

PDCAA 235

**FILE**

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UNCLASSIFIED

PROJECT PAPER

BANGLADESH 388-0050

FAMILY PLANNING SERVICES



UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY  
AGENCY FOR INTERNATIONAL DEVELOPMENT  
WASHINGTON, D C 20523

PROJECT AUTHORIZATION

BANGLADESH

Family Planning Services  
Project No. 388-0050

1. Pursuant to Section 104(b) of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Family Planning Services Project (the "Project") for the Government of Bangladesh (the "Cooperating Country") and certain nongovernmental organizations in Bangladesh ("NGOs") involving planned obligations of not to exceed Sixty-Four Million Eight Hundred Sixty-Five Thousand Six Hundred Eighty United States Dollars (\$64,865,680), in Grant funds over a three year period from date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the Project.
2. The Project will support Bangladesh's national family planning program through participant training, operations research, contraceptive commodities, voluntary sterilization, training materials, prevalence surveys, and community level family planning services in order to assist in the development of an improved national family planning program.
3. The Project Agreement which may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority shall contain, in substance, the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.
4. a. Source and Origin of Goods and Services.

Goods and services, except for ocean shipping, financed by A.I.D. under the Project shall have their source and origin in the Cooperating Country or in countries included in A.I.D. Geographic Code 941, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Project shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the Cooperating Country or the United States.
- b. Conditions Precedent to Disbursement.

Prior to any disbursement under the Grant or the issuance by A.I.D. of any documentation under the Project Agreement pursuant to which disbursement will be made for commodities or services related to voluntary surgical contraception, the Cooperating Country will, except as A.I.D. may agree otherwise in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

(1) A comprehensive plan for a sterilization surveillance system; and

(2) A standardized informed consent form which shall be completed by all acceptors of such voluntary surgical contraception financed in whole or part by A.I.D. funds, and which may not be modified during the life of this agreement without the prior written agreement of the Cooperating Country and A.I.D.

c. Covenants.

(1) The Cooperating Country shall agree to establish and operate a sterilization surveillance system in accordance with the plan accepted by A.I.D. under paragraph 4. b. (1) above and in a manner satisfactory to A.I.D.

(2) None of the funds provided under the Grant, or goods or services financed thereby, may be used for the performance of abortions as a method of family planning or to motivate or coerce any person to undergo an abortion.

(3) None of the funds provided under the Grant, or goods or services financed thereby, may be used for, or in support of a program that includes, involuntary sterilization as a method of family planning or coercion or financial incentives to any person to undergo sterilization. In this connection, the Cooperating Country shall agree as follows:

(A) Informed consent to each sterilization procedure under this Project shall be documented by the standard form required under paragraph 4. b. (2) above properly executed by each person accepting sterilization services.

(B) No payments in cash or in kind shall be made to any acceptor or provider of sterilization services under this Project unless such payment is made to acceptors for items of cost, such as wage loss, child care expenses and food expenses calculated for the Project on the basis of reasonable average cost or to compensate medical staff and field workers for medical and support services provided by such personnel.

(C) Payments approved by A.I.D. shall not be increased without the prior written agreement of the Cooperating Country and A.I.D.

(4) The Cooperating Country shall agree to establish and maintain systems that lead to verifiable improvements in the quality of sterilization services.

Clearances:	Date	Initial
Frederick W. Schieck, A/AA/Asia	<u>1/27</u>	<u>chatt</u>
Kelly C. Kammerer, GC	<u>1/27</u>	<u>KK</u>
Alexander Shakow, AA/PPC	<u>1/27</u>	<u>ash</u>
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Signature *Joseph C. Wheeler*  
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*February 17, 1981*

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## **B. Definitions**

<b>ANM</b>	<b>Auxilliary Nurse Midwives</b>
<b>APHA</b>	<b>American Public Health Association</b>
<b>BDG</b>	<b>Bangladesh Government</b>
<b>BFS</b>	<b>Bangladesh Fertility Survey</b>
<b>BFPA</b>	<b>Bangladesh Family Planning Association</b>
<b>BAVS</b>	<b>Bangladesh Association for Voluntary Sterilization</b>
<b>CBR</b>	<b>Crude Birth Rate</b>
<b>CDC</b>	<b>Center for Disease Control</b>
<b>DG</b>	<b>Director General</b>
<b>ERD</b>	<b>External Resources Division</b>
<b>FPA</b>	<b>Family Planning Assistant</b>
<b>FWA</b>	<b>Family Welfare Assistant</b>
<b>FWW</b>	<b>Family Welfare Workers</b>
<b>FWV</b>	<b>Family Welfare Visitor</b>
<b>FWC</b>	<b>Family Welfare Center</b>
<b>FPSTC</b>	<b>Family Planning Services and Training Center</b>
<b>FPIA</b>	<b>Family Planning International Assistant</b>
<b>FWVTI</b>	<b>Family Welfare Visitor Training Institute</b>
<b>GDP</b>	<b>Gross Domestic Product</b>
<b>IFRP</b>	<b>International Fertility Research Program</b>
<b>IPAVS</b>	<b>International Project, Association For Voluntary Sterilization</b>
<b>IBRD</b>	<b>International Bank for Reconstruction and Development</b>

IEC	-	Information, Education and Communication
MA	-	Medical Assistant
MCH	-	Maternal and Child Health
NGO	-	Non-Government Organization
NIPORT	-	National Institute of Population Research and Training
PID	-	Project Identification Document
PC&FPD	-	Population Control and Family Planning Division
PVO	-	Private Voluntary Organization
PSI	-	Population Services International
PSC	-	Personnel Services Contract
RESP	-	Research, Evaluation, Statistics and Planning
SFYP	-	Second Five Years Plan
TFPC	-	Thana Family Planning Officer
TBA	-	Traditional Birth Attendant
TAF	-	The Asia Foundation
THC	-	Thana Health Center
WHO	-	World Health Organization

**Part I**

**C. Recommendation**

USAID recommends this project be approved on grant terms for a total three year funding of \$64,865,680 \ USAID will execute annual Project Grant Agreements with the Government of Bangladesh (BDG) through the Ministry of Finance and with non-governmental organizations operating in Bangladesh. Funds will be sub-obligated through Project Implementation Orders and Project Implementation Letters.

**D. Project Description**

The project will support the Government's national family planning program through participant training, operations research, contraceptive commodities, voluntary sterilization, training materials, prevalence surveys, and community level family planning services. The intent of continuing AID support to the Government is to assist it to develop an effective national family planning program.

The project will also support family planning activities in the private sector through innovative projects with seven non-governmental organizations (NGCs) which are already providing services through many indigenous organizations. The intent of increasing support for non-governmental organizations is to enable them to expand high quality family planning services to complement Government programs and perform those functions best handled by the private sector. Increased NGO family planning activity will also increase community support and involvement in family planning.

The project will be implemented in cooperation with the Population Control and Family Planning Division of the Ministry of Health and Population Control, and the individual non-governmental organizations receiving support under the project. Grant Agreements between USAID and the BDG will be used to obligate funds. Grant Agreements between USAID and non-governmental organizations will be used to obligate funds to them. Non-governmental organizations receiving funds under this project will coordinate their program activities with the Government.

The purpose of this project is to increase the prevalence of contraceptive use from its estimated current level of 13 percent to 25 percent. The activities financed under this project are designed to have the most rapid and direct impact on increasing the prevalence of contraceptive use. They complement other donors' support and rely on inputs from other donors and the BDG to achieve the purpose.

The goal of this project is to reduce population growth as a critical factor in overall economic development.

USAID estimates that contraceptive prevalence will increase to 25 percent of all eligible couples by the end of the project. The Crude Birth Rate (CBR) will be reduced from the estimated 44 per thousand in early 1980 to 38.7 per thousand by late 1983. If mortality remains unchanged during this time, the growth rate should be reduced from its current estimated level of 2.8 percent per annum to 2.2 percent. If mortality decreases slightly, say two points, due to improvements in health, especially maternal and child health, the growth rate will be 2.4 percent per annum.

#### E. Summary Findings

This project is ready for implementation. It builds on seven years of USAID population assistance in Bangladesh. All analyses of the project from the technical, financial, social, economic and administrative standpoints indicate that the project design is sound.

#### F. Project Issues

Issues and topics raised by AID/Washington regarding this project in the PID approval cable, State 262270 dated October 6, 1979, are addressed in this Project Paper as noted below.

<u>Issues</u>	<u>Where Addressed</u>
1. Support to the Asia Foundation	Part II, B., 2., (F)
2. USAID Staffing	Part IV, A., 3.
3. Administration and Management of BDC	Part II, A, 2 and 3; and Part IV, A., 1.

<u>Topics</u>	<u>Where Addressed</u>
1. Contraceptive Requirements	Part II, B. 1 & 2.
2. Target Setting	Part II, B. 3.
3. Voluntary Sterilization	Part II, B. 1. & 2.
4. Role of Women	Part III, C.

### Part II. Project Background and Detailed Description

#### A. Background

With the exception of Singapore, Hong Kong and Malta, Bangladesh is the most densely populated nation-state in the world with 1,630 people per square mile. It is over three times as dense as its neighbour, India. It has a population four times that of the combined population of the countries of Central America. Its people are crowded into an area the size of the State of Wisconsin.

Bangladesh's mid-1980 population is estimated to be 90 million and growing at the rate of 2.8 percent per annum. At this rate, the population, which more than doubled since 1951, will double again in twenty-six years, and Bangladesh will surpass Japan to become the world's seventh most populous nation. Approximately 29 million metric tons of foodgrains annually will be required to feed this population at current low rates of consumption. To meet this requirement, Bangladesh will have to increase foodgrain output by 225 percent. All available arable land is already utilized, leaving virtually no space within the country for the population to expand. The addition of almost 800,000 people to the job market each year worsens the problems of unemployment and underemployment, now estimated at 32 percent.

