whether they simply stop using any method, risking an unwanted pregnancy. Given the low levels of income of most Bangladeshis, this second possibility may well be the case. If, however, the SMC were to increase prices more substantially than it has to date (with purchased commodities sold at cost plus

overhead and fee), the company would achieve financial sustainability but its products would be too expensive for most Bangladeshis and overall sales would drop.

Adding new commercially viable product lines (hair oil? perfume?) is also a risky proposition as these more profitable products would, in all probability, distract management's sales and marketing staff from family planning. Local retailers, with their very limited access to finances to purchase stocks, might well select from the salesman those items that have the highest return and the highest turnover (non-family planning items). Likewise, the local distribution system has limited carrying capacity: When it comes time to select sales items for loading a small van, most salesmen likely would select high-profit, non-family planning product lines over bulky, low-profit condoms. The resulting loss of family planning focus of social marketing would unquestionably damage the quality of the national family planning program.

The prospect that the CBS program might be implemented on a wide-scale basis is a significant variable in this equation. No matter how much SMC improves cost recovery, it is unlikely that it could achieve expectations in the face of the very high costs of a CBS program.

#### **4.5.2 Technical Sustainability**

The SMC, on the other hand, has made strides in another area of sustainability — institutional or technical sustainability, which (as already stated in the chapter on the NGOs) refers to the ability of an institution to continue operations with little or no technical or institutional support. The SMC's success in this area is evident throughout its operations. It has developed human resources, having substantially increased activities, product lines and services (i.e., ORS, new contraceptive brands, CBS) with the use of increasing numbers of national, not external, staff. Its impressive distribution effort means that now there is in place a large cohort of trained distributors and distribution specialists.

Likewise, the social marketing model, consisting of developing a communications strategy, designing campaigns, targeting messages, and evaluating audience response, has been carried out by private sector research firms. Perhaps most important, its establishment as a private indigenous organization should provide new incentives for other donors to provide support. In short, it has contributed to the technical sustainability of family planning services by developing human resources, testing new models of operation, and developing better channels of communication.

Clearly, a number of the SMC's characteristics are not transferrable to the government or NGO family planning efforts, which are labor-intensive in nature, better equipped, and often obligated to deal with a wide range of methods. For example, as a commercially oriented organization, the SMC can operate with a lean personnel structure designed for efficiency; a sales line based on convenience, cost, and sales considerations; and the option of referring clients with side effects. On the other hand, the government and NGOs could learn much from the SMC's success in gaining technical sustainability. In particular, in the areas of communication and distribution, networks of SMC-trained individuals now exist that could be available to assist IEC and service delivery components of the NGOs and commercial and government sectors. Over time, these could help these programs also make progress toward technical sustainability.

### **4.5.3 Prospective Loss of Subsidized Condoms**

Although SMC should be able to achieve modest levels of cost recovery, its ability to achieve USAID's goals of doubling recovery of both operating and total costs presupposes it will continue to receive subsidized branded condoms. Whether these subsidies will continue to be available is now becoming an issue. SMC has been operating since its inception with USAID-provided contraceptives, sold at prices far below both international costs and even further below the U.S. purchase price. USAID will provide pills to SMC until 1995, but current plans are for the last USAID condoms to be purchased in 1990 (1991 delivery).<sup>19</sup> Alternative sources to meet the multi-million dollar annual condom requirements have been painstakingly explored. Recent discussions with the World Bank, its co-financiers, and the European Economic Community (EEC) have resulted in a strong proposal from the EEC and the Norwegian Agency for Development Cooperation (NORAD) that they fund all future condoms for the SMC (and possibly for the BDG and NGO programs as well). The mission anticipates a positive decision in this regard. Even if other donors materialize, the volume is becoming too large for any multilateral donor to manage, and the SMC's private sector status makes bilaterally funded commodity purchases (which by their nature are government-to-government) unlikely.

The loss of subsidized, branded condoms could lead to the collapse of the SMC, to diminution of the success of the family planning program in Bangladesh, and to erosion in the rate of contraceptive prevalence in the country. To avert these consequences, subsidies to the SMC in the form of branded commodities will be essential for at least the next five years and likely for the rest of the century.

At the same time, SMC should consider a gradual phasing down of condom sales over the next few years. Condoms are the most expensive of methods at U.S. cost levels (and therefore require the greatest cost subsidy) while providing the least protection in terms of CYPs. Pills, on the other hand, are more effective and less costly (an argument *for* CBS, which sells only orals) and the SMC could focus future marketing efforts on encouraging customers to shift to this method. Also, commercial marketing efforts aimed at increasing the sales volume of contraceptives (orals) might be helpful. This could be done through increased advertising or greater profit margins for salesmen and retailers.

Given the importance of the SMC to the overall national family program in Bangladesh, the prospect of its demise requires urgent action. The first recommendation below is one of three recommendations in this report that should be acted upon forthwith (see Section 5.6 for the other two).

#### **Recommendations**

- 1. USAID should continue to negotiate with the EEC and other donors to ensure a plan for continued provision of subsidized, branded condoms to the SMC beyond 1992. If these negotiations do not bear fruit, USAID should make contingency plans to provide them beyond 1992.**

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<sup>19</sup>Since departure of the Evaluation Team, the mission decided to make one more condom buy in FY 1991.

2. **USAID** should encourage a gradual SMC market shift from condoms to more effective, less costly methods such as orals.
3. **USAID** should help SMC review its warehousing system, with the objective of identifying possible efficiencies in operations (see Section 5.4 below for background on this recommendation). (Note: also recommended in 1986 Evaluation.)

### **Research**

4. **USAID** should encourage cooperation in research development between all USAID-supported organizations, including the SMC, in order to achieve the maximum use from the outputs of each group's efforts.
5. The SMC should focus research efforts on new, not existing, products and attempt to coordinate with other research efforts to obtain data on current products and baseline uses.
6. The SMC's policy of using private sector research firms should be continued.
7. **USAID** and the SMC should obtain market research technical assistance to allow for development of an overall research strategy and plan for product research.
8. **USAID** should support the development of qualitative research methods for use by the SMC, and, where appropriate, with other research organizations with which it deals.
9. The SMC should document and disseminate research procedures, findings, and implications, and should archive the computer data files for use by others.

## 5. Commodities and Logistics

### 5.1 Background

#### 5.1.1 Overview

Since 1984, USAID has been providing technical assistance to the BDG in contraceptive logistics management. The prime purpose of these efforts has been to keep contraceptive supplies (of which A.I.D.-procured commodities represent the largest proportion) moving through the government's vast administrative network of over 2,500 outlets which provide family planning services, as well as to NGOs supported by USAID.

Despite massive inputs of technical assistance, the system still does not function as it should, with stockouts common and supplies insufficient in both government and NGO facilities. As of 1988, incremental improvements in the efficiency of the MOHFW logistics system were noted, but these were erratic and unsustainable.<sup>20</sup> USAID, other donors, NGOs and BDG officials agree that the system has improved considerably since then. Nonetheless, serious problems remain.

#### 5.1.2 Commodities

Among all the donors, USAID has been the major supplier of contraceptive commodities. Currently, USAID provides all the condoms that are being distributed in Bangladesh through the MOHFW and the SMC, all the oral contraceptives for the SMC, all Norplant® for clinical trials, and all IUDs and catgut needs of the MOHFW and NGO programs. Oral contraceptives and injectables for the BDG and NGOs are provided by other donors.

During 1989, the average monthly consumption by the BDG/NGO program was 6.5 million condoms, 1.6 million cycles of oral pills, 31,000 IUDs, and 50,000 doses of injectables. Of this total, in the year between July 1988 and June 1989, the consumption reported by NGOs in the MIS was 27.6 million condoms (about 2.3 million a month or about 35 percent of the total BDG/NGO consumption), 5.5 million cycles of oral pills (458,000 a month or about 29 percent of the total government/NGO consumption), 14,000 IUDs (about 1,167 a month or only 3.8 percent of the total) and 159,800 doses of injectables (13,250 a month or 27 percent of the total government/NGO consumption). For SMC, the total 1989 figures were 119.3 million condoms and 6 million OC cycles. Compared to the government program, the SMC was therefore consuming more condoms per month than the government/NGO program — about 10 million compared with 6.5 million — and about one-third the number of pills — about 500,000 million cycles compared with 1.6 million cycles by the government/NGO program. In addition to contraceptive commodities, the system is also responsible for the distribution of umbrellas (to protect field workers from the elements) and various kits, IEC materials and other family planning-related articles.

Since the national family planning began, commodity requirements and their associated costs have steadily escalated and all projections forecast tremendous increases in need for commodities and for sobering increases in costs. These projections include BDG forecasts of its

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<sup>20</sup>The 1988 National Physical Inventory Executive Summary.

future 10-year contraceptive needs (using computer projections coordinated by USAID) and two donor projections, also for the remainder of the century.<sup>21</sup>

### 5.1.3 USAID Technical Assistance

#### Early Phases

Recognizing that family planning program success requires an adequate and uninterrupted supply of commodities, USAID has long made provision of contraceptive commodities, together with technical assistance in logistics, an important part of its family planning assistance.

In 1976, with USAID support, the MOHFW published the first Supply Manual for the Logistics Unit of the Directorate of Family Planning (DFP). As demand for contraceptives increased, so did the need for strengthening the logistics unit of the DFP. Since 1984, USAID has been providing technical assistance in logistics management to the MOHFW in coordination with UNFPA and other donors.

From 1984 to 1988, this technical assistance was carried out by USAID's Logistics Management Advisor and local staff. The Advisor developed and supervised storekeeper training. He also organized three annual National Physical Inventories (NPI) of contraceptives, surgical equipment, drugs and MCH materials.

#### FPLM Subproject

Since September 1988, USAID has been providing expanded logistics technical assistance to the MOHFW, NGOs and the SMC, through a buy-in to the centrally funded Family Planning Logistics Management (FPLM) project with John Snow, Inc. (JSI). The objectives of the Bangladesh Commodities and Logistics subproject are

- to assist USAID manage its direct family planning commodity procurement activities under the FPHSP and carry out its mandated responsibilities for monitoring the distribution and utilization of A.I.D.-supplied commodities in Bangladesh;

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<sup>21</sup>Major commodity donors recognize USAID's leadership in forecasting of contraceptive needs. In November 1989, the Family Planning Logistics Management (FPLM) project conducted a Commodity Projection Workshop for USAID which included the BDG, NGOs and all major donors. Commodity projections and costs for the years 1991-1995 were developed. For the workshop, the John Snow, Inc. (JSI) Cocoplan Model was used. This is a Lotus-based program designed to estimate, under different scenarios, the amounts and costs of family planning commodities a program will require to reach a specific level of contraceptive use. Calculations from this model can serve as a catalyst to discussion of other logistics management issues. Another advantage to USAID is that the model will provide quick estimates of commodities required by year for up to 10 years, one of the inputs required to prepare the Contraceptive Procurement Tables. Using another JSI program (NEWCPT), the Family Planning Logistics Management (FPLM) project can prepare these tables, the shipping schedule, and the budget required per budgeting period specific for USAID-funded contraceptives. At the field level, the NGOs have not yet been fully integrated into the system for projecting contraceptive requirements. Rather, projection of contraceptive needs initially are performed by each CA for all NGO projects based on the performance of the last year. There is no standardization of projection methodology. FPAB aggregates the projections of the CAs it assists and send these to FPLM, which reviews, revises, and folds them into the total MOHFW projections.

- to continue strengthening existing systems and procedures of MOHFW, SMC and the NGOs in family planning commodities management;
- to institutionalize capabilities in commodity management within these organizations through continued provision of in-country training and limited third-country participant training; and
- to continue development of the national family planning Logistics Management Information System (LMIS) as the most important tool for monitoring and managing commodity flow to the peripheral levels of the service delivery system.

FPLM<sup>22</sup> assistance to the national family planning program includes the services of an expatriate logistics management advisor and expatriate training advisor, funds to support two local LMIS specialists, support staff, and office and transportation equipment.

#### **5.1.4 Role of Other Donors**

With respect to commodities, in 1990, the World Bank began to fund BDG and NGO program condoms and to supplement other donors' supplies of oral pills and injectables. Meanwhile, USAID has begun to phase out its support: 1989 was the Agency's last year of funding for condoms for the BDG and NGO program, and, as pointed out in Section 4.3.7 above, it currently plans no additional funding for SMC condoms after FY 1991 (1992 delivery). As also indicated above, however, most likely the World Bank, its co-financiers, and the EEC will fund all future condoms for at least the SMC and possibly for the BDG and NGO programs as well.

Other donors are also providing support for the logistics system. UNFPA, together with CIDA, has been supporting a Logistics Advisor to the DFP and a team of monitors for the family planning program (see Section 5.2.5 below). The GTZ provides support for logistics training.

## **5.2 The MOHFW Program**

### **5.2.1 Functioning of the Distribution System**

In spite of massive inputs of commodities and technical assistance, the BDG contraceptive logistics and supply system fails to maintain sufficient or reasonable stock levels at distribution points under the Division level. This failure violates the MOHFW's own policies, which require maintaining a three-month contraceptive commodity pipeline at all Division and below supply points, including those of the NGOs.

The 1988 NPI indicated that over 25 percent of FWAs were out of oral pill stocks and over 30 percent out of condoms, evidence of an inadequate logistics system. Despite the assistance provided by USAID, in late 1989 the MOHFW was still reporting sporadic insufficient quantities of contraceptives in field stations and problems in the logistic system. Most problems appeared to stem from insufficient MOHFW managerial experience and poor coordination of resources.

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<sup>22</sup>Throughout the rest of this discussion, unless otherwise indicated, "FPLM" will refer to the Bangladesh activity.

## **5.2.2 Distribution System**

The problems described above do not have their origin in the initial shipments of contraceptives. Sufficient quantities of contraceptive commodities are arriving in country (at Chittagong port) on time. Here, they are divided into five equal allotments (one for each of the country's four Divisions and one for the NGOs), four of which are shipped to the Dhaka Central Warehouse, where the problems begin. The warehouse's job is to distribute the commodities among the two other Regional Warehouses and to the NGOs. These amounts are theoretically based on reports on contraceptive use reported by field-level service providers through the government's Management Information System (MIS). The MIS, however, which reports consumption of commodities based on service statistics, has information that tends to be out of date and inaccurate (underreporting the amounts of commodities distributed) and therefore the allocations it makes may not be fully in line with the needs. The 17 District Reserve Stores (DRS) which provide supplies for further distribution throughout the system rely on a different set of information, using indents (requisitions) that are based on contraceptives actually distributed.

## **5.2.3 Management Information Systems**

In addition to the MIS, the distribution system uses a second management information systems — the FPLM-supported LMIS — which depends upon different contraceptive logistics data. Data from the MIS and the LMIS are not comparable: The LMIS consistently reports different amounts of contraceptives needed and distributed than does the MIS. These conflicting sets of data result in considerable confusion among Central Warehouse staff during the monthly forecasting of quantities to be distributed to lower levels. Indeed, people in the field believe that the problems they encounter with low stock levels are due to the confusion these conflicting reports bring to the managers of the program (see Appendix I for a detailed description).

Recently, UNFPA proposed the merger (or link) of the LMIS and the MIS. It is not clear to the MOHFW, FPLM, the UNFPA Logistics Advisor, nor USAID what "merge" means. Any such merger would be premature, however, until actual information needs are agreed upon and a complete assessment of both information systems is done. Arrangements are under way to acquire services of an MIS specialist to evaluate the information needs of MOHFW and the donors, and to recommend how these needs best could be met by one, both, or a combination of the two systems, or by a different management information system.

## **5.2.4 Training**

Since the inception of the FPLM Logistics Management Training Program in 1989, 2,850 MOHFW staff members have been trained in the Divisions of Khulna and Rajshahi; currently training is taking place in Chittagong. Reaction to these training activities by participants has been very favorable. There is a general consensus among government officials and donors interviewed that the training has improved job performance, including compliance to reporting requirements.

Training is coordinated with the National Institute for Population Research and Training (NIPORT) to assure government concurrence and participation. Problems have arisen, however, relating to delays in training activities that were scheduled to have been conducted at NIPORT. NIPORT was established in 1976 to serve as a training center to provide training for family planning managers. USAID had anticipated that it would eventually be institutionalized as the

center for training for logistics field personnel and logistics managers. At present the NIPORT Training Unit is fully staffed and funded by FPLM.

The problems began in 1986 when the BDG, for unexplained reasons, failed to honor commitments to provide a cadre of trainers to train logistics field staff in accordance with the terms of the FPLM Project. FPLM went ahead with plans for the training course, but in 1988-89, NIPORT refused to include the activities in its training calendar, pleading a full schedule, after which DFP unexpectedly canceled all training courses. This decision was later revoked, but it further delayed all the training activities. To this day, although donors continue to discuss with NIPORT the plan that the logistics management training should be incorporated in its activities, the actual training is still done by FPLM, with NIPORT concurrence.

### **5.2.5 Monitors**

The UNFPA-CIDA effort to support monitors has also run into difficulties. This initiative, spearheaded by the UNFPA Logistics Advisor, is designed to improve and institutionalize a monitoring unit capable of regularly inspecting the entire commodity distribution system. The responsibility would include verifying and updating MIS and LMIS data and identifying and correcting such problems as stock levels vs. desired inventory levels; warehousing procedures; distribution policies; and record keeping and preparation of reports. In addition to reporting problems in the system itself, the monitors are also expected to provide feedback to all training units that train family planning personnel on deficiencies and training needs. This effort has foundered due to lack of government cooperation. First, several times after the monitors were trained and functioning, they were transferred from their posts. More recently, UNFPA was informed that the MOHFW had decided to eliminate the monitoring positions. The current suspension of this program has serious implications for the MOHFW logistics program, considering the large number of facilities MOHFW has around the country.

### **5.2.6 Transport System**

The entire family planning program can be threatened by interruption of the transportation system; it is essential to have a healthy transportation system in place and a contingency plan for emergencies. The MOHFW lacks an experienced supervisor with skills to develop and implement an acceptable transportation plan for the MOHFW. UNFPA has provided vehicles to support the transportation system, but poor coordination and lack of adequate supervision has led to inadequate maintenance of the vehicles, deficient delivery schedules, and poor utilization of available transport space. In addition, there are lengthy bidding procedures to obtain replacement parts and unreasonable delays for funds disbursement. UNFPA's Logistics Advisor volunteered to provide technical assistance in this area, but was refused. The UNFPA Logistics Advisor is leaving his position in December, and UNFPA has no plans to replace him (see Appendix I for further details on USAID assistance to the government commodities and logistics system).

### **5.2.7 Warehousing**

Warehousing facilities are not adequate at all levels of the system, but efforts are under way to make necessary improvements. The World Bank is funding the construction of the Chittagong Family Planning Regional Warehouse; USAID agreed to fund the rental of the Chittagong Regional Warehouse facilities through February 1992, when the new facility should be

completed. To provide needed storage space and improve facilities in the *upazila* health complexes, USAID is funding the construction of approximately 200 free-standing storerooms, although construction problems are causing delays and may result in fewer being built.

### 5.3 Assistance to CAs and Non-Governmental Organizations

The erratic and insufficient supplies of commodities characteristic of the BDG system is even more acutely evident among NGO outlets. The three NGOs under discussion here (the Family Planning Association of Bangladesh [FPAB] and two other CAs it supplies, the Asia Foundation and the Pathfinder Fund)<sup>23</sup> report that the quantities of contraceptives they are supplied are insufficient, often even less than the amount that they should be receiving in accordance with the underestimates suggested by the MIS reports.<sup>24</sup> It is government policy to maintain a three-month reserve of stock at each distribution level and a one-month supply at the field worker level, but currently the Central Warehouse is supplying the NGOs on a month-to-month basis, and there are no reserve stocks at any level of the NGO system. Many NGOs are struggling to provide services to growing numbers of clients under the constraint of a month-to-month supply. When subgrantees run out of stock, they occasionally get "loans" from *upazila* storerooms or from other FPAB-assisted projects, and supposedly, reporting figures are adjusted accordingly to prevent double counting. These "loans" are repaid from subsequent supplies. Ideally, the FPAB head office should be able to increase allocations to the other NGOs if contraceptive performance and/or average monthly consumption warrant it, but in reality the limited stock levels and quantities received from the Central Warehouse determine the allocations.

The finding by Technical Assistance, Inc., NPI, and others, that the government is not supplying NGOs with sufficient amounts of contraceptives is validated by an examination of the level of their contribution to contraceptive prevalence. NGOs are receiving only one-fifth of the total amount of each shipment that arrives in country. In 1988, however, the NGOs were providing 24 percent of the total active users/CYPs while the government was providing 58 percent. Logically then, the NGOs should be eligible for an equivalent 40 percent of the contraceptives provided, not 20 percent. Moreover, as pointed out above, the NGO MIS indicated that NGO clients were consuming about 35 percent of the monthly BDG/NGO consumption of condoms, about 29 percent of the total government/NGO consumption of oral contraceptives, and about 27 percent of the total government/NGO consumption of injectables. In short, one-fifth is an arbitrary figure, not based on actual consumption figures.