The consequences of over population are manifest. The country's population profile reveals a terribly poor agrarian society with per capita GDP amounting to the equivalent of \$100, one of the lowest in the world. Rural population represents 92 percent of the total, making Bangladesh one of the most rural populations as well. Due to consistently high fertility and mortality in the past, the population has remained young, with approximately 46 percent of the population under 14 years. Life expectancy at birth is about 46 years.

In sum, population growth in Bangladesh erodes gains in food production, industrial output, increases in real income, and the standard of living. In the face of the rapid population growth, food grain self-sufficiency, Bangladesh's most immediate and pressing need, will become more difficult to achieve and the number of families who are functionally landless will increase.

A reduction in population growth will not, in and of itself, solve the many other development obstacles facing Bangladesh. Without progress on the population front, however, the prospects for economic development are very poor.

## 1. Project Rationale

The BDC recognizes that population growth jeopardizes its chances to improve the quality of life of its people. President Zia has made population one of the three pillars of his "revolution" and speaks frequently of the need to reduce fertility. Few if any other heads of State especially from Islamic countries have given population such high priority. How this commitment translates into action will be discussed later in this paper.

The project described in this paper focuses primarily on the strengthening of the supply side of reducing fertility, that is, the improvement and expansion of family planning services, although many of these services also have an impact on demand. For example, community based experimental efforts described in the paper, maternal/child health interventions, field worker training and IEC activities will stimulate demand. Given the limited success of family planning efforts to date in Bangladesh, a legitimate issue is whether or not there is a demand for fertility control services, and if so, is that demand large enough to effect a rapid fertility decline. Does it make sense to continue efforts to develop

family planning services in the context of a traditional, rural, illiterate society.

There is evidence that many women are having more children than they want. Data from the Bangladesh Fertility Survey (BFS) conducted in 1975 indicate that for all women, the mean number of children wanted is 4.1; this is considerably below the current completed family size in Bangladesh. For those married women who had not yet begun childbearing, the average number of children desired is 2.8. As these women are younger, this figure suggests a recent acceptance of a small family norm. If these women could be reached to adopt contraception early in their childbearing years, contraceptive practice with significant demographic impact would ensue.

In the BFS, 61 percent of all married women said they wanted no more children. As expected, the percentage who wanted no more increased with the number of living children. Similar results have been obtained in other studies. A recent intensive study of beliefs and fertility in Bangladesh reported that 54 percent of males and 60 percent of the females did not want any more children, and that the percentage increased with age. For men, the majority who had four or more living children wanted no more. For women, the majority of those who had three children by the age of 25-34 said they wanted no more.

This apparent desire of a large part of the eligible population to have no more children has been reflected only modestly in contraceptive prevalence and has been greatest for those whose desired family size was less than their actual size.

A better predictor of contraceptive behavior in Bangladesh has been the availability and quality of services. Large increases in the acceptance rate have been achieved in small areas where family planning services have been effectively delivered, e.g., in various family planning service delivery projects of private voluntary agencies and in the BDC's sterilization program. Furthermore, studies of the Government family planning service delivery system have found that where Family Welfare Assistants (FWAs)\*\* actually do work as they are supposed to, marked increases in family planning acceptance have occurred.\*\*\* Thus, one of the best ways to assess the actual demand for service is to have the services effectively implemented.

Throughout the history of family planning in Bangladesh, every program attempt has been disrupted by political instability, natural calamities, or war.

\* Clarence Maloney, K.M.A. Aziz, Profulla C. Sarker, Beliefs and Fertility in Bangladesh. (Rajshahi University, Institute of Bangladesh Studies, 1980), p. 136.

\*\* BDC family planning female field workers.

\*\*\* See for example, A.B.C. Qudus, Performance of Family Welfare Assistants (University of Chittagong, Chittagong, 1979), and A. Sattar, Evaluating Family Planning Programme Effectiveness and Efficiency--A Case Study of Operations Research Project (Rajshahi University, Department of Statistics, 1979).

It has only been during the last five years, during a period of relative political calm and generally good weather, that the BDG has begun to make significant progress in developing a systematic approach to services delivery. It is during this time period when the prevalence of contraceptive use has risen the fastest, from approximately 8.3% to 13.5%. Given the experience of other developing countries, especially in East Asia, where the availability of services has demonstrated large demand, and the experience within Bangladesh when services are made available, it is reasonable to assume there is a significant unmet demand for fertility control services. USAID estimates that with improved and expanded services 25 percent of eligible couples will be practicing family planning by the end of this project.

However, the existing level of demand is not large enough at this time for Bangladesh to achieve replacement level fertility by the end of the century without fundamental changes in the society. Clearly, there are a number of social and economic pressures which limit the demand for fertility control. Factors relating to the economic value of children, especially males, the need to assure security in an insecure rural setting, social influence through kin, patronage, the maintenance of purdah, religiosity, the patriarchal family structure, illiteracy, and the low status of women are some of most important of these pressures.\* Together they represent a powerful pro-natalist influence on society. Significant and rapid social and economic improvements affecting these factors will have to occur in order for demand to reach replacement level fertility by the end of the century. This is not likely to happen. Some fertility decline will probably occur during the next 20 years due to improvement in the quality of life for some families and a deterioration for others. In the short term, however, expanding and improving family planning services will reduce fertility by meeting the current unmet demand.

The strategy for addressing social and economic constraints to reducing fertility and creating demand will be contained in the FY 83 CDSS. The core of this strategy will be to raise the status of women through delay of marriage, increase in female education, increase in female employment and other rural development projects which have women as the primary beneficiaries.

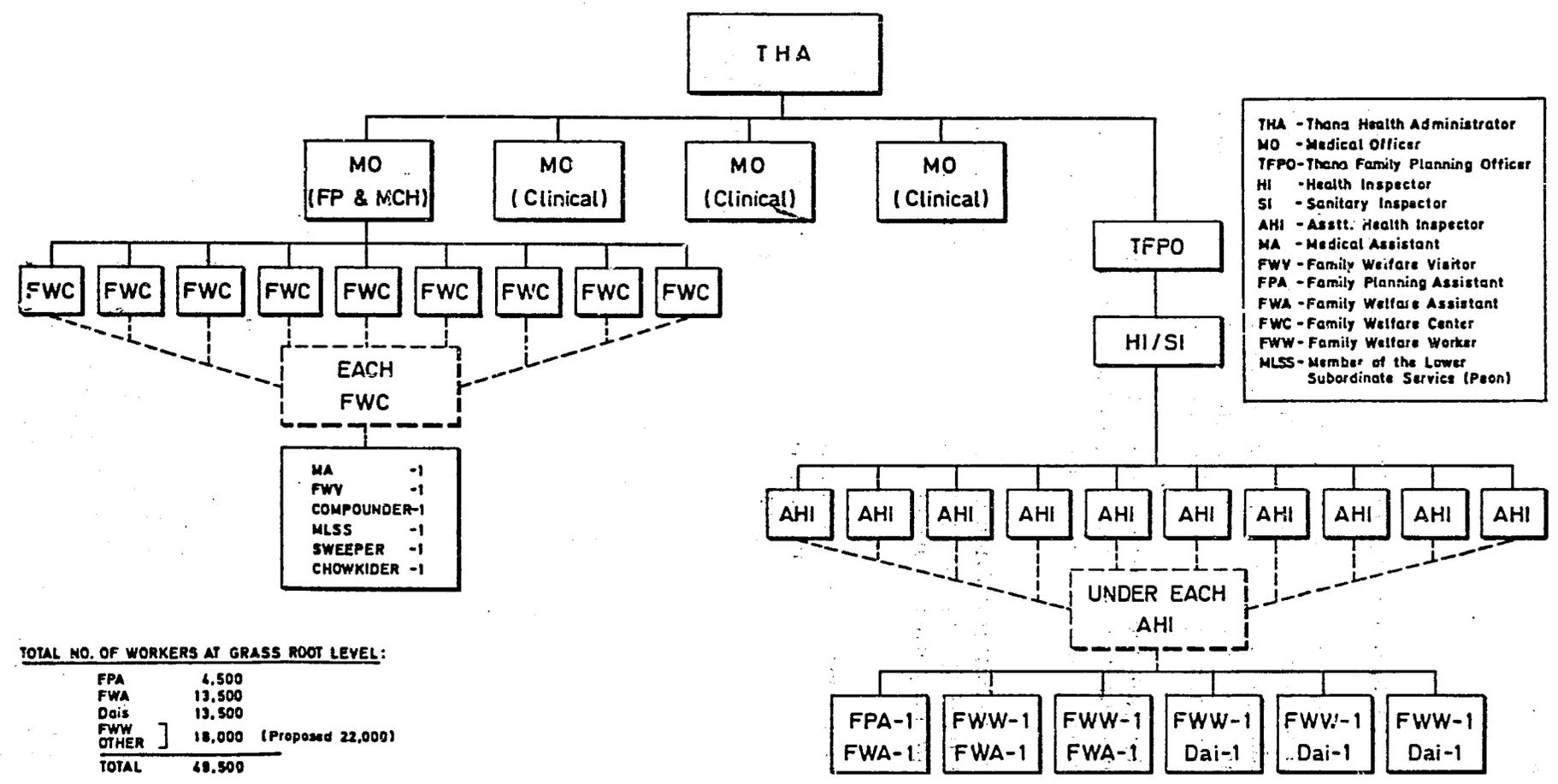
In this project, in addition to the impact on demand from service delivery efforts, we have reserved a small amount of funds to explicitly explore the demand side of the population problem. The intent is to use these funds to develop either small experimental projects or to undertake feasibility studies which will provide us the basis to develop projects to increase demand for fertility control services. Such activities could lead to discrete projects, but not necessarily so.

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\* See Clarence Maloney and K.M.A. Aziz, Beliefs and Fertility, 1980; and Mohammad Alaiddin, Socio-Economic Determinants of Fertility; A Review, 1980. Both are AID-financed publications.

FIGURE I

INTEGRATED HEALTH-FP-MCH SERVICES AT PEOPLES LEVEL  
PROPOSED ORGANIZATION AND PROBABLE LINKAGE



TOTAL NO. OF WORKERS AT GRASS ROOT LEVEL:

FPA	4,500	
FWA	13,500	
Dais	13,500	
FWW	18,000	(Proposed 22,000)
OTHER		
<b>TOTAL</b>	<b>48,500</b>	

as well as salary support for fieldworkers, equipment, vehicles, technical assistance, information, education and communications services (IEC), statistics, evaluation, and support for family planning activities in six other development Ministries.

The IBRD consortium's second 4 year population project, 1979 to 1983, totals \$110 million. IDA provides \$32 million in credit. The BDC will contribute approximately \$11 million, and the balance will be provided by the same co-financers as the first project with the addition of the Netherlands.

The second project will continue and expand the activities of the first project. The emphasis is on construction of Family Welfare Centers, manpower development, IEC, salary support, medicines, vehicles, service statistics, MCH, and women's programs. Almost 50% of the project costs will be devoted to construction.

UNFPA signed an agreement with the BDC in July 1974 for assistance valued at \$10 million for three years. This project provided support for salaries and training of fieldworkers, repair and equipping of clinical facilities, construction of central warehousing facilities, logistical management, vehicles, population education, technical assistance, support for the 1981 national census, some contraceptives, and voluntary sterilization.

UNFPA's second project is for five years beginning in 1979 and is budgeted for \$50 million. Twenty-five million dollars are from UNFPA and the balance is to be raised through bilateral donors. Due to budgetary constraints, UNFPA is experiencing some difficulty in meeting all of its earlier commitments and the total amount available under its current project may be slightly lower than \$50 million.

UNFPA's second project is basically a continuation of its first with emphasis placed on equipment and supplies for MCH and family planning services, long term technical assistance and in country training of fieldworkers.

AID's project is designed as an integral part of the national program complementing the service delivery inputs of the other donors, and building upon the more long term institutional nature of the other donor activities.

For example, the logistics management support of UNFPA assures better distribution and accountability of AID supplied contraceptives. AID support to the voluntary sterilization program will rely on the provision of expatriate advisors provided by the IBRD to improve surveillance. IBRD's emphasis on construction of FWV Training Institutes and Family Welfare Centers complements

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\* Family Welfare Visitors - FP/MCH paramedics at the Union level.

AIDs support to improve the quality of FWV training. The provision of training and fieldworkers' manuals and other educational materials will improve the effectiveness of fieldworkers and complements the in-country training efforts supported by UNFPA and the BDG.

In the same manner, AID inputs to NCOs support their existing activities. AID support to BAVS will not only strengthen and expand its sterilization capabilities, but will also improve the quality of services provided by the BDC through improved training for BDC doctors.

The combined inputs of the BDC, donors and NCOs work together to provide both an immediate impact on family planning services availability and long range infrastructure and manpower development.

### 3. Program Results

Service Statistics for 1972 through 1979 are shown in Table I. Hong assessed the family planning program effects on population growth since 1975 using a one-sex (female) component projection model.\* Due to the incompleteness of the data available in Bangladesh a number of assumptions had to be used.\*\* Her analysis, which can be used as a general guide in determining the impact of the family planning program, found that "the 1975-79 program can be credited with a total 2.4 million births averted during 1976-80." Emphasizing again the calculation of the number of births averted due to the family planning program is based on a number of theoretical assumptions, nonetheless it does demonstrate that the program's impact in the second half of the 1970's had some significance.\*\*\*

The Bangladesh Fertility Survey (BFS) of late 1975-early 1976 was the most recent measurement of fertility in Bangladesh. The BFS estimated a CBR of 47/1000, which was only 3.2 points lower than the CBR estimated during the 1961 national census 14 years earlier and one year after the Government's initial support to family planning. In 1977, the Government, on the basis of service statistics, small regional prevalence surveys, and trends evidenced in the BFS, estimated a CBR of 44/1000 for 1977. USAID believes that a CBR of 44/1000 is a reasonable estimate of fertility in Bangladesh at this time. It is reasonable to assume, in the absence of significant economic development gains during this period, that the family

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\* Sawong Hong, Demographic Characteristics of Bangladesh (USAID, 1980)

\*\* See Annex A for these assumptions.

\*\*\* This estimate will be verified after receipt of data from the 1979 national prevalence survey. If program efforts did contribute to 2.4 million births averted, the national prevalence survey should record a somewhat lower CBR than which is currently assumed to be the case.

Table I  
Family Planning Service Statistics, 1972-79

	IUD	Vasectomy	Tubectomy	Condom (doz)	Pills (cycles)	Emko (vials)	Injection	M.R.
Jan-Jun '72	1,595	139	151	295,757	14,510	9,512	-	-
July-Dec '72	6,882	126	56	754,302	53,267	28,636	-	-
Jan-Jun '73	8,778	114	63	934,505	86,504	44,085	-	-
July-Dec '73	9,788	58	168	493,832	124,502	46,862	-	-
Jan-June '74	17,802	388	847	142,799	316,471	52,842	-	-
July-Dec '74	17,840	3,802	1,718	334,118	441,500	35,625	-	-
Jan-June '75	32,551	10,667	2,989	439,420	816,972	63,466	58	686
July-Dec '75	35,089	18,701	4,836	2,157,279	2,309,622	60,168	175	1,140
Jan-June '76	41,551	19,138	6,240	2,499,766	3,633,433	64,616	1,733	3,139
July-Dec '76	35,960	19,545	8,081	1,664,259	2,276,409	33,560	-	3,269
Jan-June '77	23,461	55,521	32,165	1,273,871	2,362,188	25,919	1,319	3,424
July-Dec '77	21,062	18,293	18,266	2,037,127	3,655,737	18,131	2,209	2,813
Jan-June '78	19,502	14,350	26,456	3,410,072	3,831,571	14,093	2,318	3,322
July-Dec '78	12,996	17,272	44,281	2,331,755	3,899,438	17,552	3,924	2,287
Jan-June '79	9,641	7,411	37,413	2,483,544	3,223,969	21,220	7,104	2,125
July-Dec '79	9,453	17,918	73,049	2,662,325	3,486,715	23,030	9,000	2,356

Source: PCFP monthly service statistics.

planning program has been a major contributing factor to whatever fertility decline may have occurred.\* Analysis of the National Prevalence Survey should reveal more current information on fertility levels.

Program results have to be viewed from the knowledge that a full-fledged program has not really been operating. The current program approach was begun in May 1976, but not nationally staffed with fieldworkers in all thanas until 1978. Key vacancies still remain in training institutions, in the central office, and in the field. Lack of coordination and cooperation between the health and population divisions and constant organizational and personnel changes (which more often than not are responses to internal bureaucratic needs rather than a result of program-generated information) have prevented the program from developing a continuity of time-tested systems of management. Important components of the infrastructure, such as the union Family Welfare Centers, are not scheduled for completion until 1985. Practical training programs for mid-level managers and fieldworkers are just being developed. Services and supply reporting systems still do not meet the needs of program administrators. Resources from some donors are tied up due to cumbersome reimbursement procedures. These and other inadequacies in program development and administration have led to a situation where a significant percentage of the population does not have access to dependable services.

It is important to point out that once the BDC decided upon its current program strategy of placing fieldworkers in rural areas, it proceeded to do so on a crash basis without planning and developing administrative and training skills and procedures required by such an ambitious undertaking. To some extent, the BDC's rapidity in launching this nation-wide field structure was in response to donor pressure.

It should also be noted, however, that since the organization of the present program approach in 1976, improvements have been made and services are being provided to increasing numbers of families. A USAID-financed operations research project\*\*found that Family Welfare Assistants (FWAs) were by far the major source of family planning knowledge and services. The same study concluded that with improved training and supervision FWAs could improve the output of the program significantly.

The program's ability to expand sterilization services is also noteworthy in that it is filling a large unmet demand and has been able to provide quality services at most centers under adverse circumstances.

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\* The increase in the average age of first marriage for females, while slight, is probably a contributing factor as well.

\*\* A. B. G. Quddus, Performance of Family Welfare Assistants, (University of Chittagong, Chittagong, 1979).

In sum, program results since Independence have been exceedingly modest. Although this is in part due to the traditional, pronatalist cultural milieu, there are indications that unmet demand for family planning services does exist. The program's inability to meet this demand is a result of organizational and managerial problems in delivering services. There is evidence to suggest that the prevalence of contraceptive use has risen from the 1975/76 level of 8.3 percent of currently married women to about 13.6 percent in mid 1979. Based on these data it is reasonable to estimate that the CBR has declined from 47/1000 in 1975/76 to about 44/1000 in 1979 and that the family planning program is probably one of the principal causes of the decline.

## B. DETAILED PROJECT DESCRIPTION

This project is a three year (FY 1981 to 1983) grant with two major components: support to the Government's national family planning program and support to non-governmental family planning programs. A logical framework matrix contains the design of the project and is attached as Annex B.

The purpose of the project is to increase the prevalence of contraceptive use from approximately 13.6 percent of currently married women to 25 percent. This should reduce fertility, as measured in terms of the Crude Birth Rate, from 44/1000 to 37.8/1000. The goal of the project is to reduce population growth as a critical factor in overall economic development.

### 1. Support to the BDG Family Planning Program

#### a. Foreign Exchange Costs

##### (1) Contraceptive Supplies and Medical Kits

Since the beginning of the Bangladesh program, AID has been the principal supplier of contraceptives and medical kits. In fact, the majority of AID resources provided under the first population project were for contraceptive supplies. Under this project, USAID will continue to provide both the BDG and the non governmental organizations with the bulk of their needs for pills, condoms, vaginal tablets and foam, IUDs and mini-laboratory and vasectomy kits. The quantity of supplies ordered each year will be related to actual growth in the program, in-country warehousing space, and the maintenance of an adequate pipeline. The budget prepared for contraceptive supplies in this paper is the best estimate of the need for these commodities at this time and matches anticipated levels of use. Each year during the life of this project, however, USAID will review carefully the quantity of supplies needed to be ordered taking into consideration changes in method mix and distribution trends. We will continue to utilize the excellent technical assistance of CDC to improve the logistics of the program.