The reason for the undersupply to the individual NGOs reflects the inadequate initial supply from the Central Warehouse for all NGOs. The Central Warehouse, however, claims that it is using MIS reports to provide supplies to FPAB and charges that the fault for the low supplies lies with the NGOs, because they have not kept up with reporting requirements. This is not relevant, since the Central Warehouse only theoretically uses the MIS data as the basis for its distribution to

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<sup>23</sup>The other CAs, AVSC, FPSTC and Concerned Women for Family Planning (CWFP), have worked out mechanisms to acquire their allotments directly from the Central Warehouse. One of the CAs funds a staff position within the Warehouse to track its allotments.

<sup>24</sup>These complaints have been substantiated by NPI findings and by an assessment of the NGO commodities distribution scheme conducted by a local firm, Technical Assistance, Inc.

the NGOs. Moreover, although the MIS system is not producing accurate figures (see Appendix I), it is likely that NGOs are using the system better than is the government.

#### **5.4 Assistance to the Social Marketing Company**

The cooperative agreement under which PSI provides assistance to the SMC includes provisions for technical assistance in transportation, distribution, repackaging, and adequate storage of contraceptives to maintain product quality. Currently, the SMC is distributing two brands of condoms, three brands of oral pills, and since 1985, a brand of oral rehydration salts (see Chapter 4). All condoms and oral contraceptives sold by SMC are provided through the central A.I.D. contraceptive procurement process. The prepackaged ORS is purchased locally at government-set non-subsidized prices.

SMC prepares sales projections for three to four years in advance to ensure an adequate supply of commodities. These projections are prepared regionally, based on past sales trends and are revised annually. Since the SMC does not distribute commodities on consignment, it can be assumed that stockists and stores are buying commodities to replace actual sales. The FPLM Chief of Party reviews, revises and consolidates these projections, prepares the shipping schedule and the PIO/Cs for A.I.D.-procured commodities, and keeps track of the shipments.

Contraceptive commodities arrive in Chittagong Port and, after completing port clearance, are transported to Dhaka for repackaging and storage. At current levels of distribution, the SMC Central Warehouse is packing for two months ahead. The SMC Central Warehouse supplies 16 Regional Offices using SMC or hiring private transport. The Regional Offices use commercial channels of distribution through wholesalers ("stockists"), but rely heavily on their own sales representatives for distribution to retailers. Stock-outs never occur at the regional level or above, and SMC has no difficulty maintaining stock levels requested (purchased) by stockists or retailers.

Major storage deficiencies were noted in the SMC Central Warehouse and the Regional Storerooms visited. Storage space was limited or distributed inadequately and basic storage procedures were not followed. It is PSI's responsibility to ensure that commodities are adequately stored and that warehousing procedures are followed to maintain the quality of the products.

The biggest logistics issue for the SMC is the projected reduction in A.I.D. condom procurements. This is fully described above, in Section 4.5.3.

#### **5.5 Continuation of USAID Logistics Management Assistance**

Improvement in logistics management is a necessary condition for continuing gains in an already impressive program. USAID especially, and other donors to a lesser extent, have invested great amounts of resources trying to assist the BDG to institutionalize capabilities in commodity management within the family planning program. Institutionalization of logistics activities within the BDG certainly is far from complete. Even BDG managerial staff realize that many government policies and procedures are restraining institutionalization of these activities. Indisputably, high quality technical assistance of the type provided by FPLM within the contraceptive logistics system is essential.

The FPLM cooperative agreement was scheduled to end September 30, 1990. Following months of discussion with the MOHFW, a PIL was submitted to the MOHFW in June seeking concurrence for an extension of activity from October 1, 1990, to September 30, 1995. The PIL provided for extended and increased support in logistics management activities, forecasting and MIS, transportation, procurement and quality control, and training of MOHFW personnel. In response to BDG requests, successive drafts of the PILs were necessary to significantly reduce the duration, scope and level of advisory effort. The PIL had not been signed one day before the deadline. Unless the scaled-back PIL was signed by September 30, 1990, or USAID received emergency funds from A.I.D. for an approximate additional four weeks activity, the FPLM office in Dhaka would close. The BDG was aware of this. In view of the lengthy and tedious process required to design, approve and begin a new activity, an extended hiatus and loss of momentum could be expected before establishing another commodities and logistics assistance project. This is yet one more example of unexplained BDG resistance to technical assistance in areas of known need.<sup>25</sup>

## 5.6 Issues

### 5.6.1 Underlying Causes of Problems and Solutions

This chapter has recorded many instances of inexplicable decisions that have directly and deleteriously affected contraceptive supply in the field. Examples have included unexplained refusal to use trainers of trainers for agreed upon purposes and failure to provide replacements, failure to provide training space and time at NIPORT, cancellation of agreed upon training courses (later reinstated), inability to establish a management information system useful for rational and timely management decision making, chronic undersupply of commodities to FPAB and other NGOs, and a two-year failure of the government to fill vacant positions essential for the smooth operation of the logistics system (i.e., mid-level logistics management positions at headquarters, district and some *upazila* warehouses).

None of these problems, however, can fully explain the persistent supply problems that are plaguing the distribution of commodities to BDG and NGO outlets. USAID and other donors have provided inputs that should have been sufficient for a much more efficient operation of the supply system, and the only plausible explanation is that the inputs have been misused, underused or sabotaged.

Correction of contraceptive supply problems must rest with the BDG. Over the past decade, the donors have been generous with assistance to improve the distributor system, but unless the BDG is willing to demand improvement, progress will continue to be painfully slow. At this point, the situation has reached crisis proportions and the need for immediate action is paramount. The first two recommendations below (together with the recommendation that USAID should assure continued provision of branded condoms to SMC beyond 1992 — see Section 4.5.3) require more urgent attention than any other recommendations in this report. The first reflects the project's experience that no donor singly has been able to engender an adequate government response to problems in the system; if it is to be implemented, however, this recommendation will require hard

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<sup>25</sup>The PIL was signed on October 31, 1990, and was retroactive to October 1, 1990. Central funds were made available to keep the FPLM office operational.

negotiations. The other recommendations below, although they represent necessary interim actions, will not cure the underlying problems in the system.

### **Recommendations**

- 1. USAID should organize and participate in an intensive, coordinated collaboration of donors and the BDG to insist that the MOHFW use all its available government- and donor-provided resources to implement its own policies of maintaining a three-month contraceptive commodity pipeline at all Division and below supply points, including those of the NGOs.**
- 2. USAID immediately should bring pressure to bear to the extent necessary to assure that the Central Warehouse provides and maintains the required stock levels for a three-month pipeline for the NGOs. Technical assistance to the Central Warehouse would include its accurate forecasting and allocation of commodities to meet NGO needs.**
- 3. The recent MOHFW decision to eliminate the logistics monitor positions that were being sponsored by UNFPA and CIDA should be addressed by USAID and other donors whose commodity supplies are disrupted by the loss of these positions. The donors should insist that the positions be maintained and new positions added so that from four to six monitors would be stationed at each Division and would report to the top family planning officials in each Division. The purpose should be to ensure that a reliable monitoring system is operating effectively.**
- 4. USAID/FPLM should increase logistics technical assistance to all CAs and serve as the official liaison between the NGOs and the Central Warehouse. Technical assistance to CAs should include areas such as standardization of FPAB logistics system with that of MOHFW, facilitating flow of information to the MIS and LMIS, warehousing, and participation in ongoing logistics management training activities.**
- 5. If the scheduled review of the MIS and the LMIS indicates the desirability of continuing the LMIS, BDG/FPLM should develop and implement a plan to institutionalize the LMIS within the BDG. BDG managers and decision-makers should be required to receive training in data analysis, report interpretation, planning and evaluation through the FPLM project.**
- 6. The current practice of the Chittagong Regional Warehouse of dividing each shipment of contraceptive commodities received into five equal allotments should be replaced by a method in which allocations to each Division and to the NGOs correspond to the calculated projections of need.**
- 7. Under conditions of massive real and BDG-imposed difficulties, USAID should consider seriously whether it or some other source should provide obviously necessary assistance in logistics management, but should be assured the BDG receives (and uses) it from some source.**
- 8. PSI should provide technical assistance to improve warehousing conditions and should consider relocating its inadequate warehouses to more adequate facilities.**

## 6. Research

## 6. Research

### 6.1 Overview

Like commodities and logistics, the research component has relevance to all three family planning service delivery channels. The project supports three major research activities:

- Contraceptive Prevalence Surveys are research-cum-evaluation studies which are the primary instruments for assessing overall performance of the family planning program in Bangladesh and which provide estimations of unmet needs and identify geographic and programmatic problem areas for additional study.
- The International Center for Diarrheal Disease Research, Bangladesh (ICDDR,B) conducts high-quality operations research (OR) to evaluate demographic and health effects of family planning and MCH services and to identify specific causes of program success. It has benefitted the entire Bangladesh family planning program and all the components supported by USAID.
- The Bangladesh Fertility Research Program (BFRP) examines the safety and effectiveness of presently used and new clinical contraceptive methods and appropriate strategies for introduction of new contraceptive methods into the national program (e.g., clinical trials of Norplant®).

Research through the IEC OR aspects of the *Upazila* Communication Project and the SMC are discussed respectively in Chapters 2 and 4.<sup>26</sup>

### 6.2 Contraceptive Prevalence Surveys

#### 6.2.1 Contraceptive Prevalence and Fertility Surveys

##### Background

The five Contraceptive Prevalence Surveys (CPS) that have been undertaken in Bangladesh since 1979 have provided benchmark data for planning the national family planning program. Although other data useful for program planning and evaluation were collected by each survey, there was a central data core which permitted comparisons among all rounds of the surveys. The surveys include

- A 1979 survey funded through the Westinghouse Contraceptive Prevalence Survey Project, which brought a standardized methodology and analytic approach and which became the basis for subsequent surveys.

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<sup>26</sup>Other research and monitoring activities supported by the project were not evaluated because of lack of time. The primary example is an important annual external IUD monitoring exercise conducted by a local private firm for overall program surveillance, quality control and determination of voluntary participation, access to services and program impact.

- A 1981 survey carried out by the Management Information Systems (MIS) Unit of the then Ministry of Health and Population Control without external technical assistance.
- A 1983 survey carried out by the private sector firm of MITRA and Associates. This CPS expanded the original design by including samples of men and matching samples of couples.
- The 1986 and 1989 CPSs, also carried out by MITRA and Associates.

In 1989, NIPORT carried out a comparable survey — the Bangladesh Fertility Survey (BFS), funded by the World Bank. Although the BFS collected more fertility and mortality data, the results are not significantly different or more informative than results of the 1989 CPS. In addition, the CPS is more informative on program issues than the BFS. The BFS used considerably more external technical assistance than did the CPS.

### Contribution of CPSs to National Program

It is impossible to overstate the importance of these periodic surveys to the national family planning effort. The government program has used the data to monitor various aspects of program performance and trends in fertility and to identify problem areas in its service delivery strategy. The surveys have been an important morale builder because they have revealed a trend of increased contraceptive use. Donors have used the data in planning and have been able to justify programs based on actual accomplishments as measured in the surveys. In addition, the surveys have allowed the donors to monitor the impact of program-specific subcomponents (e.g., the SMC). The surveys are an important component of the database used to evaluate virtually all aspects of USAID's program as well as the activities of other donors.

The CPSs have served another important function in that they have supported and promoted a privatization of research capabilities in Bangladesh. Once the precedent of competitive procurement and contracting for research services was established by regular rounds of the CPS, other projects also used this mechanism. As a consequence, Bangladesh now has a number of commercial social research firms providing services to a wide variety of clients. The development of this private sector research capability is directly attributable to USAID's emphasis in this area and the successful implementation and utilization of the prevalence surveys.

### Technical Issues

An examination of the CPS reports and supporting documentation reveals no significant problems that would hinder the utilization of the results or cause consumer concerns over the quality of the findings. In some areas, however, fine-tuning might improve the overall product.

The 1989 CPS<sup>27</sup> questionnaire was excellent and monitoring procedures used for supervising and managing field operations were found to be extremely good. The questionnaire is a version of the traditional CPS questionnaire, updated using the latest Demographic and Health Survey (DHS) model questionnaire. Any further improvements would generally be at the expense of loss of comparability with previous surveys. The monitoring procedures use reinterview procedures

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<sup>27</sup>This was the only CPS reviewed for technical issues.

and the running of preliminary tabulations for comparison purposes which should result in a substantial reduction in the amount of systematic reporting bias.

Issues exist in four other areas: the sample frame and sample design, the time needed for data processing, the level of analysis, and the absence of graphics in the reports.

The sample design uses the standard probability sample design. The description of the sample procedures does not indicate substantial sample-introduced biases, but greater efficiency could be achieved in field operations by using clustering, by increasing stratification, and by refining listing procedures. Additionally, a review by a professional sampling statistician might suggest that a smaller sample would not substantially increase the sampling error.

Data processing for the CPS was not completed until February 1990, a full six months after the field work was finished. The entire data-processing task took nine months. This represents an unusually long time. By comparison, DHS, using data entry and editing software, has produced basic tables within 30 days of completion of fieldwork.

The analysis done for the 1989 CPS report consists primarily of descriptive bivariate or trivariate analysis. The wealth of data captured over time by the serial CPSs, including a large amount of unused information contained in the data sets, argue strongly for additional analysis, e.g., for trend analysis, more sophisticated analysis and comparative analysis with other data sets. To date, USAID has taken a leadership role in doing secondary analysis of these data sets.

The CPS report, following the standard report formats of other CPS- and DHS-type surveys, provides all the basic information produced by the survey in a primarily descriptive format. It suffers, however, from a lack of graphics for data presentation.

## **6.2.2 Shifting CPS to the Government Sector**

### **Current Status**

In the Fourth Five Year Plan, the BDG has given to the research unit at NIPORT the mandate for conducting future CPSs. The government delayed routine clearances for 1991 CPS implementation by NIPORT, however, and so now USAID will probably carry out the 1991 round using the private sector, as in previous rounds. At the time of the evaluation, USAID was still considering the long-term implications of the mandated move to NIPORT.

For the 1991 CPS, USAID has been moving toward having the DHS project collaborate in some way. The DHS project has made a considerable number of advances in survey methodology in the areas of sampling, questionnaire format, interviewer training, data processing, analysis, and report presentation. The use of DHS, even on a limited basis, would facilitate the full integration of DHS in subsequent rounds of the survey. The involvement of the DHS project would be helpful, whether the survey is carried out by the private sector or by NIPORT. If it were to be NIPORT, transfer of technical skills from the DHS and CPS would facilitate other research activities and help develop NIPORT before it takes overall responsibility for major survey implementation.

## **Pros and Cons of Switching CPSs to NIPORT**

NIPORT was recently designated as the official research arm of the Bangladesh family planning program, providing the rationale for turning the CPSs over to its Research Unit. From USAID's perspective, the full range of factors needs to be taken into consideration in deciding how to react to this change. A close look at the pros and the cons suggests that the costs would be greater than the benefits.

A prime issue is NIPORT's capability as a research body. The research unit currently has questionable ability to implement the surveys. The unit staff seems to have mastered the basic principles of family planning research, but it has also published many poorer quality research reports which are not only badly produced but whose recommendations have little or no relevance to policy. The great diversity of the unit's published reports suggest a second flaw: that NIPORT lacks a research strategy and has not yet identified a primary client or consumer. NIPORT capability to do in-house data processing is also limited. Despite conscientious efforts to disseminate results, there was little evidence that NIPORT research plays a major role in setting government policy. Quite likely, historical relationships with the MOHFW and the inability of the MOHFW to incorporate research findings into its national family planning program play a role in this. Also responsible, however, may be the variable quality of the analyses and the failure of topics studied to reflect policy issue needs (see Appendix J for further details on NIPORT's research activities).

This overview of NIPORT readiness to undertake the next round of CPSs suggests a second drawback to this move: Using the unit would almost certainly increase costs, as considerable technical assistance would be needed to enhance unit staff capabilities.

Other factors militating against a switch include that

- It would not further A.I.D.'s attempt to develop private sector research capability.
- It could reduce USAID's influence on the content and quality of the survey, depending on the assistance modality planned.
- The high turnover rate of government employees and BDG's inability to recruit experienced staff suggest that there would be little institutionalization of survey skills in NIPORT.

Some benefits might also accrue from giving NIPORT jurisdiction over CPSs. For example,

- Putting a highly visible survey in a government component of the bilateral population program might facilitate implementation of other programs supported by the BDG.
- The use of NIPORT might result in a greater likelihood of sharing the funding responsibilities with bilateral donors.
- Policymakers would be more likely to view a NIPORT survey as a BDG initiative and thus be more willing to accept its findings.

### **6.2.3 Alternative Strategies for Survey Implementation**

Although surveys have traditionally been undertaken at two- to three-year intervals, other alternatives could be considered. One approach would be to increase the interval between rounds to three to four years. This would reduce costs but would have the disadvantage of making timely data less available for the planning process. The longer interval would also make it difficult to maintain technical skills.

Another approach would be to implement major and minor surveys in alternating rounds. The first round of the survey would be a traditional full-scale national CPS. The subsequent round could be made considerably smaller through modifying the sample design, reducing the number of questions asked, and/or reducing the geographic coverage. The next round would again be a full-scale national survey, and so forth. The problem with this approach is that the smaller mid-term surveys might tend to be neglected in terms of technical inputs and resources. As a consequence, quality of data would be more problematic and the data less comparable for trend analysis.

Yet another approach might be to increase the interval between surveys but monitor change using the sentinel approach commonly used in epidemiological surveillance. A sample of sentinel sites (randomly rotated) could be selected for ongoing monitoring of contraceptive behavior. Management of the sentinel sites would be similar to the techniques currently used in the Extension Project (see Section 6.3 below). It is probable that the use of sentinel sites would represent only a marginal savings from a national survey, while increasing the management burden.

USAID might consider the use of analytic models to estimate current contraceptive prevalence. Using the national prevalence survey as a benchmark for setting prevalence based on commodities flows, USAID could develop a model to calculate the level of prevalence on a regular basis using logistics data. This would allow greater intervals between national surveys, which would be used to confirm or revise the conversion factors in the model.

#### **Recommendations**

1. Because of their importance as an integral part of the program planning process, CPSs, regardless of the form, should be continued.
2. USAID should continue to work towards moving the CPS to NIPORT, while maintaining other options and contingency plans.
3. NIPORT should be incorporated into the process as soon and as completely as possible, including by participating as much as possible in planning and implementation of the 1991 round.
4. DHS should be encouraged to provide technical support to the next round of the CPS regardless of whether it is a full-scale CPS or an abbreviated one. DHS should be asked to provide technical assistance in the areas of sampling, questionnaire format, interviewer training, data processing, analysis and report presentation.
5. USAID should coordinate closely with GTZ with regard to technical assistance needs and should informally assist in strengthening NIPORT's research capability by offering

it access to the demographic and research technical skills within the mission and within the various projects.

6. Before another round of the CPS is started, USAID should arrange that an experienced sampling statistician undertake a serious review of the sample frame and sample design. The DHS project is the most logical source of technical expertise.
7. USAID should provide for more secondary analysis of CPS data.
8. USAID should work with the BDG to develop a policy to archive the CPS data and to service would-be users. If the BDG is not responsive, the International Statistical Institute's survey archive or the DHS project should be considered.

(See Appendix J for suggestions on a future course for NIPORT.)

### **6.3 The ICDDR,B MCH/Family Planning Extension Project**

#### **6.3.1 Background**

The Matlab Project of the ICDDR,B is one of the most famous study sites in the field of family planning research. The project was started in 1977 to test the hypothesis that health and family planning services can be effectively delivered in rural Bangladesh. The success of the Matlab experiment led the BDG to request a second project site at which the interventions pioneered in the Matlab area could be tested without many of the special resources and operational structures available at Matlab. This project, known as the MCH/Family Planning Extension Project, was launched in 1982 and its first interventions began in 1983. The project operates in the Sirajgonj District of central Bangladesh and Abhoynager near the Bangladesh-Indian border. Adjacent subdistricts were also included in the project to serve as control areas. The Extension Project in these areas uses the government service delivery system to introduce health and family planning interventions. The data resulting from the interventions are not channeled to the local managers of health and family planning services, but are directed instead at national level policymakers. This procedure also avoids pollution of the experimental area.

#### **6.3.2 Performance**

##### **Achievements**

The Extension Project identifies six primary activities in its scope of work:

- improving female workers to population staffing ratios,
- expanding contraceptive choice,
- strengthening of MOHFW field management and supervisory capabilities,
- decentralizing paramedical services,
- training, and
- research.