This area of support is a logical one for AID given its well established history of bulk procurement and low prices. Contraceptive procurement requirements are found in Annex C.

## (2) Participant Training

One of the fundamental constraints to delivering high quality family planning services is inadequate training and supervision of fieldworkers. The most important supervisor in the program is the Thana Family Planning Officer (TFPO) who is responsible for supervising FWAs, FPAs, and sanitary inspectors.\* He/She is also the direct link between the workers who actually deliver services and the managers of the program. In addition to technical supervision, he/she is looked to by the fieldworkers for leadership. There are no adequate training programs yet established in Bangladesh for these officers.

Beginning in FY 1979, USAID supported a training program for TFPOs in Indonesia which was designed by Bangladeshis and Indonesians. The program is designed to provide TFPOs with supervisory and organization skills so lacking in the Bangladesh program. Over 80 percent of the participant training budget will be devoted to this training. A formal evaluation of the program will be conducted at the end of the first year's experience to determine how the training can be followed up in Bangladesh and to make whatever changes are needed in the training program itself.

During the first population project, USAID supported 27 participants in long term academic training, and 167 in short term training. The BDC has recognized the limitations of long term academic training (e.g., language barriers, social adjustment difficulties, desire to emigrate) and has requested USAID to support shorter, non-academic training whose purpose will be to impart practical administration and technical skills to senior and mid-level program managers. USAID will work closely with the BDC in identifying appropriate courses at U.S. universities and institutions and in third countries, especially in Asia. Recognizing the value of academic training, however, USAID has agreed with the BDC to support exceptional candidates for academic study on a case by case basis.

While there is no organized resistance to family planning in Bangladesh, there remains a hesitancy among religious leaders to support family planning openly and, in some instances, there are individual religious leaders who have vociferously denounced the use of modern birth control methods.

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\* FPAs = Family Planning Assistants

FWWs = Family Welfare Workers

See Figure I for an organization diagram of these cadres of field workers.

A number of seminars have been organized over the past years to persuade religious leaders to support family planning. There is no longer any open opposition. Some religious leaders have travelled to Indonesia with World Bank support to discuss family planning with their more liberal colleagues there. The Bank continues to support this effort. What is lacking, however, in garnering more active religious support for the program is to persuade the 30 to 40 senior Muslim scholars in Bangladesh to teach openly that the Koran supports family planning. The BDG is developing a training program for these scholars to visit eminent Islamic scholars in the Middle East who do support family planning. USAID will support such an approach in this project, if a realistic training program can be developed.

The final area of participant training is support for short term technical training for program managers in non-government organizations. As these private organizations expand their activities, there will be a need to upgrade administrative and managerial skills. Resources in Asia, such as Mechai's family planning training center in Bangkok, will be used for this training.

b. Local Currency Costs

(i) Voluntary Sterilization

In the Second Five Year Plan (SFYP), the Government plans to expand voluntary sterilization services and estimates a significant increase in the use of these services. For the three years covered by this project, the Government has estimated that 407,000 procedures will be performed in 80-81; 552,000 in 81-82; and 660,000 in 82-83 for a total of 1,625,000. As a proportion of the method mix, sterilization will rise from its present level of 19 per cent to 35 per cent. The BDG intends to ensure that non-clinical methods of contraception continue to represent the largest share of contraceptive use.

The popularity of sterilization became evident in early 1977 when the Government launched a nine week sterilization campaign. During this nine week period 75,852 sterilizations were performed in 155 thanas against an expected total of 61,260. In all respects that campaign was a success. It demonstrated a large demand for services. Client satisfaction with services was positive.\* Half of the tubectomy clients and one-third of the vasectomy clients claimed that they advised others to be sterilized.

Since then, the Government has not been able to sustain the availability, of sterilization services due to bureaucratic and institutional problems. Many of these problems have now been solved and in late 1979 and early 1980 the accomplishments of 1977 were replicated with impressive results. Thana Medical Officers are now willing to work in the sterilization program. Supplies and equipment have been distributed on a more regular basis. With other aspects of the program slowly coming together, the Government has been able to spend more time on administrative improvements. Training programs for physicians and paramedical personnel have expanded. Private physicians are beginning to be trained in sterilization surgery through the Bangladesh Private Medical Practitioners Association.

There are a number of reasons for the acceptability of sterilization in Bangladesh. First, unlike temporary methods, sterilization has a one time inconvenience associated with it. Having undergone surgery, the client does not have to rely on an inefficient delivery system for continued supplies of services. Second, there are few or no side effects with sterilization. This is a positive advantage in Bangladesh where there are so many real and imagined problems with other methods, especially the pill and the IUD. Third, because

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\* Sterilization Campaign of 1977 - A National Long Term Follow-up Survey. Nawab Ali and al., Bangladesh Fertility Research Program, Technical Report No.25.

of the permanency of sterilization, discipline is not needed as it is to comply with the daily use of pills or condoms. Fourth, there are many families who have completed their family size and want no more children. As a method of birth control for this cohort, sterilization is ideal. Fifth, the Government compensates clients for expenses incurred in accepting this method in order to reduce impediments and so that this method may be as accessible as non-clinical methods.

The total donor cost for the sterilization programs for this three year period is approximately \$ 32,043,013. Cost components are shown in the following Table.

Table II Donor Financing of the BDG Voluntary Sterilization Program.

	81	82	83	Total
a) Physicians fees	542,667	736,000	888,000	2,166,667
b) Supporting staff	263,194	356,960	430,680	1,050,834
c) Field Workers compensation	135,667	184,000	222,000	,541,667
d) Food Cost	1,172,160	1,589,780	1,918,080	4,680,000
e) Transport	929,316	1,260,400	1,520,700	3,710,416
f) Surgical Apparel	1,275,266	1,729,600	2,086,800	5,091,666
g) Wage Loss	1,166,734	1,582,400	1,909,200	4,658,334
h) Audit	60,000	60,000	60,000	180,000
i) Medicine	2,027,063	2,749,236	3,287,130	8,063,429
j) Life saving equipment	350,000	200,000	150,000	700,000
k) Technical assistance	400,000	400,000	400,000	1,200,000
	<u>\$ 8,322,067</u>	<u>10,848,356</u>	<u>12,872,590</u>	<u>32,043,013</u>

The BDG will finance salaries of clinical staff, operating costs of clinics, some supplies and training. These costs are difficult to disaggregate in the BDG budget, but the total value of the BDG Support to the sterilization program is estimated to be approximately 25 per cent of the total.

Of the total \$ 32 million which is expected to be provided by the donors, AID's contribution will amount to \$ 16,828,761 or 52 per cent of the total. The balance will be provided by UNFPA and IBRD.

IBRD will provide support for medicines and technical assistance in FY 1981 and medicines, technical assistance and surgical apparel in FY 1982 and 1983. Its total support is estimated at approximately \$ 12,279,829 or 38 per cent of donor provided resources.\* UNFPA will provide approximately \$ 2,400,000 or 7 per cent of donor provided resources. During the first year UNFPA will provide support for medicines. During the remaining two years, UNFPA will finance physician fees.

At the request of the BDG and after careful review of PD70\*\* we intend to reimburse the following local costs of the sterilization program.

(i) Doctor's fee - Tk. 20 (\$ 1.33) per tubectomy or vasectomy. Doctors are paid on a per case basis for the surgery performed. They do not motivate clients. Doctors are responsible for all pre and post surgical care of clients while they are at the clinics. We will finance this part of the program<sup>in</sup> FY1981 and expect UNFPA to finance it for the remaining two years.

(ii) Supporting clinic staff - Tk. 10 (\$ 0.66) per tubectomy.  
Tk. 8.00 (\$ 0.53) per vasectomy. These fees are paid to the trained paramedic or nurse who assists the doctor with surgery. These personnel are also responsible for the routine medical care of clients after surgery. They do not motivate clients to accept sterilization. Differential payment is justified on the basis that more intensive care is required to tubectomy clients than for vasectomy clients.

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\* The exact budgetary levels of IBRD support have not been finalized. The levels discussed in this paper are based on discussions with IBRD officials.

\*\* PD(Policy Determination)-70 is the statement of AID guidelines to ensure that sterilization programs receiving AID assistance are entirely voluntary and contain no element of coercion including monetary incentives to either the client or the service provider.

(iii) Field worker compensation for non-routine services - Tk. 5.00 (\$0.33) per tubectomy or vasectomy. Given the extraordinary amount of time fieldworkers spend on assisting clients both before and after surgery, these fees are reasonable and justified. To receive this payment, fieldworkers must accompany their clients to the clinic and remain with them to provide such services as fetching food and caring for children. The payment will be made to any field-worker who accompanies a client, whether from PCFPD or from another BDG agency or private voluntary agency.

(iv) Food Cost - Tk. 48 (\$ 3.20) per tubectomy and Tk. 16 (\$ 1.06) for vasectomy. Most facilities providing sterilization services in Bangladesh do not maintain kitchen facilities. This budget item represents the average costs of providing food to clients and is given to them so that relatives and field-workers assisting them at the clinics can purchase food for them.

(v) Transportation Cost - Tk. 35 (\$2.33) per tubectomy and Tk. 30 (\$2.00) per vasectomy. These costs represent the average costs to clients to travel to and from sterilization centers. The same amount is given to all to avoid administrative chaos in determining exact fees. Some clients may gain and some may lose, but the system is as equitable as is possible in Bangladesh.

(vi) Wage Loss - Tk. 40 (\$2.66) per tubectomy and Tk. 60 (\$4.00) per vasectomy. The payment has been reduced in response to reexamination by the BDG of the value of wages lost to ensure that this compensation is not perceived as an incentive. Patients will be told not to work for four days and compensation is based on four days lost labor. The differential rates between vasectomy and tubectomy are meant to reflect actual wages realistically, since men earn more than women. (From USAID's standpoint, this will also reduce the tendency for men to send their wives for the more difficult tubectomy procedure rather than undergo vasectomy themselves.)

Given the economic status of the rural population, the loss of wages incurred acts as a constraint to the acceptance of sterilization. People are simply too poor to sacrifice the time away from employment to undergo surgery. This may be a principal reason for the low number of vasectomies. By providing a fixed amount for wage loss, there will also be less tendency for both men and women to return to work earlier than is medically indicated and thus increase the chance for infection. Wage loss for women is justified on the basis that many poor women do work. While the BDG does not encourage women to linger at the sterilization centers, it does allow women to recuperate at their own speed. An operation, even one as relatively minor as tubectomy, depletes a woman's limited physical resources. Returning home too early, often by arduous means, will enhance the risk of infection and other side effects. In those cases when women do not stay at a clinic for very long it is all the more important to reimburse them the means to pay relatives or

or neighbors in kind or cash to assist them at home with heavy chores. For those women who do not have a cash paying job, costs in kind or in cash are incurred for work left undone while they are at the sterilization center.

For vasectomy clients, reimbursement for wage loss encourages them to avoid heavy work and physical exertion which is medically indicated and will contribute to lowering mortality and morbidity.

(vii) Reimbursement for the procurement costs of surgical apparel. - Tk. 50 (\$3.33) for tubectomy and Tk. 30 (\$2.00) for vasectomy. In the absence of laundry facilities at service centers, the provision of a new lungi for men and a new saree for women diminishes the chances of infection. This element of the program was supported by USAID during the last three years of the first population project, and was cleared by General Counsel in AID/W as appropriate support in light of PD 70.

(viii) Surveillance and Improving Quality of Service - The BDG and USAID are extremely conscious of the need to insure that the best possible services are made available to sterilization clients.

In mid-1980, USAID allotted \$ 150,000 of its bilateral funds to IPAVS for the purchase of emergency life saving equipment for all BDG clinics. USAID also requested the services of two CDC physicians to conduct an epidemiological investigation of sterilization deaths and an anesthesiologist to review the sedation routine used in the program. In addition, a physician from CDC, with IFRP support, conduct a prospective Study of Sterilization deaths in Bangladesh.

In February 1981, a national conference will be held to review the reports and recommendations of all three consultancies to determine specific steps to improve sterilization services. The decisions of this conference will be the basis for training and re-training programs for physicians, with particular attention given to sedation of clients and maintaining sterile techniques.

A condition precedent for our support for sterilization under this project is the establishment of a competent surveillance system. Responsibility for surveillance will be under the Director General (D.G.) of Program Development in the Population Control and Family Planning Division (PC&FPD). The D.G. will be responsible for:

- insuring real compliance with informed consent requirements. The BDG has agreed to use an informed consent form modelled on the one used by BAVS. ( See Annex K for copy of BDG consent form ).

- insuring that appropriate medical procedures are followed and that emergency life saving equipment is in place and usable.
- through sample surveys, insuring that a representative number of clients are followed up in order to measure morbidity and client satisfaction with services. USAID will fund this element of the surveillance system through our operations research grant.
- conducting full epidemiological investigations of all deaths associated with sterilization.
- monitoring local costs of the program.

For the first several years, four expatriate physician advisors will assist the Government in monitoring the medical aspects of the program. They have been requested by the Government and will be financed by IBRD. Through APHA or CDC we will provide whatever short term technical assistance is necessary. The Assistant Directors for MCH/Family Planning in each District will be counterpart personnel for the expatriate physicians.

Costs of training, retraining, and additional life saving equipment will be part of AID support for upgrading the quality of services. In addition, AID will audit these costs independently on a continuous basis to check veracity of reporting and to avoid abuses.

## (2) Operations Research

One of the major constraints in the Bangladesh program is the lack of accurate information by which program administrators can assess the progress of the program and make informed decisions.

Starting in late FY 1977, AID funded an operations research project with the Government which had two purposes. First, it provided a mechanism to evaluate components of the program. Second, it funded action research whereby new family planning and MCH interventions could be introduced and

their effectiveness evaluated. (See Annex D for a summary of projects funded under operations research.)

This project component has had mixed results. Some research projects were not screened well, so that their results were not relevant to the program. Others, however, were done well and provided useful information for program administrators. In early 1980, responsibility for monitoring this project was transferred to the National Institute of Population Research and Training (NIPORT). With this transfer, project proposals and ideas have increased and provision has been made to hold two seminars a year to disseminate the findings of the research to program managers.

Under this project a minimum of 20 new projects will be funded. Research will be focused on solving service delivery problems and research results will be more fully disseminated and utilized than in the past.

In addition to supporting evaluation studies, the operations research grant will be used to support experiments in community family planning. This will be explained later in this section.

### (3) Annual Prevalence Surveys

In mid-1979, the Research, Evaluation, and Statistical Programs (RESP) Division of the old Population Directorate undertook a national prevalence survey with Westinghouse Health Systems support. Since the development of a national service statistics system is many years away from full implementation, it is vitally important that the program have a means to measure overall progress on a continuing basis. In this project AID will fund annual national prevalence surveys. The IBRD Consortium intends to provide an expatriate advisor for prevalence surveys and thus the continuing assistance of Westinghouse is no longer needed. In addition, USAID will request AID/W to provide short term technical assistance as required through APHA or CDC.

Annual prevalence surveys will be a principal means of evaluating this project.

### (4) Maternal and Child Health

The relationship between fertility and maternal and child health (MCH) in Bangladesh is not clearly understood. What is known is that when fertility control services are delivered to women along with some other desired service, the acceptance of fertility control increases. The BDG has clearly identified MCH care as the most important service to be linked with family planning.

The BDG is engaged in a major effort to utilize fully the fieldworker structure that is already in place. For MCH services, key field personnel, particularly Family Welfare Visitors (FWVs) and Family Welfare Assistants (FWAs) are being trained (and retrained) in MCH, and the FWVs are being utilized to teach rudimentary MCH skills to village traditional birth attendants (TBAs). MCH drugs and supplies are being supplied in quantity to the rural health centers for the retrained personnel to use. Donor agency involvement in these activities is extensive. (See Annex E for a description of other donors support to MCH activities.)

After consultation with the other donor agencies, USAID agreed to fill a critical gap in the training of the field workers in MCH, i.e., to fund the production costs of some of the essential educational materials. (See NGO section of this paper for a description of in-country training of FWVs.) A working group for MCH materials production has been formed, consisting of a representative from Family Planning and MCH Services and the Training Units of the PC&FP Division, UNICEF, UNFPA, CARE, and USAID. The following materials are being developed and reviewed:

- (i) A comprehensive MCH/FP manual for the FWVs, for training and reference in the field.
- (ii) A small booklet for the FWVs to use for refresher training of FWAs, and for both FWVs and FWAs to use in their field work. This illustrated booklet entitled "Better Child Care" was produced by the Voluntary Health Association of India and is being adapted for use in Bangladesh.
- (iii) In conjunction with resources from UNICEF, a set of wire bound illustrated manuals for training and use of traditional birth attendants (TBAs), who will be trained by UNICEF.
- (iv) Child growth charts.\* Recently USAID initiated an effort to prepare a standard growth chart by convening a meeting of all agencies which utilize them. A committee was designated to develop the new chart. USAID intends to produce it once it is pretested and finalized. Initially, 200,000 will be printed for use in 86 MCH Centers and Mothers' Clubs.
- (v) Teaching kits (flash cards, story boards, pamphlets, etc.) for field workers (FWVs, FWAs, FPAs, MAs.) A prototype kit will be

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\* Louisa B. Comes, et al., "A Growth Chart for use in Child Care and Nutrition in Bangladesh: Suggestions for Design and Implementation." (USAID, September, 1979). A large variety of charts are now in use.

developed and field tested prior to reaching decisions about large-scale production. A proposal for funding the prototype kit and 3,100 finalized kits is being formulated at this time and will be submitted to USAID.

As other MCH training material needs are identified, the Working Group, in cooperation with PC&FP Division, will meet to develop them. These materials will then be recommended to USAID for production support.

(5) Community Level Family Planning Services

The success of almost every family planning program in the developing world depends on gaining community support for fertility control. Bangladesh has no social or political cohesiveness at the village level which lends itself to creating community support for something as elusive and intangible as fertility control.

The Government has identified Swanirvar, or Village Self-Reliance, as the political movement for the villages. Swanirvar, which began in Bangladesh in 1975, has development of health and family planning services as one of its priority objectives. There are indications that fertility rates in some Swanirvar villages have been reduced significantly. USAID will experiment through the operations research grant by providing small grants to selected Swanirvar villages for MCH and family planning services. If this approach proves productive, AID will consider expanding support to the Swanirvar movement through a separate population project.

AID will also support project proposals of Thana Family Planning Officers. During training in Indonesia, each TFPO develops a plan of action for improving family planning services in his or her thana.

Program implementation of this component of AID support will be modelled somewhat on the Indonesian Mission's approach to local cost financing. Although projects which directly involve the community will be given priority under this component, other family planning services approaches not covered by the "main scheme" will also be encouraged.

The following are examples of projects which may be funded under this component.