Within these areas, a variety of interventions has been tested and more are being planned. The results of many of these interventions have been documented and adopted by the national program for use in the field. Among them are the following:

- The effectiveness of female outreach workers in the provision of family planning and MCH services in the rural areas of Bangladesh has been proved to the satisfaction of all. As a result, the Extension Project is involved in setting recruitment procedures for hiring 10,000 new FWAs.
- The Extension Project has recommended that the grass roots health providers, called Health Assistants, usually men, be replaced by women as positions fall vacant. This recommendation has been accepted as policy, but is not being well implemented. If fully implemented, it should result in a substantial increase in the access of women and children to health services.
- The use of temporary rental clinics until the planned construction of union-level clinics is completed has been shown to be an acceptable alternate source of union-level clinical services and has been accepted as policy, but the project has also shown that the government has consistently under supported these facilities.
- The project has proved that satellite clinics operating regularly one day per month greatly increase the access of women and children to clinical services. As a result, the BDG has mandated the regular holding of the satellite clinics nationally. The project is also providing information on how best to implement and support satellite clinics.
- A major breakthrough in service delivery has been the doorstep injectable program, first tested in Extension Project areas. The easy access to injectables has substantially increased the demand for and utilization of this method. It has also proved that injections can be provided by FWAs with only limited clinical training. The government subsequently has approved a plan to phase in doorstep injectables nationwide.
- The family planning reporting system used by the national program is an outgrowth of the system developed by the Extension Project.

### Issues

Contribution to Government Program. As seen above, the Extension Project has been successful in stripping out policy data of relevance to Bangladesh and has had moderate success in integrating results of its efforts into the policy-level considerations of the BDG. No one, however, has the responsibility of providing direct liaison between the government and the project to ensure the continued policy relevance of its research. If the BDG were to appoint a counterpart liaison officer, ease of communication would be increased and more skills might be transferred to the BDG.

The project is expanding its role of providing technical assistance to the BDG. In addition to regularly filling requests from the BDG for information, project staff are increasingly being asked to participate in workshops, seminars, training sessions, missions, and program reviews. This represents a change in BDG-project relations and offers an important opportunity for increasing BDG support for the project and achieving maximum utilization of research findings. With respect

to family planning operations in other countries, the project could no doubt shed light on problems encountered elsewhere, but the full potential benefits in this area have not yet been explored. Likewise, the project could probably be more effective in improving BDG capabilities if it were to provide increased levels of non-formal training to non-project BDG and NGO personnel. The training efforts could include in-service training, medical and research internships, workshops, preparation of training notes, testing training modalities for field workers and participation in other informal training programs. Training could be conducted wholly by ICDDR,B staff or in collaboration with the BDG and NGOs.

**Further Data Analysis.** Despite the large amount of analysis undertaken, considerable data that have been generated in the extension areas remain unused. In particular, in most registration rounds, there has been only superficial analysis of responses to special study questions. In addition, unique data sets have been generated by the sample registration system which would allow useful analysis in such areas as determinants of use effectiveness, patterns of method shifting, continuation rate studies, method failure studies, patterns of client contact, and unimaginable numbers of case studies. Further analysis could yield valuable information to the government and USAID.

**Two Project Sites.** Some discussion has taken place on restructuring the two project sites. This raises a number of questions: Can the project afford two sites? Have the two existing sites been contaminated by the accumulation of interventions carried out to the project? Do the two project sites represent the real constraints to service delivery currently operating in Bangladesh? The answers to the three questions are "Probably, maybe but not significantly, and unknown." With respect to the first issue: the benefits of two extension sites are significant, and the loss of a site for financial reasons would hinder operations by eliminating the research opportunities of a rich longitudinal database and the benefits of opportunity to use differing interventions concurrently while simultaneously controlling for desired variables. Regarding the issue of contamination, the degree to which the Extension Project has "polluted" the two study areas is difficult to ascertain. The project tries to avoid pollution by making every effort to avoid using its information to micromanage service delivery in the sites. Field observations suggest some accumulation of intervention effect, but little awareness of the degree to which services are being monitored and evaluated. Thus, although some contamination has taken place, the loss of longitudinal data, infrastructure and trust caused by closing a site would probably outweigh any negative aspects of contamination. The final point, that the study sites no longer represent the current constraints to service delivery in the most difficult areas, may or may not be true and is beyond the scope of work of this evaluation, but may well be worth further study.

**Staffing.** Another issue in the Extension Project is that of future staffing needs. Currently, many of the staff hold multiple functions in management, administration, research, and training. Adding to the confusion are the short- and long-term contractual relationships and internships used to staff the project. In light of the fluid staffing patterns, together with possible redirection of the Extension Project under the new bilateral project, Extension Project staff should probably be asked to participate in a strategic planning session, followed by a personnel needs assessment.

With these qualifiers, it is possible to make some preliminary comments on possible staffing strategies. The need for continued expatriate management of the Project goes almost without question. Even among the Bangladesh staff, expatriate managers are considered absolutely essential for the effective operations of the Project. The assignment of staff to both technical and management responsibilities has made possible maximum outputs of the project, while minimizing the

need for a larger number of specialized staff. The current division of technical responsibilities — research, service delivery, and management — among the three expatriates seems appropriate, although it may have some costs, specifically in the areas of government cooperation and program development. The project director position has traditionally been filled by a researcher with management skills. The clinical services position provides ongoing medical and clinical services management and operations assistance. The third position currently filled by management specialist is also essential to the smooth operations of the project. Whether this division is by design or in response to staff capabilities is impossible to tell.

The expatriate multi-purpose staff should be continued in order to minimize the labor costs. The project director would retain current research and management skills, but a greater emphasis could be placed on policy, and research analysis responsibilities could be reduced by using locally available short-term staff for some of this work. The management specialist should incorporate a stronger training element to support the project shift in this direction.

Additional technical support will be needed in the areas of communication, research analysis, and micro-economics. A communications specialist could help improve the quality and utility of reports and publications and report production and facilitate skills transfer and collaboration; an applied economist would help meet the demand for increased costing and various forms of macro- and micro-economic analysis; and additional analytic staff could assist in processing unused data.

### **Recommendations**

1. In developing the follow-on to the project, USAID should put emphasis on maintaining the strong research capability of the Extension Project and expanding the utilization of research findings. The latter can best be accomplished through a mixture of publication of findings and utilization of the networks developed by the project. Maintaining research capability and expanding utilization of findings should have precedence over other activities such as increased analysis of data sets, more refined publications, institutionalization of skills and procedures, and meeting international interests.
2. The Office of Population should provide funding support from central resources for family planning OR for some parts of the Extension Project and use the project's findings as part of its dissemination of lessons learned. Support could be used for a new study site, technical assistance, or specific intervention activities.
3. USAID should commit funds for some preliminary research activities in potential new low prevalence districts to determine whether the constraints to service delivery are sufficiently different from the rest of Bangladesh to justify the costs of an additional project site or sites.

## **6.4 Bangladesh Fertility Research Program (BFRP)**

### **6.4.1 Background**

The Bangladesh Fertility Research Program (BFRP), established in 1976, was founded in collaboration with Family Health International (FHI) as part of an international network of national contraceptive research institutions. Using local researchers, BFRP carries out a wide variety of studies with a primary focus on clinical trials of contraceptive methods and reproductive health studies and serves as the BDG's advisor on contraceptive technologies. Recently BFRP has attempted to expand its scope into other epidemiological and OR activities.

BFRP is a parastatal with an executive council chaired by the Secretary of the MOHFW. The council makes major policy decisions, sets research priorities, and develops long-term institutional development strategies. BFRP staff includes a director, two deputy directors, four researchers, four management and eleven support staff. It uses consultants on a project-specific basis.

FHI has been a major source of both technical and financial support for development of BFRP. USAID/Dhaka provides the major block of core support through FHI. In recent years, other organizations have contracted with BFRP to carry out studies and programs and have contributed substantially to BFRP's diversification of funding sources.

### **6.4.2 Activities**

#### **Research**

BFRP has been involved in 152 studies relating to male and female reproduction. It has used a variety of techniques including observation, epidemiologic surveillance, clinical trials and double-blind drug trials. Current research activities include

- Norplant® pre-introduction trials (FHI and Ford Foundation)
- Comparative trials of low dose pills (Schering)
- Anemia study (WHO)
- Contraceptive use dynamics (WHO)
- Reproductive health survey (FHI)
- Foot-length study (UNFPA)
- Injectable Doryxas (MOHFW)
- Hazards of teenage pregnancy (Bangladesh Medical Research Council)

A superficial review of a few recent research reports suggests that BFRP is doing quality research. Study designs are consistent with international standards. Implementation procedures seem reasonable, although it is impossible to judge the quality of field work from written reports. Analysis is adequate, stressing standard bivariant techniques with occasional use of more statistically sophisticated procedures. Research findings in the reports are primarily descriptive. This is to be expected in research focusing on clinical trials and research done by an institution not involved in large-scale service delivery. The descriptive component is generally of higher quality than that usually found in developing countries.

The January 1989 BFRP assessment stressed the need for staff development in research design and analysis techniques. It was observed that BFRP has a propensity to interpret

results beyond a level that is statistically appropriate. Findings are often based on a relatively small number of cases, recommendations result from studies in which the loss to follow-up is high enough to invalidate statistical comparisons, and the reports do not contain adequate descriptions of limitations in research design of which the reader should be aware before making interpretations. The gaps in design skills and potential for statistical misinterpretation could damage the credibility of BFRP. Time available for staff training is limited because of the current BFRP workload, but a broader range of experience is necessary if a multi-talented staff is to be developed.

BFRP has limited itself to work in the clinical areas where it has a predominant and unique capability, but BFRP has endorsed wider goals that include moving into non-medical areas of family planning research such as service delivery, evaluation and general causal research. This seems a poor option for the immediate future: There is enough work for BFRP in clinical areas at present; a change in focus would bring BFRP into competition with other research organizations; and the shift would distract or BFRP or take limited resources away from its specific area of specialization. One case in particular raises questions about BFRP's present ability to jump from clinical trials to large-scale service delivery research. Problems that arose with Norplant® field trials suggest that BFRP has not fully absorbed the necessity for scientific objectivity and careful dedication to research protocols. This experience suggests that a more conservative approach to expansion may be advisable.

### Dissemination of Research Findings

The quality of BFRP dissemination efforts is probably the highest of any family planning organization in Bangladesh and would stand up to efforts elsewhere. Particularly notable, BFRP has attempted to influence policy through its documents, achieving a level of influence within the BDG that is enhanced by its being a parastatal organization.

BFRP uses presentation seminars, publications and participation in various procedural and policy setting workshops to make its work known. Materials on BFRP seminars suggest the seminars are well organized and well attended. Research reports are of relatively high quality and invite repeated use by decision makers. Dissemination of results of research and general discussions of issues have been greatly facilitated by the quarterly BFRP newsletter, "News and Views," which goes beyond research findings to address a wide range of social policy issues of interest to family planners.

BFRP has done little to disseminate its research findings outside Bangladesh or to publish in international publications. To some extent this situation may be the result of a decision on the part of BFRP to serve a primarily Bangladesh audience. It may also reflect an unwillingness to refocus resources from research to the production of research and reports that would meet international standards. In view of its expertise in disseminating research results using standard techniques, BFRP should consider assisting other organizations in developing alternative dissemination strategies and/or modifying dissemination strategies to reach a wider audience.

In another aspect of dissemination, BFRP rarely cooperates with other research organizations in Bangladesh. Due to its unique abilities, it could strengthen both its own and the work of other in-country institutions such as ICDDR,B, NIPORT, and some private firms through such collaborative efforts as jointly managed field research, staff exchanges, utilization of specialized services (interviewer training, data processing, etc.), supportive dissemination efforts, and policy advice.

## **Sustainability**

Although BFRP is still some way from being self-sustaining, its progress in recognizing this issue and making efforts to change operating procedures to increase sustainability is commendable. The institutional base it has developed has increased the probability of its continued participation in the Bangladesh family planning movement. Compared to other research organizations in Bangladesh and comparable organizations in other developing countries, BFRP must be judged a success by all of the supporting organizations.

In the area of financial sustainability, BFRP has been moving away from core support from FHI and USAID towards project funding in an effort to be self-sustaining. With funding from, among others, WHO, UNFPA, the BDG, and the Ford Foundation, BFRP's success in diversifying the donor base is unique in the family planning community in Bangladesh. Although this is a relatively recent endeavor, it is likely that the early successes will continue and the donor base will expand. One proviso: a totally donor-funded BFRP would not be desirable because it would mean that research priorities would be determined internationally rather than locally.

In the area of technical sustainability, BFRP has developed a sound reputation and a technically capable staff, which has benefitted from a broad range of applied experiences and training opportunities. It is difficult to tell how deep BFRP capabilities actually go, however, as local researchers are used to implement field work. The small headquarters staff appears to have limited capacity for additional activities and could be severely hurt by the loss of only one or two people. Adding to its technical sustainability, BFRP has an infrastructure that includes a reference library and some in-house computer capacity.

An important issue in the area of technical sustainability is the lack of adequate management systems. Without these, BFRP's potential for financial and technical expansion may be constrained. These limitations are recognized and efforts are under way to develop new management systems. For example, with technical support from FHI, BFRP is trying to shift to a financial management system that will allow core cost recovery. This should be helpful both in development of a new management system and in increasing financial sustainability.

## **Recommendations**

1. FHI and USAID should continue core or non-earmarked project support to allow BFRP to respond to the family planning research needs of Bangladesh, respond immediately to changing research needs, and develop programs or activities in advance of project funding.
2. USAID should consider providing resident technical assistance for BFRP in research methodology (two years), management systems (six months), and program development (six months). For research methodology, the most immediate need for technical assistance is in the area of statistical analysis and interpretation. Specific areas identified as benefiting from technical support include proposal development, project design, field work monitoring (quality control), analysis (especially statistical analysis techniques), report writing, and policy application of research results. With respect to management assistance, technical assistance would enhance the effort to improve management already under way. A program development advisor (six months) could be helpful to BFRP when the current backlog of studies is completed.

**The advisor could facilitate donor liaison, help prepare a marketing strategy and help develop the background materials required for proposal submissions.**

- 3. USAID should encourage BFRP to continue its focus on family planning clinical research. FHI may wish to increase documentation on research protocols and recognize that BFRP is not yet a technically "graduated" institution, and donors must recognize that there are limits in both technical and managerial areas and must act accordingly in their dealings with BFRP.**
- 4. USAID should encourage BFRP to prepare a long-term staff development plan and make every attempt to encourage staff participation in training and professional activities that will increase its skills, including practicums, participation in consulting teams, internships, etc.**

## **7. Follow-on Project Issues**

## 7. Follow-on Project Issues

### 7.1 Working with the Government Program

The repeated difficulties that the BDG program has experienced in absorbing USAID assistance in recent years, coupled with the expectation that USAID may have less leverage in future, suggest that USAID should reexamine its level of involvement in BDG institution-building activities. All too often, its assistance has not been optimally used and the chances of this situation improving are not strong.

With respect to the project's experience with institution building, USAID and the larger donor community agree on the difficult nature of doing business and implementing development programs with the BDG. An inordinate amount of unproductive time is spent by USAID staff attempting to move documents through a slowly responding BDG bureaucracy and attempting to deal with deadlines that critically affect programming but were artificially imposed through lack of prior attention and planning on the part of government agencies. Other donors have undergone similar difficulties and have frequently cited the BDG's weak management structure and cumbersome decision-making processes. In some instances, donors have chosen to avoid supporting potentially useful projects because of the three-year average period it takes for projects to be developed and approved.

It is highly unusual to find that a country that has accorded fertility regulation top governmental priority and then has failed repeatedly to remove obstacles that impede implementation. The recent history of USAID's efforts includes instance after instance of bureaucratic impediments to project activities. Nearly every component of the project has been affected. The IEM Unit has many unfilled slots, no counterpart relationships have been developed with USAID technical assistance, and little interest has been shown by Unit staff in producing materials. Significant numbers of persons who have been given training in family planning have been transferred to other BDG ministries or agencies with no family planning agenda. Likewise, although many trained family planning staff are nearing retirement, the BDG has not addressed manpower needs, developed a long-term training plan, or accorded a high priority to external training. Long and inexplicably difficult negotiations marked the creation of the private sector SMC. Attempts to have NIPORT take responsibility for logistics training were even more complicated, marred by unexplained refusal to use trainers of trainers for agreed upon purposes and not providing replacements, failure to provide training space and time at NIPORT, and cancellation of agreed upon training courses. Acquiring BDG agreement for the PIL to extend the FPLM cooperative agreement required crisis intervention and retroactive funding. Critical BDG posts have remained unfilled for excessive periods in the logistics system. There has been a chronic inability to keep in-country contraceptive pipelines filled and inability to establish a family planning management information system useful for rational and timely logistics management decision making.

Although these instances are surely not willful, they are all examples of barriers to institutionalizing program components within the BDG. The implication may be that A.I.D.'s standard strategy of targeting resources toward government institution building should be accorded a lower priority in the Bangladesh context. The government has demonstrated limited absorptive capacity in its infrastructure and has demonstrated limited ability to develop the institutional capability required for the smooth functioning of necessary systems.

Coupled with this disheartening past experience are increasingly questionable prospects for the future. Although USAID was the first and once the largest donor in the field of population assistance in Bangladesh, this is no longer the case. The assistance that is most valued by the BDG, commodities, is being significantly reduced within USAID's portfolio. In addition, USAID demands a higher standard of accountability than is required by other donors. With diminishing USAID resources may come loss of advisory leverage, with the further result that USAID's strong technical expertise and sound family planning experience may become less influential. The final result may be a reduction in the effectiveness of Bangladesh's population program.

A reexamination of USAID's role that takes into account both these factors — BDG's repeatedly demonstrated low absorptive capacity for institutional development and USAID's potentially declining influence — suggests this conclusion: It is time for USAID to consider seriously reducing the level of its support for institution-building activities within the BDG program.

## **7.2            Sustainability**

USAID/Dhaka shares A.I.D.'s worldwide concern with sustainability of results from project assistance. Given the heavily donor subsidized nature of the BDG and the very low potential for a significant or dramatic economic turnaround in the Bangladesh economy, it is unrealistic to hope that any social development, the family planning program or any specific service delivery component thereof, can sustain itself financially independent of either governmental or donor support within the next two decades.

Some project elements lend themselves more readily to varying degrees of cost recovery than others: the SMC, some fee-generating activities of the NGOs, and stimulating increased involvement of the private medical sector (physicians and hospitals) in family planning and EPI service delivery are the most obvious examples. Even with these activities, however, the economic constraints on individuals and families, particularly in rural areas, suggest that cost recovery has limits far below the level required to achieve financial sustainability. The implementors of all project components are seriously addressing the issue. Certainly, all parties (including A.I.D., the mission, the CAs, and the projects themselves) need to give vigorous and continuing emphasis to seeking innovative approaches to cost recovery. These efforts and interventions, however, must be made in full realization that overly zealous pursuit of cost recovery might do injury to the much more important objective of institutional sustainability.

The clearest example of the need for caution is the SMC, an institution that has culminated a grueling 16-year struggle with the establishment of social marketing as a fully sanctioned private sector enterprise. If cost recovery and financial sustainability become the major criteria of SMC success, however, product diversification may divert interest from contraceptive sales to more profitable product lines and pricing structures may reduce contraceptive options available to target consumers. The result will be that this flagship of social marketing might continue to sail as a commercial venture, but sink as a cornerstone of contraceptive prevalence. Similarly, although NGO activities should fully consider cost recovery and income-generating issues, these should not be carried out at the unacceptable cost of weakening the grass roots nature of their family planning and MCH charters.

Finally, the government-sponsored family planning program, even with its deficiencies, has established itself as an institution with strong support from the central authority in a traditional

Islamic society. It has enjoyed generous donor support, but as an institution is highly vulnerable to political, religious, economic and traditionalist attacks. A large degree of its strength has stemmed from its being perceived as a provider of desirable social services. The donor community should cooperate to nurture and strengthen this perception and not too vigorously insist that a government institution pursue a course of action that will result in its risking serious setbacks to its family planning activities.

In the area of technical or institutional sustainability, USAID has done a commendable job in spite of the limitations to financial sustainability outlined above. The SMC, for example, has stepped up its activities using local staff and has become an indigenous private organization that should be able to attract support of international donors outside of USAID. For the SMC's and other research activities, USAID has allowed for the development of private sector research capability. As a direct result, there are several research firms in operation, competitive procurement has become the normal procedure for making project awards, and all the firms are doing work for organizations other than A.I.D. If A.I.D. were to withdraw assistance from Bangladesh tomorrow, there would be a some failures, but the better established research firms would continue to operate.

USAID's strategy of sustained project support and strong, flexible technical assistance has helped create local institutions with skilled local staff, effective operating systems, and credibility in their respective areas.

In summary, cost recovery efforts should continue, but financial sustainability is at least two decades away and thus is not a realistic short- or medium-term goal. On the other hand, continuing and increased technical support for private sector activities is justified in view of the prospects for growing technical sustainability in this sector.

### **7.3 A.I.D. Funding and Management Constraints**

Because of the far-reaching scope of the OPH portfolio, the project management load would be burdensome in the best of circumstances. As indicated above, however, Bangladesh does not represent the best of circumstances.