- Special Information, education and communications (IEC) projects tailored to local dialects and using local media
- Seminars for local religious leaders
- Pilot MCH and nutrition projects
- Workshops for all categories of fieldworkers
- Thana level or lower prevalence surveys

## **2. Support to Non-Government Organizations**

Private organizations engaged in family planning projects are coordinated by the Family Planning Council of Voluntary Organizations. This Council is chaired by the Secretary of PC&FPD. It meets regularly to exchange experiences and to avoid overlap of project activities. As a result of private organizations growth and success, in 1979 the Government became more interested in "regulating" their role by determining where and in what manner these organizations should work. The ensuing dialogue resulted in a set of guidelines for private organizations, which by and large give maximum freedom to them to operate family planning and MCH services as long as the Government is fully informed. There remains a degree of tension between the private organizations and the Government, but in most cases, the resulting resolution of particular issues is an improvement in overall cooperation. The fact that the Government plays such a prominent role in the Council of Voluntary Organizations is a positive sign of the importance it places on private organizations to assist in delivering services.

Because of AID's experience in working with the family planning NGO's and because AID can grant funds directly to private organizations, unlike the other two major donors, the Government and the NGO's look increasingly to AID for support.

The ambitious Government demographic targets and the ambitious targets set in this project require that the private organizations increase their service delivery capability. Under this project, USAID has chosen organizations which have the capacity to expand their activities quickly and effectively.

### **a. The Bangladesh Family Planning Association (BFPA)**

Established in 1953, BFPA pioneered the family planning movement and greatly influenced the Government's decision to support family planning. With the beginning of the Government's involvement in population, BFPA's role was redefined so that it now supplements and complements the Government's program. BFPA performs the following roles:

- (i) popularizes family planning and small family norms
- (ii) involves and assists other voluntary organizations in developing family planning projects and
- (iii) demonstrates innovative projects for possible replication by the Government and other organizations.

BFPA presently supports activities in six areas of family planning:  
1) information, education and communications (IEC); 2) medical and

clinical services; 3) community based family planning; 4) planned parenthood and women development; 5) youth programs; and 6) training programs.

BFFA's programs are characterized by thoroughness, follow-up, community involvement, effective management, and innovation. One of BFFA's primary interests now and in the coming years is the development of programs with women and youth.

While BFFA has been in existence almost thirty years, the growth of its programs has been slow, primarily due to lack of resources and lack of management capability to absorb larger resources. Its management capability has grown and it is now in a position to manage larger programs.

Under this project, AID will negotiate a three year grant to BFFA so it can support projects in communications, clinical services, and service delivery programs utilizing youth, women traditional health healers and labor unions. The AID grant to BFFA will not substitute for but be additional to its annual grant from IPPF.

**b. The Pathfinder Fund**

The Pathfinder Fund concentrates on three areas of service delivery in Bangladesh: community based distribution projects; clinical services; and services for industrial workers. All three areas need greater concentration of effort, especially the latter two. Unlike some other AID/W supported intermediaries in Bangladesh, the Pathfinder Fund is severely limited by a lack of resources. Its FY 79-80 budget for Bangladesh was \$437,375, of which \$334,395 were funds provided through the AID/W worldwide grant.

Under this project, AID will negotiate a three year grant agreement with the Dacca Pathfinder Fund Office to support projects in clinical services, including MCH/FP programs for families of jute and sugar mill workers, other industries, and community based distribution projects in District and sub-Divisional towns.

**c. Social Marketing Project; Population Services International (PSI)**

In early 1975 this project began selling pills and condoms at highly subsidized prices backed up with a wide range of media advertising. Since then, it has distributed these products plus Neo-Sampoon foaming tablets and low dose pills to over 60,000 retail outlets. Total sales since the beginning of the project amount to over 100 million condoms, almost 4 million cycles of pills, and over 4 million Neo-Sampoon tablets.

In FY 79, the Mission added \$800,000 to this centrally funded project to enable it to expand further into the rural markets. In FY 80, the Mission began bilateral funding of the project. The contract with PSI, under which this project operates, expires in Feb. 1981. At that time, AID will negotiate a three year grant with PSI to continue subsidized sales of a wide range of contraceptives and to experiment with subsidized sales of MCH products. A primary goal of the three year grant with PSI is to establish a legally independent Bangladeshi organization capable of continuing to sell contraceptives and allied medical supplies throughout Bangladesh.

d. Family Planning Services and Training Center (FPSTC)

Established in January, 1979 by the National Population Council, the Family Planning Services and Training Center (FPSTC) has the following objectives: 1) to provide promotional, technical, and other services to voluntary organizations engaged in family planning, MCH, and nutrition; 2) to coordinate the activities of all voluntary organizations in these three fields; 3) to provide the Ministry of Health and Population regular information on the performance of voluntary organizations in these three fields. In addition, FPSTC also acts as the secretariat for the Family Planning Council of Voluntary Organizations discussed earlier.

FPSTC has a governing body responsible for setting policy and overall administration. The body is composed of representatives of the Government, voluntary organizations and donors. While the Chairman of the governing body is the Joint Secretary of PC&FPD, FPSTC is an autonomous non-governmental organization. It is the Government's window to NGO family planning activities.

Since FPSTC's establishment Family Planning International Assistance (FPIA) and the Ford Foundation have provided financial support for both administrative expenses and project costs. FPSTC has provided grants to nine indigenous PVOs for small projects in family planning, MCH, and nutritional activities, including one funded by Japan for family planning and parasite control.

An evaluation of FPSTC conducted by the Institute of Business Administration at the University of Dacca in April, 1980 noted that the approval, funding and monitoring process of FPSTC was highly satisfactory. During the first year of operation FPSTC conducted five training programs for personnel of indigenous PVOs working in family planning and MCH, and worked closely with other larger PVOs in improving its training programs.

USAID will provide grant funds for FPSTC to expand its support to indigenous PVOs for training and services. Ford and FPIA will continue to fund administrative costs and some projects. A three year grant agreement will be negotiated with FPSTC, but individual subgrant agreements will be approved by USAID population staff prior to the release of funds.

FPSTC plays a significant role in NGO family planning in Bangladesh and its role is likely to grow in the future. First, by helping indigenous PVOs develop, implement, and monitor small projects, FPSTC is developing the institutional framework for broad community support for family planning as well as expanding services. Second, as secretariat for the Family Planning Council of Voluntary Organizations, FPSTC acts as voice for the private organizations with the BDG. The Government relies on FPSTC to communicate its concerns to the private organizations as well.

e. The Bangladesh Association for Voluntary Sterilization (BAVS)

BAVS fulfills several important functions in the national program. First, it provides high quality sterilization training to Government and non-government physicians and allied medical personnel. BAVS will be the focal point of increased efforts to improve the quality of sterilization training in the coming years. Second, it provides high quality sterilization and other family planning services at 24 service centers located in district and sub-divisional towns throughout Bangladesh. Third, and most importantly, it provides moral and program leadership for the Government in sterilization. The Government looks to BAVS for advice on establishing standards of training and service.

AID will provide resources for BAVS to expand its training and service. Because BAVS' principal donor is IPAVS and because IPAVS is capable of providing a variety of technical and administrative services to BAVS, USAID support for the expansion of BAVS will be funnelled through IPAVS. IPAVS will administer USAID funds to BAVS in the same manner in which it administers its current projects with BAVS. The speed at which BAVS expands its activities will depend upon its ability to strengthen its management and supervisory capabilities; however, we expect that BAVS will be able to double the number of its service centers by the end of the project. IPAVS will play a key role in upgrading these skills.

f. The Asia Foundation (TAF)

In late 1979, the Mission negotiated a grant with TAF under the PVO Co-Financing Project to provide family planning and MCH services using its wide range of contacts with indigenous organizations doing other development work in Bangladesh. There are numerous organizations in

Bangladesh which are providing a wide variety of social services but no family planning and MCH services. By integrating family planning and MCH into their existing services, these organizations can institutionalize family planning services as a permanent part of their ongoing work.

To date, TAF has funded five projects with indigenous social welfare organizations which combine income-generating activities with family planning services. The new grant provides the means for TAF to continue funding population projects of indigenous NGOs when funds under its current project are depleted.

g. Family Welfare Visitor (FWV) Trainer Training with CARE

The Family Welfare Visitor (FWV) is the key BDG worker in delivering maternal and child health and family planning services in rural areas of Bangladesh. The 18 month training develops skills in health education, preventive and curative MCH, clinical family planning, and the management of services at Family Welfare Centers (FWCs). The training is divided into three six-month phases; first, classroom training covering theory and principles of MCH and family planning; second, practical training at nearby hospitals and MCH facilities; and third, field practice in rural areas.

Training is conducted at 11 (soon to be 12) Training Institutes (FWVTIs) by a faculty consisting of a Principal (usually a physician), nursing-midwifery lecturers, medical, social science, and nutrition lecturers and seven field trainers per institute. The field trainers supervise the practical aspects of the training during clinical practice and field training and give lecturers and practical demonstrations in the institutes.

The National Institute of Population Research & Training (NIPORT) is the Government office concerned with health manpower training. Recently the Training Unit of FC&FPD, which is responsible for FWV Training, has been transferred administratively to NIPORT. Thus training-of-trainers for the FWVTI will fit logically with NIPORT's new field training responsibilities. In the past their main focus has been management training and short courses for family planning personnel. They have little experience in longer courses or in training in teaching methodology and clinical areas. Outside assistance would be required to set up such a course, and new faculty positions would be required at NIPORT specifically for FWV Trainer Training.

Refresher training of FWV trainers is also necessary to improve their current performance and provide continuing education. Downstate Medical Center of New York operated a successful series of refresher training programs from February 1978 to August 1979, training 38 field trainers in clinical family planning. Since the end of its contract with AID, no further refresher training has been done. A course planned to begin in May, 1980 was never scheduled.

At the request of the Training Unit of PCFPD, CARE proposes establishment of an FWV Trainers Training Program as a permanent section of NIFORT. A permanent, full-time faculty would be created at NIFORT to conduct this training including three or four nurse-tutors, a social science lecturer and an education specialist. NIFORT would provide administrative support. Existing clinical facilities and field practice areas would be used for practical training.