In planning the management workload for the follow-on project, the Project Design Team may find it necessary to reduce the management load in order to balance project activities and potentially reduced funding levels.<sup>28</sup> In this case, none of the ongoing activities in the current portfolio (with the exception of proposed funding for the Family Planning Headquarters building) should be eliminated. The existing subactivities constitute a finely balanced and sharply targeted family planning and MCH assistance package, particularly when viewed within the context of BDG and other donor-assisted activities.

Rather, emphasis should be shifted in a variety of ways: support for non-governmental activities should be given priority over governmental institutional building, family planning should prevail over non-population MCH activities, preserving family planning service delivery activities should come before supporting activities, maintaining well-established activities should receive

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<sup>28</sup>Since preparation of the evaluation scope of work, A.I.D. has signaled probable lower levels of funding for follow-on activities at current or lower staffing levels.

preference over newer projects, and reducing the number of subprojects and activities should be stressed rather than attempting to maintain the current number under conditions of management overload. In making these choices, utmost attention must be given to mission population strategy, comparative advantage, and intentions of other donors. The rationale for each of these choices is provided below.

- **Non-governmental activities should be given priority over governmental institutional building.** Institution building is a cornerstone of overall A.I.D. policy. Although in Bangladesh more may have been achieved in institution building in the population sector than in many other sectors, the willingness or ability of the government to absorb assistance of this nature and gain family planning program benefits thereby has been extremely disappointing in view of the management and programmatic effort expended. Of the three targets of OPH assistance (BDG, NGOs and SMC), management investment in the NGO and SMC components appears to be a more effective option than attempting to develop governmental institutional capabilities: Project experience has shown the non-governmental private sector to be the more receptive, adaptive and dedicated to shared goals. Between the USAID-supported SMC and NGOs, more than 40 percent of total Bangladesh users are being provided. Other donors seem willing and available to take the lead for BDG institution-building assistance.
- **Family planning should prevail over non-population MCH activities.** Of all sectoral linkages, those of selected non-family planning MCH activities are the closest to family planning in terms both of fertility reduction and child survival. Moreover, the mission's non-family planning MCH interventions, EPI and ORT, are two of its most effective project activities. Normally, MCH and family planning are considered intra-sectoral, but in Bangladesh, this is not the case. Functional integration of the two in the field is talked about, but the reality is that it may take a decade or longer to achieve. Thus, if constraints require reductions in management load, family planning should be preserved over MCH in order to continue the mission's family planning focus. Alternative management arrangements could include folding EPI into the NGO component, resumption of the earlier centrally funded arrangement, or shifting funds to UNICEF to carry on the assistance (assuming, of course, that funding levels would permit).
- **Preserving family planning service delivery activities should come before supporting activities.** Training and research are vital components of successful family planning programs, and A.I.D. clearly has comparative advantages in each. On the other hand, the more important ingredient of family planning programs is contraceptive prevalence, and the "condition precedent" for prevalence is service delivery. In a worse-case scenario, service delivery elements should take priority over training and research. (IEC is more closely related to service delivery than to research or training).
- **Maintaining well-established activities should receive preference over newer projects.** Establishing a *modus operandi* for project implementation takes an incredibly long time in Bangladesh. A.I.D. and USAID have made the necessary heavy investments in terms of funding, management effort and time required in the population sector in order to achieve family planning program success. In view of these investments,

USAID's proven established portfolio should be given preference over emphasis on new directions or development of new projects.

- **Reducing the number of subprojects and activities should be stressed rather than attempting to maintain the current number under conditions of management overload.** The advantages of the strategy of reducing numbers of projects in favor of trying to maintain current levels of effort in all activities are self-evident when project management issues such as quality control, monitoring, reporting and accountability are taken in consideration.

The strategy suggested above for management workload reduction differs radically in emphasis from that suggested by the conclusions of the Population Sector Review and may cause conflicts and hard choices. On the other hand, all strategies would result in hardship if reductions in funds and management load become necessary.

#### **7.4 Isolation from Many Centrally Funded Activities**

The size of the bilateral population assistance in Bangladesh has resulted in a reluctance on the part of A.I.D. to involve centrally funded projects in local activities except as a result of buy-ins. To some extent, the mission has accepted this, preferring to focus its stretched management resources on activities funded by the bilateral program. One result of this situation is that the mission is unduly isolated from technical and policy developments of the globally oriented, centrally funded contracts except those that are parts of buy-ins. The problem is one of degree, not of intent, and there is no definable ideal balance, but awareness of the difference in perspective over the long term should influence communications to improve operations. The new two-year posting policy should improve information flow by rotating staff, but at the potential cost of some degree of loss in program continuity. One way to improve the information flow might be for A.I.D. to fund increased participation by centrally funded projects in Bangladesh population activities, particularly given the crunch in the bilateral budget. The role of the centrally funded activities should be to contribute to the implementation of the bilateral program while supplementing (not further taxing) the technical and managerial resources of the mission. Examples of some technical areas of potentially useful centrally funded support include

- DHS for a training program in computerized survey processing skills;
- The Family Planning Management Development (FPMD) project to do a manpower needs assessment for the MOHFW;
- The Social Marketing for Change (SOMARC) project to do a training program on qualitative research methods;
- Population Council to do a training program on statistical analysis techniques;
- Program for International Training in Health (INTRAH) for a review of clinical training; and
- AIDSTECH/AIDSCOM, if the mission adds this component of assistance.

## **Recommendations**

1. **USAID should reexamine, and reduce, its degree of involvement with BDG institution building.**
2. **USAID should continue cost-recovery efforts but also recognize that financial self-sustainability of the family planning program is an unrealistic expectation for at least the next two decades.**
3. **Technical support should be sustained or increased to continue the process of achieving technical or institutional sustainability of the private sector.**
4. **Given probable future funding constraints and fixed or reduced personnel levels, future project design should support non-governmental activities in preference to governmental institution building, family planning over non-population MCH activities, preserving family planning service delivery activities over supporting activities, maintaining well-established activities in preference to newer activities, and reducing the number of subprojects and activities rather than attempting to maintain the current number under conditions of management overload.**
5. **A.I.D. should fund increased participation of centrally funded projects in Bangladesh. The activities should supplement, not tax, mission technical and management resources.**

## 8. List of Major Recommendations

### 8.1 Recommendations Requiring Immediate Attention

Three issues, all related to contraceptive supplies, will require immediate attention if the day-to-day operations of the family planning program are not to be disrupted. The first two arise from the inability of the logistics system to maintain a three-month pipeline of contraceptives beyond the Division level. Operating on a month-to-month basis is particularly damaging to the NGOs, but also affects at least some of the Districts. The third issue relates to USAID's plan to stop supplying subsidized branded condoms to SMC beyond 1992, a situation that could lead to the demise of the SMC.

The three recommendations below should address these problems and are based on the assumption that a reliable, uninterrupted supply of commodities is essential to the functioning of Bangladesh's family planning program.

1. **USAID should organize and participate in an intensive, coordinated collaboration of donors and the BDG to insist that the MOHFW use all its available government- and donor-provided resources to implement its own policies of maintaining a three-month contraceptive commodity pipeline at all Division and below supply points, including those of the NGOs.**
2. **USAID immediately should bring pressure to bear to the extent necessary to assure that the Central Warehouse provides and maintains the required stock levels for a three-month pipeline for the NGOs.**
3. **USAID should continue to negotiate with the EEC and other donors to ensure a plan for continued provision of subsidized, branded condoms to SMC beyond 1992. If these negotiations do not bear fruit, USAID should make contingency plans to provide them beyond 1992.**

### 8.2 Other Recommendations for Current Project

The following recommendations are a recapitulation of all the recommendations in the report. Those in bold face type (all or in part) are those that should be accorded priority in the context of the national program, whereas those in regular type face are of secondary importance in this context.<sup>29</sup>

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<sup>29</sup>In general, the recommendations in bold face type above are also those that appear in the executive summary. Since, however, the recommendations listed in the executive summary are those of principal importance to USAID, as opposed to their significance to the national program, some recommendations not in bold face appear in the executive summary (i.e., they are of major importance to USAID but not to the national program) and one or two recommendations in bold face do not appear in the executive summary (i.e., they are of major importance to the national program but not to USAID). A recommendation not in bold face in Chapter 8 and included in the list of recommendations in the executive summary is designated in the above listing by a single asterisk. A recommendation in bold face that is not included in the executive summary has a double asterisk in the following listing.

## **BDG Component**

### **IEC**

1. **USAID should continue support of IEC activities throughout this and successive projects.**
2. **USAID and JHU/PCS immediately should explore and implement mechanisms for expanding IEC technical assistance to CAs and contractors supported by USAID and to other interested non-governmental entities.**
3. **USAID involvement with IEM headquarters activities should be limited to coordination, with discrete technical assistance that responds only to direct requests and that concentrates on policy formulation and planning. JHU/PCS or future CAs should maintain strong liaison with the IEM Unit and provide high level technical assistance to the IEM Unit on matters of strategy and policy.**
4. **The *Upazila* Communication Project should be continued.**
5. **Based on experience to date, JHU/PCS should scale down its workplan for 1991 to less ambitious targets.**
6. **Because of continued non-supervision by government and failure to demonstrate programmatic impact, USAID should no longer support the National Folk Singing Project.\***

### **Urban Immunization**

1. **USAID should review project documentation and its contract with CCC and consider revising them to be more explicit in quantitative terms and to provide time lines for specific components.\***
2. **The workplan of the contractor should be presented in a format to be agreed upon by USAID and approved preceding the period that it is to cover.\***
3. **Until urban EPI coverage reaches or exceeds the level of the national program and is BDG-sustainable with minimal UNICEF or other donor assistance, USAID assistance to this segment of the national program should continue, presuming the continuation of sufficient USAID funding and management staff.\***

### **Training**

1. **USAID should continue its current low-intensity participant training activity instead of a developing a more costly and labor-intensive program until an information needs assessment has been conducted, a BDG training plan developed to respond to identified need, and until the BDG has accorded higher priority for external training needs.**

2. **The mainstay of OPH training for government personnel should remain the *Upazila* Family Planning Initiatives Project.**
3. **USAID should not participate in the ODA-coordinated development of a project designed to improve MOHFW manpower planning capability unless a needs assessment is included as part of the undertaking.**

### **NGO Component**

1. **In efforts to strengthen clinical activities and quality assurance, USAID and the CAs should broaden the focus of these activities beyond clinical staff to include field staff. Future planning and implementation of this project should stress the linkages between the clinical and paramedical cadres of family planning workers and the fieldworkers.\***
2. **USAID should encourage CAs and NGOs to integrate EPI and ORT into ongoing programs.**
3. **USAID and the CAs should maintain only realistic and modest expectations of gains in achieving financial sustainability. In considering possible cost-recovery schemes, NGOs should favor interventions that are related to and support their programming and organizational objectives; that are low maintenance and require minimal levels of management; and that are not directly competitive with private enterprise. Feasibility studies and sound business plans should be required prerequisites to implementation and regular monitoring and evaluation will be necessary from the outset to ensure the success of the program.\***
4. **USAID should support technical assistance from international organizations to assist the CAs to expand and strengthen their knowledge and resource bases with reference to the principles of sustainability and cost recovery in general and specifically in the Bangladesh context.\***
5. **USAID and the CAs should promote the process of developing community ownership of NGO programs and objectives and linkages at the local government level in order to achieve technical sustainability.\***

**Social Marketing Company (SMC) Component** (The principal recommendation for this component is found at the start of this chapter.)

1. **USAID should encourage a gradual SMC market shift from condoms to more effective, less costly methods such as orals.**
2. **USAID should help SMC review its warehousing system, with the objective of identifying possible efficiencies in operations.\***
3. **USAID should encourage cooperation in research development between all USAID-supported organizations, including the SMC, in order to achieve the maximum use from the outputs of each group's efforts.**

4. **The SMC should focus research efforts on new, not existing, products and attempt to coordinate with other research efforts to obtain data on current products and baseline uses.**
5. **The SMC's policy of using private sector research firms should be continued.\*\***
6. **USAID and the SMC should obtain market research technical assistance to allow for development of an overall research strategy and plan for product research.**
7. **USAID should support the development of qualitative research methods for use by the SMC, and, where appropriate, with other research organizations with which it deals.**
8. **The SMC should document and disseminate research procedures, findings, and implications, and should archive the computer data files for use by others.**

**Commodities and Logistics Component** (The two principal recommendations for this activity are found at the start of this chapter.)

1. **The recent MOHFW decision to eliminate the logistics monitor positions that were being sponsored by UNFPA and CIDA should be addressed by USAID and other donors whose commodity supplies are disrupted by the loss of these positions. The donors should insist that the positions be maintained and new positions added so that from four to six monitors would be stationed at each Division and would report to the top family planning officials in each Division. The purpose should be to ensure that a reliable monitoring system is operating effectively.**
2. **USAID/FPLM should increase logistics technical assistance to all CAs and serve as the official liaison between the NGOs and the Central Warehouse. Technical assistance to CAs should include areas such as standardization of the FPAB logistics system with that of MOHFW, facilitating flow of information to the MIS and LMIS, warehousing, and participation in ongoing logistics management training activities.**
3. **If the scheduled review of the MIS and the LMIS indicates the desirability of continuing the LMIS, BDG/FPLM should develop and implement a plan to institutionalize the LMIS within the BDG. BDG managers and decision-makers should be required to receive training in data analysis, report interpretation, planning, and evaluation through the FPLM project.**
4. **The current practice of the Chittagong Regional Warehouse of dividing each shipment of contraceptive commodities received into five equal allotments should be replaced by a method in which allocations to each Division and to the NGOs correspond to the calculated projections of need.**
5. **Under conditions of massive real and BDG-imposed difficulties, USAID should consider seriously whether it or some other source should provide obviously necessary assistance in logistics management, but should be assured the BDG receives (and uses) it from some source.**

6. **PSI should provide technical assistance to improve warehousing conditions and should consider relocating its inadequate warehouses to more adequate facilities.**

### **Research Component**

#### **Contraceptive Prevalence Surveys**

1. **Because of their importance as an integral part of the program planning process, CPSs, regardless of the form, should be continued.**
2. **USAID should continue to work towards moving the CPS to NIPORT, while maintaining other options and contingency plans.**
3. **NIPORT should be incorporated into the process as soon and as completely as possible, including by participating as much as possible in planning and implementation of the 1991 round.**
4. **DHS should be encouraged to provide technical support to the next round of the CPS regardless of whether it is a full-scale CPS or an abbreviated one. DHS should be asked to provide technical assistance in the areas of sampling, questionnaire format, interviewer training, data processing, analysis and report presentation.**
5. **USAID should coordinate closely with GTZ with regard to technical assistance needs and should informally assist in strengthening NIPORT's research capability by offering it access to the demographic and research technical skills within the mission and within the various projects.**
6. **Before another round of the CPS is started, USAID should arrange that an experienced sampling statistician undertake a serious review of the sample frame and sample design. The DHS project is the most logical source of technical expertise.**
7. **USAID should provide for more secondary analysis of CPS data.\***
8. **USAID should work with the BDG to develop a policy to archive the CPS data and to service would-be users. If the BDG is not responsive, the International Statistical Institute's survey archive or the DHS project should be considered.\***

#### **ICDDR, B Extension**

1. **In developing the follow-on to the project, USAID should put emphasis on maintaining the strong research capability of the Extension Project and expanding the utilization of research findings. (Additional suggestions on implementation of this recommendation are provided in Section 6.3.)**
2. **The Office of Population should provide funding support from central resources for family planning OR for some parts of the Extension Project and use the project's findings as part of its dissemination of lessons learned. Support could be used for a new study site, technical assistance, or specific intervention activities.**

3. USAID should commit funds for some preliminary research activities in potential new low prevalence districts to determine whether the constraints to service delivery are sufficiently different from the rest of Bangladesh to justify the costs of an additional project site or sites.

## **BFRP**

1. FHI and USAID should continue core or non-earmarked project support to allow BFRP to respond to the family planning research needs of Bangladesh, respond immediately to changing research needs, and develop programs or activities in advance of project funding.
2. USAID should consider providing resident technical assistance for BFRP in research methodology (two years), management systems (six months), and program development (six months). (Additional suggestions on implementation of this recommendation are provided in Section 6.4.)\*
3. USAID should encourage BFRP to continue its focus on family planning clinical research. FHI may wish to increase documentation on research protocols and recognize that BFRP is not yet a technically "graduated" institution, and donors must recognize that there are limits in both technical and managerial areas and must act accordingly in their dealings with BFRP.
4. USAID should encourage BFRP to prepare a long-term staff development plan and make every attempt to encourage staff participation in training and professional activities that will increase its skills, including practicums, participation in consulting teams, internships, etc.\*

## **8.3**

### **Recommendations for a Follow-On Project**

1. USAID should reexamine, and reduce, its degree of involvement with BDG institution building.
2. USAID should continue cost-recovery efforts, but recognize that financial self-sustainability of the family planning program is an unrealistic expectation for at least the next two decades.
3. Technical support should be sustained or increased to continue the process of achieving technical or institutional sustainability of the private sector.
4. Given probable future funding constraints and fixed or reduced personnel levels, future project design should support non-governmental activities in preference to governmental institution building, family planning over non-population MCH activities, preserving family planning service delivery activities over supporting activities, maintaining well-established activities in preference to newer activities, and reducing the number of subprojects and activities rather than attempting to maintain the current number under conditions of management overload.

5. **A.I.D. should fund increased participation of centrally funded projects in Bangladesh. The activities should supplement, not tax, mission technical and management resources.**

## **Appendices**

**Appendix A**  
**Description of Evaluation**

## Appendix A

### Description of Evaluation

#### 1. Purpose of Assignment

This report was prepared at the request of the United States Agency for International Development (USAID) mission in Bangladesh. The assignment was to evaluate performance progress and achievements at mid-term (1987-1992) of the Family Planning and Health Services Project (FPHSP), to review strategy linkages among the three major areas of implementation and the Government of Bangladesh (BDG) national family planning program objectives, and to examine issues concerned with the duration of this project and for a proposed follow-on project. A four-person team carried out the Bangladesh field work during September, 1990.

#### 2. Scope of Work

The scope of work for this external mid-term evaluation included: examination of performance and achievements of the three categories of grantees implementing the project (the BDG, Cooperating Agencies [CA] managing family planning activities of non-governmental organizations [NGO] and the Social Marketing Company [SMC]); assessing the contribution of each to accomplishing project activities; and, linking those contributions to the BDG program and strategy in order to recommend directions for future USAID family planning assistance. After the Evaluation Team arrival, the mission emphasized its desire that the Team give increased emphasis to recommendations for the 1990-1995 Country Development Strategy Statement (CDSS) period, under scenarios of possibly reduced resource levels. The mission also indicated that USAID, not the BDG, had the most interest in the results of the evaluation. The Scope of Work appears in Attachment 1.

#### 3. Evaluation Methodology

Prior to Team arrival, its members were provided voluminous and informative background documents. After arrival, the Team was briefed by mission personnel, then as a group by BDG officials, some major donors, and the SMC. The Team then split up, each member according to the division of labor agreed on between the Team and the mission. Field trips were made by all Team members. The Team met formally or informally on nearly a daily basis, and repeatedly, as individuals and as a team, with Embassy and USAID officials, to review the status of progress towards accomplishing the objectives of the scope of work and to analyze findings. Because of the extensive number of interviews required for the many subproject components and donor agencies, and the time required to review and analyze additional project and subproject documents, research papers, surveys and other materials concerning this well-documented project, the Team was unable to provide a draft report during its too-short visit. Individual Team member contributions to the report were later integrated into a draft report by the Team Leader and sent to the mission for review and comment prior to revision for submission to the firm contracted for the evaluation, which performed final editing and published the report. Key persons interviewed and a list of documents reviewed are included in Attachments B and C.

Attachment 1 (Appendix A)

Midterm Evaluation of the USAID Bangladesh Family Planning  
Health Services Project (388-0071)

Scope of Work

II. OBJECTIVES OF THE EVALUATION

The major objectives of the evaluation can be divided into three broad areas:

- A. FPNSP Performance Progress and Achievements.
- B. Strategy Linkage Review: Program Balance among the 3 major areas of implementation of SMP, NGOs and the BDG program; and linkages with the BDG national family planning program objectives.
- C. Follow-on Project Issues.

III. FPNSP PERFORMANCE PROGRESS AND ACHIEVEMENTS

The emphasis here is on learning from past experience for future improvements. The evaluation questions are divided into two areas:

- o Overall Family Planning and Health Services Project: Accomplishments and issues.
  - o Specific Components: Contribution of each, and linkage to other project components. Other than for linkages to the overall program, sub-components recently evaluated (specifically the Upazila Initiative Project) or not yet implemented (such as clinical services and MIS) need not be examined by the team.
- A. Overall Project Accomplishment and Issues. The evaluation should:
- 1. Assess the contribution of the FPNSP and its components to the overall national program, and its relationship to what other donors are doing.
  - 2. Determine extent to which the FPNSP is effectively achieving its goals to reduce high fertility and mortality as stated in the project paper, including appropriateness of success indicators.
  - 3. Comment on the "three pronged" approach of simultaneous support to the BDG, NGOs and the private sector relative to effectiveness and efficiency, and special concerns of monitoring of clinical services and BDG policy on decentralization.