External consultants from CARE will provide assistance in establishing the program including an educational consultant and a nurse-tutor consultant. CARE currently provides assistance to FWVTI training through nurse consultants on site at five FWVTIs and a medical consultant assisting with MCH training and curriculum development in Dacca. The focus is to improve the practical aspects of training to develop the clinical, health education and community development skills of the FWV trainees. This program is closely coordinated with other training inputs for related workers by UNFPA, UNICEF and the Netherlands. Thus the trainer training will be linked through the CARE/MEDICO Program Coordinator to the FWVTI program and related training programs. The need for external assistance is anticipated for three to five years, at which time the program would be continued by the Government.

During each year of the project at least one six month trainer training course will be conducted for approximately twenty candidates per class. In the first two years of the project an additional class will be trained. Thus in three years a total of 80 trainers will complete initial training meeting current personnel needs. Also each year four to six refresher courses of approximately one month duration will be given for existing field trainers and other faculty of the FWVTIs. Since major changes in the FWV curriculum are being introduced which will require changes in teaching methodology, this is especially important and timely. Continuing education for these faculty is an urgent and ongoing need which can best be provided by the same faculty as for initial trainer training.

The trainer training program will emphasize practical skills necessary for teaching, organizing field practice, and demonstrating clinical MCH and family planning skills so that the Family Welfare Visitor can assume an effective role in providing rural MCH and family planning services.

USAID will provide a grant to CARE for expatriate technical assistance, salaries and operational support for key faculty staff, equipment, educational and training materials, two vehicles and transport costs, and Bangladeshi consultants.

### 3. Increasing Demand for Fertility Control

While the intent of this project is to assist the Government and the private sector expand the availability of family planning services, we recognize that fundamental social, cultural, and economic constraints stand in the way of Bangladesh's desire and need to achieve a complete demographic transition. Therefore, within this project we have set aside a small amount of funds to support initiatives to increase demand for services.

Within the family planning sector we intend to strengthen and expand the demand for services through increased use of mass media, principally through the use of radio. Grants will be provided to both Government and private organizations to develop radio programs with consistent anti-fertility messages in the context of real life dramas, entertainment, and role models. Other demand creating ideas will also be considered for support under this project.

Outside the family planning sector, we will utilize funds under this project to increase our understanding of the determinants of fertility in Bangladesh; to fund feasibility studies in areas which seem to hold the most promise for project interventions; and to actually experiment with small scale projects which will include strong emphasis on evaluation. Our initial emphasis

will be to explore project possibilities aimed at improving the status of women. The feasibility of formal and non-formal female education approaches will be explored as well as schemes to raise the age of marriage and increase female employment.

Given the complexity of these issues, we anticipate that activity under this component of our project will not commence until FY 1982.

#### 4. Project Outputs

The project outputs will be family planning service availability throughout the country by the end of FY 83; an increase in the number of trained personnel to provide services and manage the program more effectively; and an increase in the quality and quantity of relevant data upon which program managers can make decisions to improve service delivery. NGO projects will have made services available through an array of indigenous PVOs. Community support for and participation in family planning will be greatly enhanced by Government and private organizations' programs. Experimental activities principally through mass media will strengthen and increase demand for services. Feasibility studies will determine the range and appropriateness of other activities meant to increase demand.

Project outputs by project components are contained in Table III. Table IV attributes gains in contraceptive prevalence to different contraceptives by source of supply.

Table III

3. Project Outputs

<u>Input</u>	<u>Output</u>	<u>Expected Results</u>
<b>I. <u>Training</u></b>		
a) TFPOs	a) 360 thana family planning and health officers trained in supervisory & community organizational skills.	a) Improved supervision of the field program and greater community involvement in family planning. Greater numbers of families reached with services.
b) Academic and professional training.	b) three mid-level BDG managers receive Masters degree academic training; approximately 10 senior and mid-level managers from BDG & private sector receive short term professional training in the U.S. or Asian countries.	b) Improved management of the BDG and private sector programs.
c) Religious leaders training	c) 30 to 40 senior Islamic scholars actively support family planning.	c) Positive religious support provided to family planning program.
d) FWV trainers	d) Faculty in all 12 FWV Training Institutes trained to train Family Welfare Visitors in clinical family planning and MCH care.	d) Improved quality of clinical family planning and MCH services.
e) MCH & Family Planning Materials.	e) MCH and family planning training and field-work materials and manuals available for use by FWVs, FWIs, TEAs, and other field level workers.	e) Greater acceptance of family planning due to more informed and better trained field-workers.

InputOutputExpected ResultsII. Expansion of Services

- |   |  |  |
|---|--|--|
| a) Contraceptive Supplies and medical kits              | a) Contraceptive supplies are made available to all categories of field-workers; medical kits are made available to physicians and paramedics.       | a) Greater numbers of families have modern means of birth control available to them.   |
| b) Sterilization Services                               | b) At least 400 BDG sterilization centers operating year round.  | b) A total of 1,625,000 sterilizations performed by the end of the project, resulting in 2,892,500 averted births.   |
| c) Bangladesh Family Planning Association.              | c) Clinical Services, Information and education programs, youth and women programs, and community based family planning services are made available. | c) Increased use of contraceptives, greatly increased knowledge of family planning, and increased community involvement in family planning.                      |
| d) Pathfinder Fund                                      | d) Family Planning Services made available in factories, jute mills district and Sub-Divisional towns.   | d) Increased use of contraceptives in defined areas of society.  |
| e) Population Services International, Social Marketing. | e) Contraceptive products available universally in all rural commercial outlets.   | e) Couple years of contraceptive practice increased from 400,000 to <u>869,000</u> . Contraceptives available in all urban and rural areas at subsidized prices. |
| f) Family Planning Services and Training Center.        | f) At least 20 indigenous Bangladeshi FVOs delivering family planning services.  | f) Increased use of contraceptives through Bangladeshi organizations. Community support for family planning increased.   |

<u>Input</u>	<u>Output</u>	<u>Expected Results</u>
g) IPAVS, BAVS	g) Number of BAVS clinics doubled from 24 to 48, training activities increased.	g) At least 150,000 sterilizations performed resulting in 267,000 births averted. Quality of sterilization services improved in BDG and private organizations.
h) Asia Foundation	h) Community Based contraceptive services integrated into other development efforts of indigenous IVOs.	h) Bangladeshi organizations deliver contraceptive services along with other services, contraceptive use increases.
i) Community level family planning services.	i) Swanirvar villages receive small grants to incorporate family planning into village activities; TFPOs receive small grants to sponsor local level improvements in service.	i) Contraceptive use increases through community involvement in the program; TFPOs improve service in resulting in increased contraceptive use.

### III. Management Information

a) Annual Prevalence Surveys	a) National level prevalence of contraceptive use data available yearly	a) Program managers have periodic reliable data to measure progress of the program.
b) Operations Research	b) At least 20 evaluation studies on different components of the program are completed	b) Program managers have reliable information on the progress of developing an effective service delivery program.
c) Sterilization Surveillance System	Surveillance system monitors all aspects of the sterilization program	c) Improved quality of sterilization services achieved.

<u>Input</u>	<u>Output</u>	<u>Expected Results</u>
<b>IV. <u>Demand Generating Activities</u></b>		
a) Use of Mass Media	a) Increased frequency and quality of radio programs designed to motivate married couples to reduce their fertility.	a) Increased demand for family planning services and increased contact between eligible couples and family planning workers.
b) Feasibility Studies and small scale experiments	b) At least 5 feasibility studies and/or small scale experiments undertaken relating to increasing demand for fertility control.	b) Greater understanding of the determinants of fertility is achieved leading to projects beyond family planning.

**Table - IV**  
**Increases in the Prevalence of**  
**Contraceptive Use by Project Component**

	<u>79-80</u>	<u>80-81</u>	<u>81-82</u>	<u>82-83</u>
1. Married Women of Productive Age	16,000,000	16,448,000	16,908,544	17,381,983
2. Prevalence of Use Attributable to:				
a) Sterilization	472,200 (2.9%)	791,300 (4.8%)	1,209,000 (7.0%)	1,667,500 (9.7%)
b) BIC Pills	512,670 (3.2%)	823,076 (5.0%)	926,923 (5.4%)	1,000,000 (5.7%)
c) BIC Condoms	352,760 (2.2%)	500,000 (3.0%)	511,000 (3.0%)	711,000 (4.0%)
d) BIC IUDs & Others	65,000 (0.4%)	75,000 (0.4%)	85,000 (0.5%)	90,000 (0.5%)
38 e) Social Marketing condom	337,282 (2.1%)	400,000 (2.4%)	489,000 (2.8%)	489,000 (2.8%)
f) Social Marketing pills	59,656 (0.3%)	80,000 (0.5%)	115,000 (0.6%)	189,615 (1.2%)
g) Social Marketing others	70,529 (0.4%)	85,000 (0.5%)	115,000 (0.6%)	115,000 (0.5%)
h) NCCs	500,000 (3.1%)	650,000 (3.9%)	825,000 (4.8%)	1,000,000 (5.7%)
3. Total*	<u>2,370,097 (14.6%)</u>	<u>3,404,376 (20.5%)</u>	<u>4,275,923 (24.7%)</u>	<u>5,282,119 (30.2%)</u>

\* Prevalence rates shown higher than projected targets are due principally to over reporting in the BIC's contraceptive distribution figures.

### Part III Project Analyses

#### A. Technical Analysis and Environmental Assessment

This project is feasible. It supports a national program which is conceptually sound and provides resources to overcome the most serious constraints to making the Government program more effective (e.g., training, services, and management information). At the same time, it provides support to private organizations so that services can be expanded as rapidly as possible.

Services are delivered by appropriately skilled personnel. Non-clinical services are provided by trained male and female non-clinical fieldworkers. IUD services and clinical MCH services are provided by specially trained paramedics in health centers. Sterilization services are provided by trained physicians assisted by trained clinic personnel.