B. Specific Component Assessment and Issues. The progress achievements for each component should be reviewed against its stated objectives. In addition, the team should comment on the contribution of the component to the success of the project overall, future directions and implications for the follow-on project. Specific component areas for the evaluation follow:

1. GOVERNMENT OF BANGLADESH

a. IEC

1. Assess need for IEC efforts and appropriateness of level, type and modality of USAID support, particularly to IEM Unit of MOHFP, in light of recent strategy program assessment recommendation to decrease USAID support for IEC.
2. Assess IEM Unit staffing and capabilities compared to its workplan for the MOHFP, USAID and UNFPA and identify areas to strengthen and recommend improvements.
3. Assess the USAID IEC strategy and workplan relative to #2.

b. EPI

1. Determine interface and complement of urban EPI project with the overall national program.
2. Assess financial sustainability of the program, examining the ratio of donor vs. indigenous (BDG, local government or private sector) support for the urban EPI effort, and need for follow-on support of recurrent costs of the program.
3. Determine level of future donor support, and comment on whether another donor (most likely UNICEF, which largely supports the rural EPI program) would more efficiently continue this project.

c. Training

1. Determine how the FPHSP training component can best assist the BDG in staff development and comment on importance/value of training to FPHSP goal attainment and how much emphasis training should receive in the project.

2. PRIVATE SECTOR: SOCIAL MARKETING/FAMILY PLANNING AND ORAL REHYDRATION THERAPY PROGRAM

1. Assess SMP's contribution toward national contraceptive prevalence, and scope for increased

contribution by changes in program orientation, promotion of different contraceptive methods (e.g., greater emphasis on pills), or other approaches.

2. Analyze and determine both SMP a) strengths that make their contribution possible and scope for application/replication in other project components such as with NGOs, and b) constraints--of funds, supplies, management capacity, etc.--that limit further expansion as a supplier of contraceptive supplies and ORS.
3. Evaluate the usefulness of SMP conducted market research including consumer surveys, retail audits, pricing studies, and SMP's capacity to manage the market research process and make practical use of the results.
4. Assess whether the Community Based Sales program is a viable delivery mode with widescale practical application in Bangladesh, relative to cost and effective use of products, particularly ORS.
5. Evaluate the compatibility between SMP's mandate for achieving contraceptive prevalence and the need to develop a more sustainable institution. To what extent are maintaining/increasing contraceptive prevalence and increasing SMP's cost recovery capacity compatible goals.
6. Evaluate viability of fully private sector (ie: non-subsidized, profit oriented) social marketing family planning initiative in Bangladesh, and identify other opportunities for SMP to generate income to support their program.

### 3. NGO ACTIVITIES

- a. Assess appropriateness and impact of current USAID/NGO CBD strategy (1987-91), in terms of the following:
  - o Determine whether NGOs should continue to be focused on urban based CBD programs and can innovative approaches to service delivery replace household visits.
  - o Assess whether and how NGOs can extend services to rural, and possibly, underserved areas.
  - o Assess role of provision of MCH services, and how such services may enhance family planning delivery.

- b. Assess CA and NGO efforts to date to initiate service delivery cost recovery to move toward self sustainable programs, and types of technical assistance USAID should provide to strengthen these efforts.
- c. Determine which NGO activities can best be shared or extended to the BDG and what are possible areas of increased collaboration, such as training, IEC and rural expansion to lesser served areas.
- d. Recommend future directions of the 1990's for the NGOs relative to their service delivery contribution and changing role/emphasis for NGOs to complement government services, and how rapidly some of recommended future directions could be initiated and made operational, including service modality approaches of CBD/clinical/mix, urban/rural mix, and appropriateness of use of six cooperating agencies in the future.

4. OTHER CROSS CUTTING COMPONENTS

a. Commodities and Logistics (C&L)

- 1. Analyze extent to which TA needs for C&L system in 3 project components (ie: BDG, NGOs and SMP) are being adequately met, and make recommendations to address gaps relative to level of assistance, ie: staffing, activities and financial resources.
- 2. Identify information and TA needs of other donors in C&L and how USAID can best meet these needs.
- 3. Assess the coordination between OPH/USAID, BDG, SMP, NGOs, other donors and JSI, and make recommendations for improvements.
- 5. Examine and recommend mechanisms to institutionalize the C&L function over the next five year project period with substantial donor (USAID) input.

b. Research

- 1. Determine extent to which USAID funded research, including Contraceptive Prevalence Surveys (CPSs), the Extension Project, and BFRP, is:
  - o Viewed as important and relevant by the BDG, other donors and CAs.

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- o Effectively utilized for program performance indicators and improvements.
  - o Complementary or duplicative of other research efforts
  - o Being optimally disseminated through identification of right audiences with right research findings, and how might dissemination be improved.
2. Assess whether the ICDDR,B Extension Project should continue to maintain a) quantitative and qualitative data collection in two field sites or be scaled down either in number of sites or level/extent of data collection, b) level and type of technical assistance; and, c) institutional locus in ICCDR,B, or another mechanisms, and how this impacts on transference of project findings to the BDG.
  4. Contraceptive Prevalence Survey (CPS): Comment on the advantages/disadvantages of shifting the exercise from an external contract modality to institutionalization within the BDG.
  5. Analyze and comment on relative costs of research (ie: Extension Project) and future research strategy that OPH should support, in light of extensive research to date and positive trends in national FP program, in order to fully utilize research findings for the support of the entire USAID population/health portfolio.

#### IV. STRATEGY LINKAGE REVIEW

The focus here is on two types of linkages.

A. Linkages between the FPHSP components and the subcomponents: The key issues are:

1. Extent to which FPHSP three prong implementation through NGOs, SMP and the BDG sub-components are logically linked together to achieve FPHSP objectives.
2. Whether some components are more critical than others to achieve the project's objectives, and impact desired for the overall project. If so, which components are these, and could any be reduced/eliminated without impeding the achievement of the objectives.

B. Linkages between the FPHSP strategy and the BDG Family Planning and MCH priorities. In particular:

1. Determine how the FPHSP strategy relates to the BDG goals as articulated in the Third Five Year Plan.

2. Identify the key issues for FPNSP implementation and the follow on project in view of the goals and objectives of the new Fourth Five Year Plan.

#### V. FOLLOW-ON PROJECT ISSUES

The issues requiring attention in the follow-on project are based on the assumption that the overall sector goals will remain the same of reduced fertility and mortality. However, some changes in design and focus will be necessary given the experience and achievements of the FPNSP. The growing size and cost of the national program, combined with AID fiscal constraints, will mandate an increasingly streamlined and focused strategy in which USAID concentrates on fewer activities in which it has a demonstrated comparative advantage and for which no other donor support is likely. In the FPNSP mid-term evaluation the team should briefly comment on future project issues of effectiveness and efficiency, institution building, sustainability and OPH organization and staffing relative to the project components reviewed in the evaluation and likely to be included in the follow-on project. While these points will be developed further in the design phase, evaluation findings will be an important contribution for the development of the follow-on project.

## Attachment 2 (Appendix A)

### Persons Contacted

#### GOVERNMENT OF BANGLADESH

Directorate of Family Planning  
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Director General

#### IEM Unit

Mr. M. Nawab Ali  
Mr. M. Alamgir Chowdhury

Director  
Deputy Director

#### EPI

Dr. A.K.M. Lutfur R. Talukdar

Project Director

#### NIPORT

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Mrs. Farida Mabud  
Mr. Mahenur Rahman  
Mr. Munshi A. Zaman  
Mr. M. Abdul Rashid

Director General  
Senior Research Assistant  
Director of Training  
Deputy Director Training  
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#### COMMODITIES AND LOGISTICS UNIT

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Add. Director Central  
Warehouse

#### US EMBASSY

Ambassador William B. Milam

#### USAID

Mr. Frank Young

Acting Director

#### Office of Population and Health

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Mr. Quasem Bhuyam  
Ms. Brenda Doe  
Ms. Louisa B. Gomes  
Ms. Sheryl Keller  
Mr. Mohammed Kobbad  
Ms. Ann Larson  
Ms. Katie McDonald  
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Pop. Development Officer  
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<b>ASIA DEVELOPMENT BANK</b> Mr. R.K. Banerjee Dr. Lata Singh	Sr. Implementation Officer Project Economist (Manila)
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<b>CHITTAGONG DIVISION</b> Mr. Maung Kyan Zaw  Mr. M. Mazibul Huq  Mr. M. Nazmulhque  Family Planning Association Project Mr. S.M. Firozeuddin Dr. Jasmin, Physician	Assistant Director Port Clearance Regional Family Planning Supply Officer SMC Regional Manager    Field Officer FBAB Clinic
<b>CIDA</b> Mr. Brian Proskurniak	First Secretary, Population and Health
<b>CONCERNED WOMEN FOR FAMILY PLANNING</b> Ms. Mufuewza Khan Ms. Jahanara Sobhani Ms. Jahanara Begum	Executive Director Director of Service Coordinator, Bakshi Bazar
<b>FAMILY PLANNING ASSOCIATION OF BANGLADESH</b> Mr. Mizanur Rahman Mrs. Shamima Hasan Mr. Ershadul Huq Mr. Kazi Mohammad Ali Jinnan	Director General-in-charge Deputy Director Senior Programme Officer Assistant Director
<b>FAMILY PLANNING INTERNATIONAL ASSISTANCE</b> Mr. Mukarram Hossain Chowdhury	Associate Reg. Director
<b>FAMILY PLANNING LOGISTICS MANAGEMENT PROJECT/JSI</b> Mr. Brice D. Atkinson Mr. Milton D'Silva  Mr. Shayam Lama Mr. Khandaker Kanam Mr. Prashanta Kumar Dey	Chief of Party Joint Administration & Finance Officer Training Advisor Program Officer Logistics MIS Specialist
<b>FAMILY PLANNING SERVICES AND TRAINING CENTER</b> Mr. Abdur Rouf Mr. Milan Bikash Paul	Chief Executive Deputy Chief Executive

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Management Adviser

**ICDDR-B EXTENSION PROJECT**

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Director

Dr. Maxine Whittaker

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Mr. Iftekheruddin Ahmed

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Mr. Abdur Rouf

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First Secretary Health and  
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**PATHFINDER FUND**

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Dr. Nilufar K. Jaha

Medical Program Officer

Mr. Moslehuddin Ahmed

Program Manager

**RAJSHAHI DIVISION**

Division Level

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Rajshahi District

Mr. Sirajul Islam

Deputy Commissioner

Mr. A. Baqui Sarker

Deputy Director (Family  
Planning)

Mr. Talukdar

Assistant Director (Family  
Planning)

Mr. Shamsul Alam

Bagma *Upazila* Family Planning  
Officer

Staff at a Satellite Clinic at Shyampur Village, Harian Union, Paba *Upazila* - MO(MCH-Family Planning), Asst. UFPO, FPA, FWV, Government FPA and FPA from FPSTC Project.

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**Boraigran Upazila**

Mr. Esharat Ali	Upazila Chairman
Dr. Nazmul H. Choudhury	UHFPO
Mr. Mazedul Islam	UFPO
Dr. Shajahan Ali	MO (MCH-Family Planning)
Mrs. A. J. Parveen	TFPA (Statistics)
Mr. A. R. Mollah	TFPA (Administration)
Majgaon Union HFWC	
Ms. Monowara Begum	Medical Assistant
Mr. Akbar Ali Mridha	FPA
Mrs. Joystna Ara Begum	FWV
Satellite Clinic, Mahmudpur Village	
Mr. Abdul Hai Gazi	FPA
Ms. Bilquis Parveen	FWV
Ms. Anjali Rani	FWA

**NGO SITES**

Pathfinder Project: Tilottoma Woman's Voluntary Organization	
Prof.(Dr.) Jubaida Khatun	President Exec. Council
Mrs. Murhida Murshed	Project Manager
FPSTC Project: Kallayani Sechhasebi Sangstha	
Mrs. Kaniz Akhter Banu	Project Coordinator
TAF Project: Gano Unnayan Academy (CDS-003)	
Mr. Sanaton Chakraborty	Project Manager
AVSC Project: BAVS, Rajshahi Branch	
Dr. Akhtaruzzaman	In-Charge
Dr. A. Karim Bhuiyan	Surgeon
Mr. Shahabuddin Ahmed	Male Counsellor cum Field Coordinator
Ms. Anowara Begum	Female Counsellor

**SOCIAL MARKETING COMPANY**

Mr. Robert L.Ciszewski	PSI Country Representative
Mr. Shahadat Ahmed	Acting Executive Director
Mr. M. Anwar	Development Manager
Mr. Waliur Rahman	Director of Marketing

**TECHNICAL ASSISTANCE, INC.**

Mr. Abu Sayeed	Executive Director
----------------	--------------------

**UNFPA**

Mr. S.K. Alok	Country Representative
Ms. Tahera Ahmed	National Program Officer
Mr. Nurul Ameen	National Program Officer
Mr. Monroe Scott	Logistics Advisor

**UNICEF**

**Mr. Philip D. O'Brien**

**Ms. Carol Rice**

**Ms. Fiona Doby**

**Coordinator, Health and  
Population**

**EPI Project Officer**

**NGO Project Coordinator for  
ODA**

**WORLD BANK**

**Mr. S.K. Sudakar**

**Population Advisor**

## **Attachment 3 (Appendix A)**

### **List of Documents Consulted**

#### **1. USAID DOCUMENTS**

USAID/Bangladesh Country Development Strategy Statement, FY 91-95. (June, 1990).

Family Planning and Health Services Project Paper (No. 388-0071).

Bangladesh: Population Sector Review. (February, 1990).

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**Appendix B**

**Family Planning and Health Services Project:  
List of Components in Project Paper**

## Appendix B

### Family Planning and Health Services Project: List of Components in Project Paper

Below is a list of subcomponents under each of four project components *as they appeared in the Project Paper*:

- 1) Support for BDG Family Planning activities;
- 2) Support for Social Marketing;
- 3) NGO Family Planning activities; and
- 4) Support for Maternal and Child Health (MCH) activities.

Of the four components, most subcomponent activities of components 1, 2, and 3 follow-on from previous USAID projects. Component 4, MCH activities, represents a departure from previous support which was focused on direct family planning interventions.

#### List of Project Components

##### Component 1: Support for BDG Family Planning Activities

- A. Information, Education and Communication Services
- \*B. Clinical and Community-Based Family Planning Services
- \*C. *Upazila* Family Planning Initiatives
- \*\*D. Contraceptive Commodities and Logistics
  - Commodities
  - Technical Assistance
- \*E. National Family Planning Headquarters Building
- \*\*F. Research, Monitoring and Training
  - Support of Recurrent Studies, CPS, IUD Analysis
  - Support of Specific Research Subprojects
  - \* • Strengthen the Planning Commission's Population Development Evaluation Unit (PDEU)
  - \* • Strengthen Management Information Systems

##### Component 2: Support for Social Marketing

- A. Social Marketing Project (Company)

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\*These sub-components were excluded from the Scope of Work. The Clinical and Community Based Family Planning Services subcomponent, initially intended to enhance quality of clinical services at the field level through provision of transport, was conceptually revised and directed towards activities in satellite clinics in Project Grant Amendment #4 in 1990, and is still undergoing internal Mission and BDG review. Title III funds have been proposed for supporting this component. *Upazila* Family Planning Initiatives recently was favorably evaluated, and is discussed briefly in this document in Part 4.1.3 Training. Construction of the National Family Planning Headquarters has not progressed, largely because of BDG failure to meet conditions precedent. The Mission had already made an internal decision not to extend support to the PDEU beyond the three year subproject due to end in 1991. Strengthening the MIS has been canceled as a subproject due to BDG failure (after 18 months) to sign the necessary Project Implementation Order. Innovative MCH Activities has a training component which has been retained and discussed later under the BDG training component, but no support for innovative MCH activities has been requested by the BDG.

\*\*While the Project Paper lists the project components as presented above, both Commodities/Logistics and Research are cross-cutting elements which support family planning activities of the government, the Social Marketing Company and the NGOs.

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**Component 3: NGO Family Planning Activities**

- A. Family Planning Association of Bangladesh
- B. Bangladesh Association For Voluntary Sterilization
- C. Family Planning Service and Training Center
- D. Family Planning International Assistance
- E. Pathfinder Fund
- F. The Asia Foundation

**Component 4: Support for MCH Activities**

- A. ORT Social Marketing
- B. Municipal Immunization Program
- C. Innovative MCH Activities

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These support activities are treated as separate components throughout the rest of this report. Sub-components of Component #4: Support for MCH Activities, have been folded into the first three components. Oral Rehydration Therapy (ORT) Social Marketing will be discussed in Part 4.3 The Social Marketing Project; Municipal Immunization will be discussed in Part 4.1.2 under the BDG component, and the training portion of Innovative MCH under Part 4.1.3 Training.

**Appendix C**

**Actual FY 1987-1992 Obligations**

Appendix C

Family Planning and Health Services Project

Actual FY 1987-1992 Obligations  
in U.S. Dollars

Component	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992 to date	Cumulative Obligations to Date	Total Obligations Planned
<b>A. MOHFP Grant</b>								
IE&C	3,510,000						3,510,000	3,510,000
Fieldworker Mobility	5,680,000						5,680,000	10,150,000
Upazila Initiative	2,000,000						3,570,000	3,570,000
Contraceptive Commod. & Logistics	800,000			1,570,000			5,390,000	5,390,000
Nat. FPHQ Bldg.	5,000,000		1,000,000	3,590,000			5,000,000	5,000,000
Res., Mon., Train.	2,670,000	1,670,000	770,000	2,490,000			7,600,000	8,100,000
FPSTC	2,440,000		1,370,000	1,000,000			4,810,000	7,000,000
Munic. Immu.	4,000,000	2,500,000					6,500,000	6,500,000
Innov. MCH		500,000	2,000,000	(3,590,000)			2,500,000	2,500,000
Contingency	3,590,000						- 0 -	- 0 -
<b>Sub Total</b>	<b>29,690,000</b>	<b>4,670,000</b>	<b>5,140,000</b>	<b>5,060,000</b>			<b>44,560,000</b>	<b>51,720,000</b>
<b>B. PSI/SMC</b>								
FP/SMC	2,636,000	3,438,000	915,724	3,480,276			10,470,000	10,470,000
ORT/CBS/SMC		455,907	1,000,000	4,108,000			5,563,907	9,000,000
SMC Effic. Study		38,000	(to be deob/reob to FP or ORT CA withing 19,470,000 total)				38,000	
<b>Sub Total</b>	<b>2,636,000</b>	<b>3,931,907</b>	<b>1,915,724</b>	<b>7,588,276</b>			<b>16,071,907</b>	<b>19,470,000</b>

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Component	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	Cumulative Obligations to Date	Total Obligations Planned
<b>C. NGO Grants/Contracts/Cooperative Agreements to NGOs and Technical Assistance/Research</b>								
FPAB			1,695,783	924,217			2,620,000	2,620,000
BAVS/AVSC			1,800,000				1,800,000	4,410,000
FPIA	486,600		469,000	606,147			1,561,147	3,820,000
Pathfinder	1,477,000	3,380,000		1,423,360			6,280,360	9,500,000
TAF	2,250,000	7,982,000	1,860,000	2,908,000			15,000,000	17,500,000
ICDDR, B (Ext. Proj.)	1,167,000		2,061,846	790,000			4,018,846	4,620,000
Pop. Council (Ext. Proj.)	294,000	290,000	437,833	500,000			1,521,833	2,220,000
University of Michigan (PSIP)		40,000	98,078				138,078	140,000
E. W. Center (NGO Eval.)			359,582				359,582	450,000
<b>Sub Total</b>	<b>5,674,000</b>	<b>11,692,000</b>	<b>8,782,122</b>	<b>7,151,724</b>			<b>33,299,846</b>	<b>45,280,000</b>
<b>D. Centrally - Procured Commodities</b>								
	6,861,000	12,202,000	20,641,154	10,500,000			33,299,846	59,530,000
<b>Sub Total</b>	<b>6,861,000</b>	<b>12,202,000</b>	<b>20,641,154</b>	<b>10,500,000</b>			<b>50,204,154</b>	<b>59,530,000</b>
<b>E. Grand Total</b>								
MOHFP	29,690	4,670,000	5,140,000	5,060,000			44,560,000	51,720,000
PSI/SMC	2,636,000	3,935,907	1,915,724	7,588,276			16,075,907	19,470,000
NGO grants contracts/CAs & TA	5,674,000	11,692,000	8,782,122	7,151,724			33,299,846	45,280,000
Centrally Procured	6,861,000	12,202,000	20,641,154	10,500,000			50,204,154	59,530,000
<b>TOTAL</b>	<b>44,861,000</b>	<b>32,499,907</b>	<b>36,479,000</b>	<b>30,300,000</b>			<b>144,139,907</b>	<b>176,000,000</b>

**Appendix D**  
**Achievements: IEC Component**

## Appendix D

### Achievements: IEC Component

#### 1. Progress on the Workplan

In April 1990, the 1990 JHU/PCS workplan was approved by the IEM Unit and USAID and by the time of this evaluation (August 1990), good progress had been made on some aspects of the plan. At the same time, however, some aspects were overambitious and achievements fell far short of targets (e.g., only 6 of 26 radio segments and 7 of 26 radio spots completed, 5 percent of TV spots, and 2 of 7 films).

Progress on materials production falls into two categories and includes the following:

- **To improve fieldworker ability to communicate with the rural populace:**
  - A contract has been awarded to Program for the Implementation of Appropriate Contraceptive Technology (PIACT)/Bangladesh to develop a Field Workers Motivational Guide to complement the Field Workers Guide. JHU/PCS provided a considerable amount of technical assistance in reviewing research studies and doing field work for developing content of the guide. Completion is expected by December 1990.
  - A Contraceptive Methods Booklet to expand the material presented in the Field Worker's Guide has been approved by the IEM Unit and was scheduled to be field tested beginning in 1990. The widespread distribution (200,000 copies) planned for this year will be delayed.
  - A series of workshops on development of interpersonal communication skills conducted in 1990 and 1991 (the first was held in Comilla in September) will lead to production of an Interpersonal Communication Skills training manual, a draft of which is expected in the spring of 1991. This training manual will complement the Field Workers Guide.
  - Outlines of 6 (of 26) radio segments for field workers have been completed and two pilot programs scheduled with Radio Bangladesh. Further development has been postponed until 1991 because of JHU/PCS's workload. Twenty-six proposed radio dramas for population awareness similarly have been postponed.
  - Publication of a bi-monthly two-color family planning newsletter (Parikrama) under JHU/PCS (replacing direct USAID support) will continue pending outcome of a needs assessment to begin in December. Two issues benefiting from JHU/PCS technical assistance have been produced using other funding.
- **To influence the rural population to adopt family planning:**
  - Development of method-specific materials for clients was not accomplished as available materials were awaiting analysis by Worldview International Foundation. The analysis was completed in July, and the results are being assessed to decide whether to modify existing materials, produce new materials, or cancel the activity.
  - Posters on delayed marriage, child spacing and vasectomy (400,000 each) have been printed and half of them distributed.

- Support for 130 national folk singing teams of four persons each has continued. The program has been evaluated by Bangladesh Unnayan Parishad (an NGO), with a report submitted in August. The program, in existence in one form or another since 1976, has huge potential for reaching rural audiences with tailored messages, but the evaluation confirmed a plethora of serious problems, many stemming from lack of interest, supervision and effective use by the Family Planning Directorate. The continuation of JHU/PCS support will hinge on the degree of remediation by the MOHFW of problems indicated by the evaluation.
- Of a projected 20 radio spots, 7 have been produced, but only 2 aired. Difficulties in securing appropriate air time forced a decision to produce no more spots until the issue is resolved.
- Of 7 films proposed, 2 25-minute family planning/immunization episodes were produced through joint efforts of JHU/PCS, John Snow, Inc. (JSI) and the EPI Unit. After post-production is completed in the U.S., the films will be shown by the IEM Unit, the Health Education Bureau, and the SMC, and perhaps later, commercial showing in cinemas throughout Bangladesh.
- One hundred copies of an audio cassette of 12 folk songs by seven popular performers have been distributed to busses and trains for passenger audiences.
- Of 10 proposed TV spots (focusing on child-spacing, delayed marriage, male responsibilities and interspouse communication), 5 were produced and are being shown in prime time on the regular health show of the Health Education Bureau.

## 2. **Training**

Training activities include

- Attendance by two participants at a JHU/PCS workshop in the U.S.
- A radio communication workshop was replaced by a training of trainers workshop and an Interpersonal Communication Workshop held in September. Participants were from the IEM Unit, the Health Education Bureau, NGOs, other projects, JHU/PCS and the *Upazila* Communication Project.
- Four presentations have been sponsored in a Communication Discussion Series held on a roughly monthly basis. The intent is to provide a regular forum for key IEM Unit personnel, donors and NGOs to raise the level of communication discussion and to learn of creative work done elsewhere.
- A proposed study tour of IEC programs in the region did not occur.

## 3. ***Upazila* Communication Project**

The following progress has been made under the *Upazila* Communication Project:

The test *upazila* has been selected; a baseline survey is near completion which will determine changes in knowledge, attitudes, and practice (KAP) and knowledge of village communication pathways (i.e., understanding of how information that counts is communicated); 20 focus groups have been conducted; field workers' IEC processes have been documented; four field assistant project officers have been recruited and trained; and a building for field office use and accommodation of staff and visitors has been selected.

#### **4. Non-Workplan Outputs**

Materials not included in the workplan but produced in response to *ad hoc* requests with project funding included the following: reprinting of 20,000 copies of a booklet on Islam and Family Welfare; translation and voice-over of two video tapes on the Copper T 380 IUD; and, printing of two sets of stickers for National Population Day.

In addition to technical assistance on all the foregoing activities, JHU/PCS produced two concept papers at the request of the MOHFW: a "Concept Paper on Information Education and Motivation: Strategy for MCH/Family Planning in the Fourth Five Year Plan," and "Proposed Organization for Health/Family Planning Communication: The National Communication Center for Health and Family Planning."

#### **Recommendations**

In scaling back the workplan, the following activities would be good candidates for termination.

1. If assurances of appropriate air times for radio messages cannot be secured, they should be eliminated.
2. If approvals for U.S. post-production work on films cannot be facilitated or cannot be done locally, movie making activities should be reduced.

**Appendix E**

**Municipal Immunization Project:  
Contract Terms and Performance**

## Appendix E

### **Municipal Immunization Project: Contract Terms and Performance**

#### **1. Contract**

The five-year urban immunization project began in October 1988 and is being implemented through three U.S.-based entities:

- The first set of activities ran 21 months (October 1988 through July 1990) and was carried out through a buy-in to the central Resources for Child Health (REACH) Project. Two REACH resident EPI advisors remained in place at the time of the evaluation.
- In April 1990, USAID signed a contract with the Cambridge Consulting Corporation (CCC) of Reston, Virginia and its subcontractor, John Snow, Inc. (JSI) of Boston, Massachusetts for the final four years of the project. This became operational in July of that year.

USAID's contract with CCC (which was very similar to the terms of the REACH buy-in) for the urban immunization project provides for technical assistance from two expatriate advisors (an Urban EPI Advisor and an EPI Communications Advisor), short-term local and international consultants, participant training, administrative and support personnel, and technical, administrative/financial, training, finance and accounting back-stopping from JSI. Vaccination equipment and cold chain supplies are the responsibility of UNICEF (the contractor's procurement responsibility is limited to vehicles, bicycles and motorcycles).

Specific tasks identified in the contract include

- advising on an urban vaccination strategy,
- assisting MOHFW in development of a national communications strategy for urban vaccination,
- production of a series of materials and messages,
- design and management of KAP and focus group studies,
- advice on training, and
- direct funding of some additional urban-level staff.

In addition to assisting with central staff in mobilization, identification, and commitment of community resources to respond to social needs, the contractor is to conduct at least three specified operations research studies, and to support monitoring and evaluation on a city-by-city basis, project monitoring, and reporting.

The line items of the budget are urban assessments, monitoring/evaluation, operational costs, supervision, facility upgrading, social mobilization/communications, training, vaccinators (temporary/non government), counterpart support for technical assistance, and contingency. Annual workplans and budgets are to be drawn up by the EPI Project Director and Urban EPI Advisor, and quarterly progress reports submitted. The PIL stipulated that the accounting system developed by REACH will be followed by EPI with assistance from CCC for accounting, record keeping and monitoring of all funds received, disbursed and expended by EPI. CCC also continues a contract with a chartered accounting firm to assist the EPI Project Director maintain the books of accounts and generate financial reports and statements.

#### **2. Achievements Under REACH**

The REACH buy-in supported project activities were conducted for 21 months (against 12 planned), from October 1988 until July 1990.

**Principal start-up activities were**

- Development of an EPI strategy and workplan for 1989 through provision of a three-person design team (January 1988 through June 1988).
- Assignment of two resident advisors in Dhaka (October 1988).

**During 1989, REACH laid the groundwork for EPI activities by participation in three studies.**

- The most significant was participation in March by a REACH consultant in an External Review of the National EPI Program. This found that the urban component was behind the national schedule. Major recommendations were increased NGO involvement and a strategy that accorded priority to Dhaka City.
- A REACH consultant conducted an anthropological study on the perception of childhood diseases and attitudes toward immunization among urban slum dwellers in Dhaka, the findings of which were made available to the EPI Program (and thus far largely ignored).
- In October, the REACH Senior EPI Technical Officer visited and made a number of technical recommendations, several of which have found their way into regular program activities.

At the program level, the resident team focused on development of activities in the two largest cities, Dhaka and Chittagong. The evaluation reported that, as of March, coverage studies had been undertaken in four cities (Chittagong, Khulna, Dhaka and Narayanganj), that 21 of the municipalities had begun the one-year intensification phase,<sup>1</sup> and that national computerized reporting of EPI was under way. In August 1989 the Intensive EPI Project was launched in the Dhaka municipality, with leadership assumed (and strongly continued) by the Municipal Health Officer. Posters, stickers, handouts, radio and TV coverage, banners and other IEC activities were developed with the assistance of REACH advisors. The First Lady sponsored the inauguration. Subsequently, the intensification phase has been inaugurated in the rest of the municipalities, the latest in February-March 1990.

Actual coverage in urban areas is difficult to ascertain since the computerized EPI MIS is thought to underreport immunizations by at least 20 percentage points. The undercount reflects the failure to include immunizations provided by private physicians (15-30 percent of immunizations given in urban areas according to some surveys). Project personnel and the Urban EPI Section are seeking a mechanism for inclusion of these reports in exchange for vaccines to the private physicians. More accurate coverage information is obtainable through a standard WHO Thirty Cluster Survey technique but this requires trained personnel and good supervision and is relatively expensive.

Periodic urban surveys using these techniques have been initiated. Table E-1 provides the results of five of these surveys that were conducted in late 1989 and early 1990. The numbers without parenthesis represent percent of children under one year who have documentation of full immunization. The accompanying number in parenthesis is the percentage of children under one year reported to be fully immunized by their mothers, and includes documented and undocumented immunizations. Although there is considerable variation among cities, the percentages show significant achievement in immunization coverage in all these municipalities.

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<sup>1</sup>Time-limited intern efforts to immunize as many as possible under-twos and mothers. After the intensification effort has cleared the backlog, under-ones will be the primary emphasis.

Table E-1

Percentage of Children Under One Year Immunized in Selected Municipalities

	BCG	DPT-1	DPT-3	Measles	Fully Immun.	TT-2
*Chittagong (3/89)	(57)	(60)	(44)	(34)	(25)	(88)
Dhaka Slums (1/90)	49 (73)	50 (76)	42 (60)	35 (50)	30	26 (52)
Khulna (2/90)	44 (78)	46 (82)	33 (60)	29 (49)	41	35 (70)
Dhaka City (7/90)	52 (85)	57 (93)	55 (83)	47 (72)	66	18 (82)
Bogra (8/90)	50 (83)	51 (84)	46 (74)	29 (54)	53	41 (87)

Source: Extracts of municipal EPI coverage surveys.

\*Less than one year operation.

**Staffing** progress included hiring of seven Urban Operations Officers to assist and monitor EPI efforts. Collectively, they cover all municipalities. Their duties include coordinating the program with the municipal mayors, NGOs and health officials. They were hired at the request of EPI and UNICEF to complement seven UNICEF National Operations Officers, and are co-officed with them, courtesy of UNICEF. They are responsible to the Urban EPI Advisor. The REACH agreement provided funds for only 41 vaccinators (all in Chittagong), far fewer than anticipated, because the program was successful in convincing the mayors and health authorities to utilize vaccinators (still on the roles from the smallpox eradication campaign) or from their own resources. The Urban Immunization Project personnel and the EPI Program consistently have obtained from the municipalities a heavy share of program responsibility. Funds for EPI-related operational costs were provided under both REACH and PIL 25.

**Training activities** during 1989 included 13 courses for urban EPI personnel in management, social mobilization and/or technical training for mid-level managers, vaccinators, and newly recruited female workers. These utilized established courses funded by UNICEF for the National Program. During 1990, workshops were conducted for urban field officers (orientation), urban dispensary medical officers (improving operations), and for administrators (surveillance). Additionally, hands-on training in computers was provided to nine administrators, one IEC officer, nine medical officers, and four clerical personnel. The EPI Medical Officer in charge of the urban program is undergoing Master of Public Health training in the US, one of three such participants planned. No short-term out of country training is planned.

**A knowledge, attitudes, and practice (KAP) study** was conducted in May 1990. Other IEC activities included production of five TV spots, three radio spots, an audio recording (for use in garment factories), two video films (tea estates and garment factories), a 44-minute, two-part film on family planning and EPI, a lesson plan for schools, and a variety of educational and motivational posters, lamp post displays, wall paintings and calendars targeted for specific audiences.

1/2

Commodities provided include four vehicles, 12 motorcycles for male medical officers in charge of zones (Chittagong 8, Khulna 3, and Rajshahi 1), 58 bicycles and 1 three-wheeled motorscooter for vaccine transport, and two computers and software for the EPI MIS. Travel allowances have been provided for female medical zone officers.

**3. Initial Activities Under CCC**

In September 1990, a three-day meeting was held to develop a new written strategy for each municipality. This is expected to lay the groundwork for the communication strategy and plans for the specific operations research activities called for in the CCC contract. The meeting followed development of municipal assessments by the seven Operations Officers who were hired under the CCC contract. It was also held partly in response to a recommendation made following an Urban EPI Mission to Bangladesh by a consultant funded by UNICEF in June 1990.

**Appendix F**  
**Overview of Training Activities**

## Appendix F

### Overview of Training Activities

USAID supports a wide range of training activities, including the *Upazila* Family Planning Initiatives Project, local and third country (including U.S.-based) training carried out through other project components, and U.S. and third country training for a small number of participants funded directly by the FPHSP. In addition, donors fund several other aspects of training.

***Upazila* Family Planning Initiatives Project.** The major participant training activity of USAID's Office of Population and Health's (OPH) has been the *Upazila* Family Planning Initiatives Project. In brief, this project sponsors four-person teams of *upazila* family planning officials, augmented by local leaders and district and central family planning officials, for two-week observational visits to the Indonesia family planning program. While there, the teams each develop a manageable *upazila* action plan for implementation in Bangladesh, for which the project provides up to two years of funding. In all, about 76 augmented *upazila* teams totaling 450 people will have been funded by the end of project. The Indonesian field portion is handled by the Indonesian National Family Planning Coordinating Board (BKKBN). Management Sciences for Health, a U.S.-based health and family planning management firm, and a local firm, Technical Assistance, Inc., share the selection, monitoring and administration. To date, 213 participants have been sent out of a planned total of 450. The project recently has received a favorable evaluation and has been excluded from the scope of work for this current evaluation except insofar as it might affect recommendations for future activities.

**Other USAID Training — Local.** Project funds for local training, workshops and seminars are contained in project activities funded through contracts and cooperative agreements, including — under the BDG component — the IEC Project and the Urban Immunization Project; under the NGO component — the Family Planning Services and Training Center (FPSTC), the Pathfinder Fund (PF), the Association for Voluntary Surgical Contraception (AVSC) and the Asia Foundation (TAF); and — under the logistics component — the Family Planning Logistics Management (FPLM) Project. This local training is discussed under each component.

**Other USAID Training — Third Country and U.S.** Funds for third country and U.S. training are provided in the SMC, IEC Project, Urban Immunization Project, FPLM Training Project, and TAF cooperative agreements. With the exception of one participant, all this training is short term and non-academic. Additional out-of-country project training support is funded from two project components: Technical Resources Research and Training (TRRT) (for family planning training to focus on development of planning, implementation, evaluation and research skills, and to update specific technical areas) and Training and Innovative MCH Activities (for primary health care, EPI, diarrhea and respiratory disease control, and MCH nutrition). Generally speaking, the majority of participants sponsored by NGOs and contracts are from the private sector, and those by TRRT and Training and Innovative MCH Activities from government.

**Training Support from Other Donors.** Local and out-of-country training is also supported by other donors, including

- GfZ, which since 1986 has funded almost all training of Family Welfare Visitors (FWVs) and Family Welfare Assistants (FWAs) conducted by the National Institute for Population Research and Training (NIPORT) in Dhaka and in 12 Family Welfare Visitors Training Institutes. It also supports 20 Regional Training Centers countrywide.

- **UNFPA, which supports record keeping training for field workers in a demonstration district; female Union Council members in MCH/family planning; personnel in the logistics system for logistics monitoring, warehousing and reporting; teachers for population education; and training/orientation of local leaders (including religious leaders).**
- **The World Bank, with construction/renovation of RTCs.**
- **UNICEF, which supports training of TBAs and all EPI training.**
- **The British Overseas Development Administration (ODA), which supports a component for revision of the midwifery component of the basic nursing curriculum and administers limited scholarship support.**

## **Appendix G**

### **Description of the NGOs and Response to 1986 Evaluation**

## Appendix G

### Description of the NGOs and CAs and Response to the 1986 Overall Evaluation

#### 1. The NGOs

##### The Asia Foundation

TAF is a private, publicly supported grant-making organization that has been active in Bangladesh since 1954. In 1979, with a \$500,000 PVO co-financing grant from A.I.D., TAF began implementing family planning activities. By 1981, when TAF began receiving bilateral funds under FPHSP, it had developed nine sub-projects with local NGOs. Today, TAF is supporting 31 projects in 75 rural and urban sites. Since 1985, the organization has also supported a pilot effort, through five NGOs in six *upazilas*, to lower fertility while improving the educational status of females. Scholarships are provided to female students in classes 6-10 to enable them to complete their secondary education. USAID support is being phased out of this component by 1991. TAF is providing technical assistance to female education sub-projects in proposal development, management, and evaluation and is active in soliciting other donor funding for project continuation.

In implementing its program, TAF has emphasized improving management of sub-projects through fine-tuning monitoring and supervisory systems; developing manuals for standardized program and clinic operations; refining workplans, reporting, and MIS; and utilizing operations research and evaluations to increase effectiveness of programs and procedures. Strengthening of institutional capability of its Dhaka office and sub-grantees has also been a focus of TAF's strategy. A training plan has been prepared to address the needs of sub-project staff. Utilizing available resources such as the CFWP training program, local level workshops, observational visits to other projects and short-term training abroad, TAF is improving the knowledge and skills of NGO staff. Provision of quarterly in-service training, and long- and short-term training opportunities abroad for TAF Dhaka staff enhances the ability to provide technical assistance to sub-grantees and to improve overall monitoring, evaluation, and program planning.

TAF has strengths in the areas of innovative programming, institutional development, and coordination among NGOs. The organization has integrated MCH services in its field projects using private funds and establishing project linkages with ODA. It is collecting information from its sub-grantees on child survival indicators and is utilizing traditional birth attendants in some projects. In urban areas, it is beginning a program with a local garment factory. TAF is addressing issues of cost recovery and sustainability with its grantees and is looking at ways to maintain and improve the high contraceptive prevalence rates achieved in many projects. To this end, TAF organized a Community-Based Self-Reliance Workshop for 16 of its sub-grantees in July 1990. The participants and resource persons shared experiences relating to revenue generation and each organization prepared an action plan.

##### Recommendation

- TAF should provide assistance to CFWP for a comprehensive management and financial review of its training project to determine the viability of establishing an independent, financially sustainable training unit that would serve as a cost recovery mechanism.

##### Association for Voluntary Surgical Contraception

AVSC supports service delivery and training activities in Bangladesh through the Bangladesh Association for Sterilization (BAVS), a local NGO established in 1974. Since 1983, it has also been providing funds to NIPORT for comprehensive and refresher VS training for BDG physicians. Recently it has initiated a comprehensive MCH and family planning training program for medical interns associated with the Model Clinics attached to the eight medical colleges.

BAVS presently has 25 clinics, which since 1986 have offered all methods of family planning. Since 1975 BAVS has performed approximately 550,000 VS operations, which is 16 percent of the national program achievement. Its training programs are extensive and targeted to government and non-government personnel at various levels (physicians, counsellors, fieldworkers and coordinators, nurses, paramedics, and trainers). During this project period, partly as a result of decreasing demand for VS services, which in turn, in part, reflects removal of subsidies for referring agents, BAVS has reduced its number of clinics from 33 to 25. It has taken part in the Norplant® clinical trials and is presently introducing non-scalpel vasectomy into its program.

AVSC is known for its high technical quality and its expertise in the field of surgical contraception, as well as its long history of operation in Bangladesh. Coupled with its effectiveness in both government and NGO sectors, this makes it a resource for transfer of technologies, training, and innovations to improve the national program.

#### **Recommendation**

- AVSC and BAVS should develop a long-term strategy and financial plan that address the future role and focus of BAVS in Bangladesh's population program in the context of the reduction in demand for VS and the most efficient use of its human and financial resources.

#### **Family Planning Association of Bangladesh**

FPAB, the Bangladesh affiliate of the International Planned Parenthood Federation (IPPF), was established in 1953 and became the pioneer of family planning activities in Bangladesh. The goal of FPAB is to support the national family planning program through the provision of services, information, and education. Programs are implemented through the community using volunteers, youth and women, with attention being given to promoting self-reliance and institutionalization of services and benefits.

Since 1981, using USAID bilateral funds, FPAB has been implementing two innovative service delivery projects: 1) Use of Voluntary Agencies in Population Activities (UVAPA); and 2) Utilization of Traditional Healers in Family Planning (UTHFP). The first project has utilized 225 of the more than 5,000 small, local-level voluntary agencies registered with the Ministry of Social Services to provide family planning motivation and services in rural areas. Between 1981 and 1989, the project recruited 326,696 family planning acceptors and referred 33,321 clients for VS. The UTHFP project involves provision of family planning motivation and service delivery by traditional healers, a group which provides health services to between 60 and 70 percent of the rural population and whose members are considered to be influential persons in the community. From 1981 to 1989, this group recruited 315,311 family planning acceptors. Through the implementation of the UTHFP project, FPAB has gained experience using depot holders for provision of contraceptive commodities as well as linking with government programs as it withdraws from mature project areas. An evaluation survey was carried out by Mitra and Associates for both of these projects during the latter half of 1989. The results of these surveys confirmed the effectiveness of these approaches as indicated by a higher contraceptive prevalence rate in the areas served by the two projects than in the rural sample of eligible women of the 1989 CPS; however, the activities did not reach all the planned target population. FPAB's current cooperative agreement (1989-1992) calls for continuation and expansion of both these projects.

FPAB also plays a role in coordinating the logistics and supply of commodities for itself and three other CAs (FPIA, TAF, and Pathfinder). It obtains supplies from the government central warehouse and, utilizing its transport and network of regional offices, distributes the contraceptives to other organizations and their sub-projects. This system often breaks down and field projects experience an irregular and inconsistent supply of contraceptive commodities. An assessment of the FPAB's commodity distribution system has been carried out by Technical Assistance Inc. and the report is presently under review by the mission. One of the major findings is that the government does not supply FPAB with enough commodities.

USAID has supported FPAB's role in IEC by providing equipment and funds for film production and in training by providing short-term training for members of its training unit.

In addition to the above-mentioned activities, FPAB in conjunction with the JSI Enterprise Project held a workshop in 1990 for the NGO community on sustainability of programs. FPAB has introduced some cost recovery mechanisms into its programs and is investigating other options. A project working with the Tea Board to introduce family planning services into seven tea estates will target a previously unserved population.

### **Recommendations**

- The training of volunteers and supervisors in the UVAPA project should be examined with regard to improving coverage of target areas. The experience of using traditional healers as depot holders and their role as family planning motivators and service providers after FPAB has withdrawn support should be reviewed and documented for use in other places, for example, in CBS of SMC.
- FPAB should continue to expand its role in the private sector and develop a capability to market its family planning expertise to the industrial sector as a means of increasing cost recovery.

### **Family Planning International Assistance**

FPIA, the international division of the Planned Parenthood Federation of America, has been supporting Bangladesh's family planning program since 1974. Its financial and commodity support to a total of 34 projects has been approximately \$17 million. During the period under evaluation, FPIA supported five sub-projects which operated in 64 sites and served about 150,000 acceptors annually. These sub-projects are mainly in rural areas, utilize a CBD approach, and implement innovative strategies for tapping different groups of the community as motivators-cum-educators. The cost per client in FPIA's current projects ranges from \$2 to \$6. As of July 31, 1990, one project with 33 sites was terminated by FPIA (Bang. 28 — Rural Family and Child Welfare Project). This project is now receiving funds from the Swiss Government through Enfants du Monde.

Some innovative approaches have included 1) involving government fieldworkers from the Directorate of Social Services in providing family planning motivation and services; 2) involving rural women as part-time fieldworkers serving about 200 ELCOs while simultaneously providing income-generating opportunities and savings schemes for them; 3) involving Village Development Party members as depot holders for family planning commodities; 4) involving youth organizations and satisfied users in implementation; and 5) involving unmarried women in population education programs.

FPIA has focused on improved project management through continuous project staff development and training. During this evaluation period, 16 senior staff from five projects attended a workshop on Project Management and 14 participants attended a workshop entitled "Acceptor Records, Data Management, and Utilization." Twelve senior project managers received training in Bangkok on personnel management. In an effort to improve quality of services and acceptance, FPIA is presently carrying out a survey on fieldworkers' characteristics and performance. A new pictorial record card has been pre-tested and introduced to enable fieldworkers with limited literacy skills to document the family planning services they provide to clients.

Cost recovery and sustainability are being encouraged through income-generating models and community involvement. In the four continuing projects, land has been donated by the community at 18 major project sites and offices have already been constructed by the organizations at 10 of these sites. A

contraceptive pricing survey is presently being analyzed to assist in introducing cost recovery mechanisms through the sale of contraceptives.

Active users and contraceptive prevalence have increased over time except during 1988 when there was a severe commodity shortage. FPIA sub-grantees are still plagued by an inconsistent commodity supply. Another problem that surfaced since the last evaluation has been the uncertainty of FPIA's future. (Since this evaluation, all FPIA activities except one, which FPIA will continue with its own funds, have been transferred to TAF. The cooperative agreement with A.I.D. expired on October 31, 1990.)

#### Recommendation

- FPIA should document its experiences, successes, and failures relating to innovative program approaches and cost recovery mechanisms for the benefit of other NGOs.

#### Family Planning Services and Training Center

FPSTC, established by the MOHFW in 1978, serves as the secretariat for the FPCVO and as an umbrella resource organization providing financial and technical assistance to local NGOs active in family planning. Originally funded by FPIA and the Ford Foundation, FPSTC now receives support from USAID, TAF, and the International Council for Management of Population Programs. Currently, FPSTC funds 49 service delivery projects (43 urban and 6 rural); provides basic and refresher management training for management, supervisory, and office staff of its sub-grantees and other NGOs; and disseminates family planning information through seminars, workshops, and a monthly newsletter entitled *Projanmo*.

In providing assistance to sub-grantees, FPSTC program staff plan three routine monitoring visits annually. Additional staff visits include an audit visit, compliance/problem solving visits, and special or follow-up visits as needed. In addition, FPSTC provides contraceptive commodities to all of its sub-grantees and assists in project evaluation. In July 1989, all 49 sub-grantees completed a survey in their project areas. This provided updated information on ELCOs since shifts in demarcation of project areas had taken place as new government FWAs were recruited and placed in the field. Most of the FPSTC sub-projects include supportive activities such as MCH services, literacy programs, and income generation activities.

Since its inception, FPSTC has become increasingly involved in providing training to the NGO community. In 1979, with one training officer and temporary resource persons, FPSTC provided basic three-day orientation courses at new project locations and a 10-day basic training course in Dhaka for project managers. Presently, the Training Unit consists of seven professional staff, five of whom are core trainers. Two of these senior trainers have participated in long-term degree level training in management and a number of the other trainers have upgraded their skills through short-term training opportunities. In 1985/86, a training consultant worked with FPSTC to improve its training program. According to FPSTC's most recent workplan, 20 courses, 4 quarterly meetings, and 3 workshops will have been conducted during the period from October 1989 to September 1990. Recently, Pathfinder's Director of Medical Services and a local counterpart reviewed FPSTC's training program.

In its role as Secretariat of the FPCVO, FPSTC is tasked with organizing FPCVO's quarterly meetings. To date, FPCVO has met sporadically. During the period from October 1988-September 1989, only one meeting was held and no meetings were held during the first three quarters of FY90. A meeting was held during the month of August 1990, at which issues related to area demarcation and solutions to this problem were discussed. FPSTC falls into a unique category somewhere between a government and a non-governmental organization. As the NGO Affairs Bureau becomes increasingly operational, the roles of FPCVO and FPSTC may become altered. To this end, FPSTC is exploring the implications and mechanisms of becoming an NGO. A new constitution has already been developed, but FPSTC wisely is assessing the changing situation before making any permanent decisions regarding its status.

FPSTC is examining sustainability and cost recovery mechanisms. Although it charges nominal amounts for its training courses, the fees cover only the costs of materials, not the facilities or salaries of associated staff. FPSTC's sub-projects are also beginning to look at these issues and have introduced the sale of condoms and the monthly FPSTC newsletter.

### Recommendations

- An evaluation planned for September 1991 should review the FPSTC mechanism of training needs assessment to ensure that it is being responsive to the actual field needs of the recipients. In addition, the mechanism and methodology for measuring impact of training should be assessed. Depending on the results of the evaluation, FPSTC may want to acquire the services of a training consultant to strengthen these areas, review course offerings and curricula, and update training materials.
- FPSTC should review and update the costs incurred by its training unit and develop a phased plan to increase gradually the revenue generated by the training activities.

### The Pathfinder Fund

Pathfinder has been active in Bangladesh since the early 1950s when it helped to establish FPAB. In 1978, a country office was established and between 1978 and 1981 a number of CBD and clinical projects were implemented using A.I.D./W funds and private resources. Currently, Pathfinder activities focus on the following six major themes: 1) service delivery; 2) decentralization and development of local leadership; 3) coordination among NGOs and between NGOs and the government; 4) technical assistance in training and development of training materials; 5) support to promote the small family norm; and 6) sustainability of family planning program activities.

Pathfinder supports 29 CBD projects with 30 urban and 33 rural sites as well as 2 clinical projects at 5 sites. These projects serve 583,000 eligible couples of which 44 percent are users of modern methods. All of the CBD projects are staffed by women and offer some MCH services. Achievement has been consistent with planned objective in these projects. Identified constraints to performance have included changes in demarcation of areas of responsibility, shortage of commodities, and non-availability or turnover of personnel. The clinical projects, which provided 33,106 couple years of protection (CYP) between July 1989 and June 1990, recently have been evaluated and the report should provide valuable information on maximizing utilization and resources of these projects.

During Pathfinder's years of operations in Bangladesh, a close relationship has developed with the government. As a result, Pathfinder has assisted in providing orientation and training to district, *upazila*, and union level officials in support of Bangladesh's population program. It has also produced training materials such as a book in Bangla entitled *Demographic Concepts and Measurements* which has been used in training 461 BDG officials and 35 NGO project personnel since June 1988. In support of BDG's policy of the small family norm, since 1987 Pathfinder has sponsored receptions for two-child couples at the national, district, and *upazila*, and union levels. Participation has increased from 128 couples in 1987 to 3,343 couples in 1990.

Pathfinder has taken the lead in coordinating workshops in Dhaka, Chittagong, and Khulna divisions which identified solutions to problems related to management, record keeping, and area demarcation.

Revenue generation initiatives began in November 1989 through sales of contraceptives, selected FWA/doctor service charges, and sharing operational costs to increase the sense of ownership of the project by the grantee organization and local community. As of June 1990, Tk. 60,682 (\$1,725) has been generated in 28 urban projects from the sales of contraceptives. A total of Tk. 16,740 (\$975) has been realized

from service fees of 23 projects. Grantees of seven projects are already providing office accommodations and four more have agreed to do so in the future. Local contributions of 22 projects amounted to Tk. 39,418 (\$1,125) between January and June. These funds are being kept in separate bank accounts. In coordination with USAID and the Enterprise Project, Pathfinder plans to hold a workshop in early 1991 to share experiences in revenue generation and to develop strategies and policy guidelines for strengthening revenue generation and self-reliance activities, including utilizing generated revenue.

Pathfinder is addressing quality aspects in its program management through continuous monitoring and provision of technical assistance to projects, training of project personnel, and active evaluation of program components. In addition to the evaluation of the clinical program, Pathfinder has completed an evaluation of training and technical assistance which it provided to FPSTC, and is in the process of evaluating Pathfinder's decentralization activities. During its present cooperative agreement, Pathfinder has also conducted mini-contraceptive prevalence surveys in its service areas as well as a general evaluation of its CBD projects.

### **Recommendations**

- Pathfinder should complete the evaluation of its clinical service sites and develop a plan to implement the relevant recommendations.
- Pathfinder should assess the need for coordinating a workshop in Rajshahi Division similar to those carried out in the other three divisions.
- In collaboration with other Cas, Pathfinder should identify issues relating to coordination in the rural areas and develop strategies to address them.

## **2. Response to the 1986 Overall Evaluation**

On a broad level, the NGOs have responded to the general recommendations of the 1986 evaluation, *An Overall Evaluation of the USAID/Bangladesh Family Planning Services Project (388-0050), Key Issues, and Future Assistance*, and have enhanced their achievements and effectiveness through a number of mechanisms. Perhaps the most important one is that of coordination among NGOs working in the field of family planning. An NGO Coordinating Committee was established by the CAs at the recommendation of USAID and meets monthly to coordinate activities, address issues, share experiences, focus on areas for improvement, and foster relationships between the government and NGOs. This body was recognized by the FPCVO through a resolution in November 1986.

Through the activities of the committee on training of the NGO Coordinating Committee, a consultant in 1986 assessed the training program for NGO management and field personnel. As a result, curricula were updated and improved and a plan for training staff development initiated. The technical assistance and follow-up in this area not only benefited NGOs providing training, but is expected to have lasting effects on the successful implementation of NGO programs and should ultimately lead to the institutionalization of benefits at the community level. The Coordinating Committee has addressed issues of area demarcation through sponsorship of conferences and workshops and is taking a lead in cost recovery and institutionalization of programs. The coordination effort includes not only the USAID-sponsored CAs, which provide nearly all of the donor support to the NGOs in family planning, but also Concerned Women for Family Planning (CWFP), a national NGO active in family planning since 1974; ODA, which supports integrated health and limited family planning activities through its NGO project; and ICDDR,B, which facilitates the transfer of innovative technologies to the government program.

The NGOs also utilize their individual comparative strengths to minimize duplication of efforts and resources. Organizations that have linkages with the government such as FPSTC and Pathfinder

serve as liaison for other NGOs; AVSC is a resource for clinical methods; TAF is a resource in the area of institutional development; FPIA is a resource for innovative models in rural areas; and FPAB coordinates commodities logistics for a large portion of the NGO community.

During the current project, the NGOs have contributed to the successful BDG adoption of a decreased worker to ELCO ratio; a record book and improved work plans and record keeping mechanisms for fieldworkers; the introduction of contraceptive prevalence rate calculation by field personnel; and the Field Guide, which was developed through the activities of the NGO Training Committee as a tool for fieldworkers to use in motivating and counseling clients. The BDG made minimal adaptations in the Field Guide and printed 40,000 copies for its personnel. In addition, the NGOs have provided tangible support to the BDG's policies relating to small family norms.

The CAs have improved and coordinated their management information systems during the project period, and although they each have slightly different formats, all can retrieve comparable information based on standard definitions for active users, referrals, ELCOs in project area, and contraceptive acceptance by method and contraceptive prevalence in their assigned work area. These data are compatible with the BDG MIS system.

USAID and the NGOs have worked together to reduce the burden of management by approving sub-projects for longer periods and consolidating sub-projects. USAID also has facilitated upgrading and computerizing the database for NGO sub-projects. Over the last two years this has become a valuable tool for both the CAs and USAID.

NGOs have expanded the scope of their activities into rural areas and are working in conjunction with local level government programs to expand coverage in underserved locales. Of the 320 projects supported through the CAs, 178 are rural and 142 are urban and increasingly are supportive of the BDG's policies of decentralization.

The CAs and USAID actively are addressing quality control aspects. Two outcomes have been the recent development of the Quality Assurance Manual for NGO Family Planning Clinical Services and the coordinated effort by the CAs to introduce clinical enhancement training to improve overall management of clinical service delivery and the clinical and counselling skills of project staff.

The East West Population Institute currently is undertaking an evaluation of family planning service delivery and related activities of the USAID-funded NGO family planning program, as a whole, and of the projects of each of the CAs individually. The objective of this evaluation is to provide family planning program managers and USAID with an information base for guiding decisions about future programming. The evaluation will assess the contribution of the NGO program and the individual CAs to the prevalence of contraceptive practice in Bangladesh, provide information on the quality of program management and service provision at the local level, and document innovative activities of various NGOs and provide evidence regarding their effectiveness. When completed in June 1991, this two-year evaluation should provide information useful in improving and increasing program effectiveness.

## **Appendix H**

### **Overview of SMC Research Activities**

## Appendix H

### Overview of SMC Research Activities

#### 1. Overview

SMC has conducted 11 major studies in the last three years. These studies have used a variety of methodologies including mini surveys, intercept surveys, household surveys, retail audits, and qualitative in-depth interviews. It has used a variety of data collection organizations, while maintaining a limited in-house capability to collect and utilize data. The studies undertaken by SMC include the following:

1. Retailers' Opinion on Panther
2. Baseline Survey of Contraceptive Knowledge and Information
3. Qualitative Study on ORT
4. Evaluation of ORT Mailing -- A mail survey
5. Market Segmentation Study of Contraceptives
6. Study on Repositioning of the Majestic Condom
7. Bangladesh Retail Audit Study (Contraceptives)
8. Diarrhoeal Morbidity and Treatment Survey
9. Brand Awareness, Trial & Usage Study
10. Baseline Study of the Evaluation of the ORT Educational Program
11. Price Survey of SMC Products

SMC has plans to implement four more studies. In collaboration with Family Health International and Mitra Associates, SMC plans to conduct a qualitative study of condom use practices and a study of price elasticity for SMC products. The retail audit done twice yearly by Mitra will be carried out in the next few months. SMC also is planning a repeat of the Baseline Survey of Contraceptive Knowledge and Information last conducted in 1987.

#### 2. Research Findings and Utilization

Some of the major findings to come from SMC research in the last four years are

- Packaging and public image of the product do influence sales. New advertising and a change of packaging resulted in a 60 percent increase in sales. Bangladeshi consumers do respond to modern marketing techniques.
- Male knowledge of contraception is lower than is desirable. Since men play a major role in the fertility decision making process and frequently acquire contraceptives for the wives limited by "purdah," IEC efforts aimed at men are likely to have a continuing impact on contraceptive use and fertility. (Note that other studies have found knowledge levels high enough to argue that IEC efforts are no longer required.)

- There is a considerable amount of misinformation on specific methods among both men and women. Survey data show a high level of knowledge of at least one modern method of family planning among women, but detailed knowledge on correct usage and where to obtain contraceptives is of lower quality.
- The causes, treatment and consequences of diarrhea are inadequately understood by the general population. For example, users reported ORS was not effective because it did not stop diarrhea, while having no concept of the consequences of dehydration. ORS is underused, often used in insufficient quantities, or is used improperly, and many people do not seek treatment when required.
- SMC was the first to distribute educational materials through the postal system and successfully test the impact of the mailing by using a mail survey of recipients.
- Fear of side effects continues to be a major constraint to pill use.
- Radio is the single most important channel of mass media communication in Bangladesh, although the coverage is low at 33 percent for the nation.

In the area of utilization, SMC has used results of its research to

- modify product packaging;
- modify message content and delivery in advertising campaigns;
- develop a broad range of education materials designed to facilitate acceptance of specific products;
- set prices on individual products and target products toward specific market segments;
- schedule advertising to permit maximum impact;
- establish baseline data for subsequent evaluation; and,
- monitor sales independently of sales data to identify service problems.

**Appendix I**  
**Logistics Assistance to the Government**

## Appendix I

### Logistics Assistance to the Government

#### 1. Overview

From 1984 to 1988, logistics technical assistance was carried out by USAID's Logistics Management Advisor and local staff. The Advisor developed and supervised storekeeper training and three annual National Physical Inventories of contraceptives, surgical equipment, drugs and MCH materials. This was supplanted in 1988, with the start of the centrally funded Family Planning Logistics Management (FPLM) project with John Snow, Inc. (JSI). FPLM assistance to the national family planning program includes the services of an expatriate Logistics Management Advisor and expatriate Training Advisor, funds to support two local LMIS specialists, support staff, and office and transportation equipment.

The prime focus of these efforts has been to keep supplies moving through the vast administrative network to the over 2,500 outlets that provide family planning services. The network includes 64 district hospitals (one for each district), 86 maternal and child welfare clinics, 347 *Upazila* health complexes (out of 464 *upazilas*), and approximately 2,050 union family welfare centers (FWC). There are 4,354 unions and MOHFW is planning to build or renovate approximately 2,500 additional FWCs. MOHFW and USAID's logistics and training advisors and staff developed the current national distribution plan and provided training in logistics management to storekeepers and field officers from the *Upazila* to the Division level.

Contraceptives have traditionally been procured by the donors and consigned to the MOHFW. As soon as the Logistics and Supply Unit of the Directorate of Family Planning becomes fully staffed and trained, the government is expected to take over this task. The BDG has already begun procuring World Bank-funded condoms and Norplant directly.

#### 2. Distribution System

The distribution system begins in Chittagong, with receipt of shipments. Once port clearance procedures are completed, the shipment is transported to the Chittagong Regional Warehouse where it is divided into five equal allotments (one for each of the country's four Divisions and one for the NGOs). The Chittagong portion is transferred to the Chittagong Division Regional Office and the other four parts are transported to the Dhaka Central Warehouse.

The distribution system used by MOHFW is a combination of a "push" and "pull" system, with the intent that it will become predominately a push system.

In the push system, the higher (supplying) level decides what commodities move down and when. This system is dependent on an accurate logistics management information system that can provide information required to make such decisions on time. The information required in a push system includes quantities issued on the previous period; amount of stock on hand; the average monthly distribution by the lower supply levels; and an established number of months of reserve stock. With accurate information, the higher level can calculate and ship the quantities required to bring the stock level up to the desired inventory level. This system is supply driven.

In the pull or indent system, the lower (requesting) facility orders commodities as it needs them, based on commodities distributed. While the push system uses the LMIS, the pull system uses the MIS. The system has the advantage that it is based on up-to-date on-site information, but it has the disadvantage that it requires many well-trained personnel at the lower levels of the system capable of making assessment of needs and submitting timely and accurate indents (requisitions). It is demand driven. The pull system is used by the three Regional Warehouses that supply the 17 District Reserve Stores (DRS), in theory in

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response to indents. The DRS's in turn supply the *upazila* Storerooms. There are between 20 to 23 *upazila* storerooms under each DRS. Field staff (FWVs and FWAs) obtain their supplies from the *upazila* Storerooms.

### 3. Management Information System

Currently, there are three different ways of estimating how many contraceptives are in the system and how many have been distributed. Two are management information systems — the Logistics Management Information System (LMIS), developed through the FPLM to track contraceptives through the system, and the government's Management Information System (MIS), which relies on service statistics and is used theoretically by the Central Warehouse to determine contraceptive shipments for the Regional Warehouses and the NGOs (see above). In addition, the FPLM monitors the Annual National Physical Inventory (NPI) of Contraceptives, Surgical Equipment and Drugs, and MCH Materials. The NPI monitors the overall performance of the management information systems (MIS and LMIS) and provides to managers a rough picture of commodity stock levels nationwide.

Comparisons between data produced by the LMIS and MIS reveal that there has been very little consistency between the reports. Thus, at present, there is no management information system that provides the basis for rational and timely management decision-making. Given the confusion arising from the LMIS and MIS, the information provided by the NPI is invaluable for annual forecasting of commodity needs.

The LMIS is a computerized program that tracks contraceptive commodities from shipments, receipts and distributions from the Central Warehouse down through the system to the field-level FWAs and FWVs. The LMIS computer hardware physically is located in DFP facilities but is managed and staffed by FPLM personnel. The information flow from the field to the LMIS data processing unit is as follows: Quantities of contraceptives issued to users by the FWVs and FWAs are reported to the supervising Family Planning Assistant (FPA) on Form #4 (Fieldworker's Monthly Contraceptive Supply, Distribution & Stock Balance Report). At the union level, the FPA consolidates Forms #4 and prepares Form #4A (Fieldworker's Consolidated Monthly Contraceptive Supply, Distribution & Stock Balance Report). After approval by the *upazila* Family Planning Officer (UFPO), the *upazila* Storekeeper compiles the *upazila* reports to prepare Form #7B (*upazila* Monthly Supply, Distribution and Stock Balance Report), and submits copies to the LMIS office, the Central Warehouse, the Director of Logistics and Supplies, and to the MIS Unit. Data from Form #7B are entered into the LMIS, which then produces the following reports: Central/Regional Warehouse Monthly Stock Balance Report, Commodity Pipeline Report, List of Overdue or Missing Form #7B Report,<sup>1</sup> Central/Regional Warehouse and *upazila* Storerooms' Desired Inventory Level Report, and Contraceptive Use Analysis and Projection Tables. The LMIS is producing monthly reports on schedule (one month after the closing date), and the percentage of *upazilas* reporting by deadline is about 75 percent.

The Director of the BDG's Logistics and Supplies Unit, who is responsible for all government commodity logistics, recently began to require each UFPO to phone in logistics information (the same type of information reported monthly to the LMIS *on a daily basis*, with a *daily* report then submitted by the LMIS to his office). This requirement seems unnecessary and impractical and no explanation for the rationale was forthcoming. Some localities do not have access to dependable phone lines and cannot or do not report; thus the daily reports produced by LMIS do not reflect the national commodities situation. Even if they did, it is unlikely that day-to-day changes would be significant or that logistics management would have time to analyze data and make any relevant decisions on a daily basis. More recently the requirement has been changed to a weekly report, but the same comments apply. This policy imposes an unnecessary and useless burden on the UFPO and the LMIS staff.

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<sup>1</sup>This report includes a list of locations and indicates if Form #7B have been submitted or not.

The MIS is a computerized service statistics program that reports method performance on a monthly basis. It is managed by the MIS Unit of the Directorate of Family Planning. The information flow from the field proceeds according to standard logistics practice, with each level counting supplies on hand, subtracting these from totals at the time of receipt of supplies, and requisitioning the difference from the next highest level. As with the LMIS, data for headquarters is amalgamated at the *Upazila* level and sent to headquarters for final tabulation.

The contraceptive usage figures of the NGO subprojects are incorporated into the MIS and LMIS. Each subgrantee submits form #7B (District Monthly Supply Distribution and Stock Balance Report) and Month-Wise Consumption Report to the FPAB district office. The district office compiles the data and submits the compiled report and all Forms #7B to the FPAB Head Office. FPAB aggregates the reports by CA and submits it with the Monthly Distribution and Stock Balance Report to the Central Warehouse and to LMIS.

One of the conclusions of the Executive Summary of the 1988 National Physical Inventory was that the MIS does not accurately reflect program accomplishments or explain differences between performance reports and distribution reports. The LMIS is thus proving to be the timelier and probably more accurate of the two systems. Currently, the MIS is producing compiled reports three months after the field reporting deadline, compared with one month for the LMIS. This means that the Central Warehouse staff is calculating quantities to distribute without having current information on hand, an unacceptable situation. Furthermore, MIS performance reports are believed to underreport amounts of contraceptives distributed, since MIS reports have always reported lower consumption levels than have the data from the National Physical Inventory. In addition, the MIS data tend to be less complete than LMIS data, since lower percentages of *upazilas* comply with MIS reporting requirements than do those who comply with LMIS requirements (75 percent report on time). Finally, MIS inaccuracy is caused in part because field workers do not care about the accuracy of their reports because they see no link between what they report and what they get.

The inconsistencies in data produced by the LMIS and the MIS create confusion among Central Warehouse staff during the monthly forecasting of quantities to be distributed to lower levels. Indeed, people in the field believe that the problems they encounter with low stock levels are due to the confusion these conflicting reports bring to the managers of the program. It is also true that some of the managers at the central level do not have the knowledge and experience to interpret the tables and reports produced by either of those two management information systems.

Recently UNFPA has proposed the merger (or link) of the LMIS and the MIS. It is not clear to the MOHFW, FPLM, the UNFPA Logistics Advisor, nor USAID what "merge" means. Any such merger would be premature, however, until MIS and LMIS agree upon actual information needs are agreed upon and a complete assessment of both information systems is done. Arrangements are under way to acquire services of an MIS specialist to evaluate the information needs of MOHFW and the donors, and to recommend how these needs best could be met by one, both, or a combination of the two systems, or by a different management information system.

### Training

Extensive assistance in logistics management training has been provided to the MOHFW during both phases of the project. During the early phases, it was provided through the USAID Logistics Advisor, and more recently, under the FPLM subproject.

1984-1989. The first training activities were storekeeper training, and a planned training of trainers to develop a cadre of logistics trainers for the National Institute for Population Research and Training (NIPORT). The first effort was successfully completed, but the second, which was initiated in 1986 by the USAID Logistics Advisor and staff, did not achieve its goal for more than three years as the BDG failed to

honor commitments to provide a cadre of trainers, supply replacements, or carry out a scheduled next round of training. The plan had been that the trainers trained at NIPORT would in turn train BDG field level officers and other logistics personnel in the FPLM Project to deliver orientation in logistics to all field grade officers involved in family planning activities. The MOHFW had agreed with USAID to this approach, and the use of this cadre of trainers was included in the design of the FPLM Project. The FPLM Chief of Party was informed only after arriving in Dhaka, that for unexplained reasons, the DFP had decided that none of the field officers previously trained would be available for the FPLM training program. As a result, the training schedule was delayed, FPLM was forced to organize a new training of trainers course and to fund salaries for these new trainers. FPLM continued with its training plans, but despite efforts to keep close coordination with the DFP and NIPORT during the organization and scheduling of these activities, it encountered new barriers from both. First, NIPORT did not include the logistics training activities in the 1989-90 training calendar, which by then was full. In October 1989, the DFP unexpectedly canceled all scheduled training courses. This decision was later revoked, but it delayed all the training activities.

**1989-Present.** Since the inception of the FPLM Logistics Management Training Program in 1989, 2,850 MOHFW staff members have been trained in the Divisions of Khulna and Rajshahi and currently training is taking place in Chittagong. Reaction to these training activities by participants has been very favorable. The general consensus among government officials and donors is that the training has improved job performance, including compliance to report requirements. At present, the Training Unit is fully staffed and funded by FPLM.

On the other hand, the longer-term goal of incorporating logistics training within NIPORT is still far from realization, in part because NIPORT's training calendar remains full. Instead, the training is coordinated with NIPORT to assure government concurrence and participation. At the same time, USAID and FPLM are participating in discussions with GTZ on how to incorporate the logistics management training component into NIPORT. GTZ helps NIPORT with indigenous training of field personnel — FWVs, FWAs, and FPAs — but not in logistics. The primary option under consideration is for NIPORT/GTZ to take on responsibility also for logistics training, with FPLM supporting a training advisor who would work closely with a GTZ-funded logistics management training staff. NIPORT would subcontract the training to a local company or NGO to implement the training program under the supervision of the NIPORT staff. While the NIPORT staff were being oriented and trained by FPLM, FPLM would continue to provide the training directly through December 1991, when the NIPORT staff should be prepared to subcontract and oversee the logistics management training program. For this to occur, a private group or NGO would have to be identified and skills imparted by FPLM. Additionally, the MOHFW would need to be willing and able to undertake such a subcontract. That all of this will occur by December 1991 seems unlikely.

**Appendix J**  
**Research Activities of NIPORT**

## Appendix J

### Research Activities of NIPORT

NIPORT, initially established as training facility for family planning managers, added research to its activities in 1978, two years after its creation. It was recently designated as the official research arm of the Bangladesh family planning program, providing the rationale for turning over to it responsibility for implementation of the CPSs. The exact nature of NIPORT's research role, however, is unclear. It has been variously described as a research coordinating body, the research arm of the program, and as the training evaluation arm of NIPORT.<sup>1</sup> GTZ is the major donor to NIPORT but has indicated that its interests primarily are in training. USAID is providing no funding for NIPORT but is providing limited technical assistance on an informal basis.

In the past four years, NIPORT has carried out a wide variety of studies and research, including evaluations of training, causes of differential performance of different categories of family planning workers, differentials affecting contraceptive practice, studies of compensation payments, the Bangladesh Fertility Survey and a 1990 "mini" contraceptive prevalence survey. (see Attachment 1 for a listing for studies, seminars, etc. conducted over the past four years).

Despite problems in assessing the quality of NIPORT's research,<sup>2</sup> it appears that some reports meet international standards for research publications, whereas others are barely comprehensible. NIPORT seems to have mastered the basic principles of family planning research. It has done a considerable amount of work with a small staff, imaginatively used a wide variety of qualitative and quantitative methodologies, and attempted to meet a diverse set of data needs. The problems with the poorer quality research reports include poor editing, poor printing, improperly laid out tables, over-reliance on descriptive analysis with little conceptual reasoning, and recommendations with limited utility and/or little relevance to policy.

The research unit at NIPORT is staffed by a director, two senior research associates, one administrative officer, three research associates and two statisticians. Field staff are recruited on a temporary contract for a specific project. NIPORT appears to have only basic research skills on the staff; when higher quality work is desired, NIPORT uses outside consultants.

NIPORT has done research in many diverse areas. In a more experienced group, this diversity might be appropriate. In NIPORT, it suggests lack of a research strategy or agenda, a failure to develop substantive skills through experience, and a failure to identify a primary client or consumer for NIPORT results. It would be more appropriate if the NIPORT Research Unit's research agenda were matched with its human resources or if it developed skills in the areas of NIPORT's principal research interests.

Another problem with NIPORT's diversity of research topics and external selection process is that it leads to one-topic studies. A single issue is identified as needing research, the methodology is selected, and fieldwork implemented. A more efficient approach would be to identify several issues that could be studied using a single methodology. For minimal increases in fieldwork costs, four issues, for example, could be addressed rather than one. Achieving these efficiencies would require a larger number of potential research topics, more flexibility in project selection, and more project design sophistication to identify issues that match with a selected methodology.

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<sup>1</sup>The objectives of the research unit within NIPORT are to conduct applied research and evaluation on program issues; carry out training needs assessments; evaluate training programs; conduct training courses in research methodology; organize national and international seminars, workshops, and conferences on family planning research issues; and, disseminate research findings through publications, seminars and the *Annotated Bibliography*.

<sup>2</sup>Assessing the quality of research by reviewing published results has many limitations. Making judgements on research quality at NIPORT from published reports is especially difficult because of the tremendous variation in the quality of its publications. Another issue is the wide diversity of topics it has studied.

NIPORT has limited capability to do in-house data processing. It has two IBM compatible micro-computers and the software to do its own processing (SPSS, graphics, ISSA), but it has chosen to contract its data entry, editing and tabulation from the Bureau of Statistics. This relationship seems to have worked well in the case of the BFS, although it is not clear whether the quality of the BFS was unique or is typical of the Bureau's ongoing skills. If it is to support an in-house analysis unit, however, NIPORT will need to upgrade both computer equipment and staff skills.

NIPORT tries to promote maximum utilization of its results by publishing them in bound volumes. This should be commended. The NIPORT reports have a character and a shelf life that encourages those who have them to keep them and refer to them. NIPORT also uses seminars to disseminate results. The usual approach is to complete the draft report, distribute the report to interested people in the family planning and/or health community, and then use a seminar to review and finalize the report. Despite conscientious efforts to disseminate results, there was little evidence that NIPORT research plays a major role in setting government policy. This could be due to a number of factors: historical relationships with the MOHFW; the variable quality of the analyses; the topics studied may not reflect policy issue needs; or a systemic inability of the MOHFW to incorporate research findings into its national family planning program.

### **Recommendations**

- Given its official status and available manpower, NIPORT should serve primarily as a coordinating body involved in soliciting and contracting research projects, disseminating findings, and generating policy dialogue rather than as an in-house research unit. To this end, NIPORT should expand its collaboration with other organizations in research implementation. For example, NIPORT could design a study, contract field work out to one of the private sector groups, contract data processing to the Bureau of Statistics, and do the analysis and report writing in collaboration with the private group and/or consultants. This approach would ensure maximum participation and output from the limited resources within NIPORT.
- USAID should consider arranging for NIPORT to acquire a disk reader (\$800) to allow access to POPLINE, the annotated bibliographic search service now available on optical disk for micro-computers. This would promote NIPORT's function as a coordinator of family planning research in Bangladesh. JHU/PCS is administering the optical disk program and providing training. Both PCS and UNFPA have been willing to provide disk reading equipment and training, and could be approached for assistance.
- NIPORT would benefit from extensive technical assistance in project design, analysis and report writing. USAID could assist through the use of training opportunities in research, facilitating collaboration with other groups in Bangladesh and from outside, and the provision to NIPORT of family planning research materials.

## Attachment 1 (Appendix J)

### List of Research Studies, Seminars and Research Findings of NIPORT

In the last four years, NIPORT has carried out the following studies:

- Evaluation of the Refresher Training Programme of BDG Physicians;
- Causes of Differential Performance of Family Planning Workers in *Upazilas*;
- Differential Factors Affecting Contraceptive Practice Among Working and Non-working Women in Bangladesh;
- Differential Performances of Family Planning Workers;
- Evaluation of the Performance of Family Welfare Assistants and *Dais* in the National Family Planning Programme;
- A Study of Community Response to Late Marriage;
- Training Need Assessment of *Upazila* Health and Family Planning Officials;
- Factors Causing Differentials Between Contraceptive Knowledge and Practice in Rural Bangladesh;
- Evaluation of Family Planning Committee at *Upazila*, Union and Word Level;
- Evaluation of the Training Programme of Health and Family Planning Field Workers;
- Organizational Issues in Community Participation within the Context of the Bangladesh Family Planning Programme;
- Needs Assessment of Foreign Training;
- Base-Line Study on MCH-Family Planning Field Workers;
- Observational Study on the Organizational Management of MCH-Family Planning Programme in Four *Upazilas* of Bangladesh;
- Study of Compensation Payments and Family Planning in Bangladesh;
- Role of Trained TBAs in Safe Deliveries in Rural Bangladesh;
- Determinants of the Utilization of H&FWCs and Maternal and Child Welfare Centers (MCWCs);
- Bangladesh Fertility Survey - 1989;
- Modernization and Religiosity of Health and Family Planning Personnel and its Influence on *Upazila* Family Planning Performance in Bangladesh;

- **Workers' Time Study: Involvement of FWAs in EPI;**
- **Role of Women in the Family Decision Making Process with Special Reference to Adoption of Family Planning;**
- **Assessment of Reasons for Static Level of Acceptance of Temporary Modern Contraception;**
- **An Assessment of Counseling for Clinical Family Planning Methods in Government of Bangladesh Clinics;**
- **Interaction between Clients and Grass-root Family Planning Workers: Implications for Programme Performance;**
- **Mini-Contraceptive Prevalence Survey - 1990;**
- **Evaluation of Traditional Birth Attendants Training - 1990;**
- **Clients Satisfaction with Sterilization Procedures;**

**NIPORT has also organized a number of seminars and workshops during the last four years.**

- **Operations Research Seminar, April, 1986;**
- **Regional Workshop on Population Training Institutes Management for South Central and East Asia, Jan-Feb. 1988;**
- **Research Methodology Course - 1987 and 1988;**
- **Regional Workshop on New Approaches in Planning, Implementation and Monitoring and Evaluation of MCH-Based Family Planning Programmes, February 1989;**

**As a result of the above activities, NIPORT has produced a variety of publications with a diversity of findings, a few of which are given below:**

- ***Upazila* level management of the government family planning program is inadequate in every sense, with special reference to record keeping, supervision, and personnel management.**
- **Family Planning Assistants are the designated supervisors of FWAs. Their level of involvement in supervision is so low that it is virtually non-existent.**
- **Some FWCs are hindered by poor location and intermittent operations. The FWVs who operate the FWC are supposed to be on duty full time, and out of the clinic only for satellite clinics.**
- **The FWVs have remarkably little contact with their health counterparts.**
- **FWVs spend less than two minutes with the average client, suggesting that very little motivation or counselling is going on.**

- The community generally perceived the quality of care at FWCs to be low. A class/economic distinction in clients also appeared in the findings, with only those clients so poor they could not afford an alternate source of service using FWCs.
- NIPORT observed that facilities seemed to be under-utilized. Although the clinics report seeing 40 to 50 clients per day, there were never more than ten when NIPORT researchers made spot visits.
- FWVs are generally weak in providing public health type services to clients.
- FWVs receive virtually no supervision from FPOs.
- Both *Upazila* and family planning officers do not see supervision or community organizing as their responsibility. Their perceived responsibilities involve sitting in the office handling "administrative matters."
- When questioned on skills, Health Assistants were found to have generally low levels of skill with especially poor skills in family planning.
- Age at marriage for women has risen about two years in the last twenty years.
- Desired family size is approximately half of the current level of fertility.
- Contraceptive prevalence of all methods was more than 31% in early 1989.
- The Total Fertility Rate nationally in 1989 was 4.9 with urban populations about 25% lower than their counterparts in rural areas.
- Tetanus toxoid protection has risen from 4 percent in 1983 to 26 percent of pregnant women in 1988.
- Infant mortality is estimated at 120 per 1,000 live births in 1988/89.
- A survey of sterilization acceptors found no direct or indirect evidence of external pressure to accept.
- Out of pocket costs (including lost wages) for sterilization clients are 350 Taka for women and 217 Taka for men.
- Virtually all of the survey sterilization clients indicated they had enough children (70 percent) or too many children (30 percent).

11/11