This project meshes well with the BDG's decision to decentralize implementation of the program, with its growing emphasis on encouraging local community involvement in family planning, and with its encouragement to private organizations to expand family planning activities.

Safe and reliable contraceptive technology is utilized. The Mini-laparotomy technique, for example, is the safest and most efficient means of female sterilization. A surveillance system will be established to improve the quality of the sterilization program. Non-clinical contraceptives, such as condom, Neo-Sampoo foaming tablets and EMKC foam, which cause little or no side effects, are provided. A low dose pill has been introduced and its use will be expanded in this project. The wide variety of contraceptive methods available in the program is consistent with operations research findings which show a significant positive correlation between the degree of success in reducing fertility and the number of methods available.

In the absence of a national service statistics reporting system, operations research and prevalence surveys are the most reliable means of obtaining management information upon which improvements in the administration of the program can be made. These two evaluation tools are part of the AID support in this project.

Training inputs in this project are aimed at improving the performance of key program personnel and complement the training activities of other donors.

Emphasis on involvement of non-governmental organizations in family planning recognizes their long term role, in that the BDC still has a long way to go before its national delivery system is fully effective. For instance,

the expansion of the Social Marketing Project into the rural areas provides services to those who prefer this more anonymous and informal method of gaining access to contraceptive supplies and also provides a national fail-safe system during disruptions in BDG services when Government field workers cannot visit homes regularly due to bureaucratic changes, strikes or floods.

Experimentation with providing resources directly to the thana level and below recognizes that community level involvement is a necessary ingredient to maximum acceptance of family planning in Bangladesh.

## B. Financial Analysis and Plan

The total AID bilateral inputs for this three year project are \$64,865,680. The budget by project component is as follows:

	<u>BDG</u>	<u>NGO</u>	<u>Evaluation</u>	<u>Total</u>
Training	1,680,000	225,000	-	1,905,000
Services	43,420,761	15,319,793	-	58,740,554
Management Information	2,500,000	-	-	2,500,000
Demand Creation	-	1,670,126	-	1,670,126
Evaluation	-	-	50,000	50,000
<b>TOTAL</b>	<u>47,600,761</u>	<u>17,214,919</u>	<u>50,000</u>	<u>64,865,680</u>

A detailed budget is contained in Annex G.

Of the total, 73% is for the BDG program and 27% is for NGO activities.\* Fifty-two percent of the funds is for dollar costs and 48% is for local costs. Total resources available for the BDG program during the three years of the project are approximately \$240,965,680.

	<u>Total</u>	<u>Percent of Total</u>
BDG	\$73,700,000	31
IBRD	75,000,000	31
UNFPA	27,400,000	11
AID	<u>64,865,680</u>	<u>27</u>
<b>TOTAL</b>	<b>\$240,965,680</b>	<b>100%</b>

\* However, some of the contraceptive commodities, for which money will be obligated to the BDG, will be used by NGOs.

\*\* This includes the NGO portion of our project. BDG budgetary figures for FY 83 are not available and so the BDG contribution in FY 83 will not be lower than in FY 82.

Most BDC resources are budgeted for ongoing salary expenses, land for buildings, operational expenses of health and family planning facilities, local procurement of some drugs and clinic material, and customs charges on imported materials of UNFPA, IBRD, and some other donors. The BDC has promised to increase its share of program costs if annual evaluations justify greater resources.

Traditionally, the BDC has not contributed in a significant way to project costs in the population sector because of the abundance of donor financing and the willingness of other donors to support this sector. However, in June 1980, the BDC began to assume financial responsibility for the salaries of 8,000 FWAs. These salaries were initially funded from the Bank project. This is a concrete demonstration of the BDC's commitment to assuming costs of the program originally financed by donors. Now that health workers are also providing family planning services, the BDC financial commitment to the program is substantially greater.

The data presented in this plan represent resources from the BDC and the three largest donors. They do not reflect other sources of financing from AID/W intermediaries, such as FPIA, Pathfinder Fund, IFRP, & IPAVS, nor do they represent financing from Ford Foundation, contributions in MCH and drugs and equipment from UNICEF, and the private organizations not receiving AID assistance. A conservative estimate of financing for family planning activities in Bangladesh during the time period of this project is \$300 million.

Sources of funding for the program seem secure. The BDC is committed to the program financially, even though it has not had to expend large amounts of its own resources due to the donors' interest in funding this sector. Given the widespread interest among the donors in reducing fertility in Bangladesh, it is safe to assume that other donors will continue their support. No innovative, thoughtful idea for reducing fertility in Bangladesh will go begging for lack of resources.

## C. Social Assessment

### 1. Introduction

The appropriateness and feasibility of this project is discussed in Part II Project Background and Detailed Description in A. Background, 1. Program Rationale. Below we will describe the social organization of Bangladesh, the beneficiaries of this project and the social impact of the project.

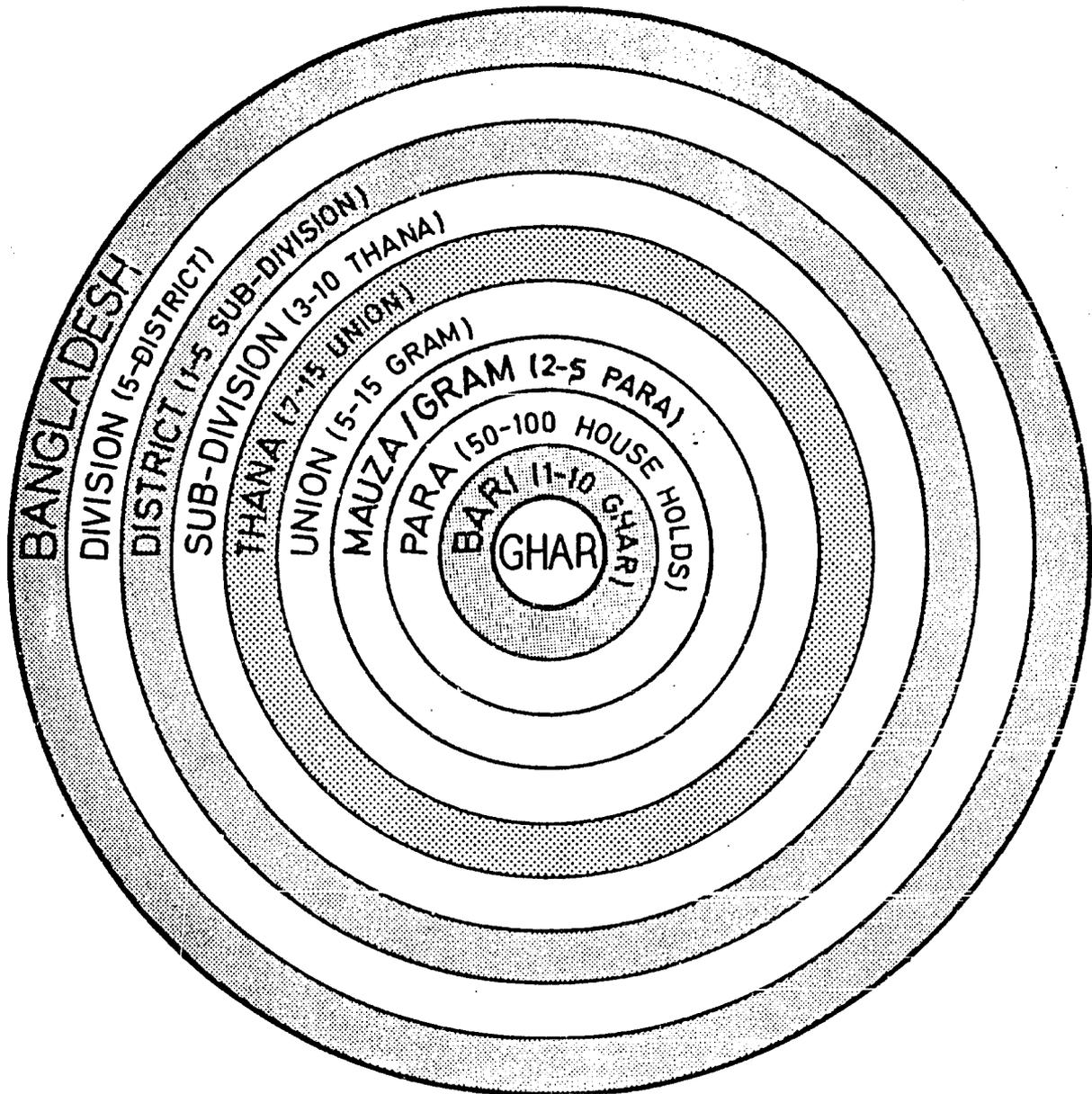
### 2. Social Organization

Bangladesh is the second-largest Muslim country in the world, after Indonesia. Eighty-five percent of the population follow Islam; but there is a significant (14%) Hindu minority as well as small percentage of Buddhists, Animists, and Christians.

Social organization and cultural traditions in Bangladesh are strongly conditioned by an intensive rice-based agrarian system, operating in a difficult environment under increasingly severe population pressure and resource scarcity. Access to the most important productive resource, agricultural land, is highly skewed. Over half of all rural villagers are landless or near-landless. Declines in productivity, employment, and real wages have been marked over the past two decades. The estimated per capital national income is \$90. per year, one of the lowest in the world.

The layers of Bangladesh's complex social structure may be depicted concisely in the illustration on the next page. Bengali society is based on the household (ghar), formed by a man, his wife and unmarried children (paribar). Several households of patrilinearly related kinsmen compose a homestead (bari), which is, in turn, part of an identified hamlet (para). Beyond the hamlet, there is little social cohesion or community involvement. The family cycle which generates this set of social forms begins with the alliance of two paribar through marriage, in which typically the young people being married have little choice of partners. The shift of the bride to her in-laws' homestead places her under the authority of the senior members--usually her mother-in-law. Relations between spouses are not expected to be close or even affectionate; separation and segregation of sexes is marked. The bride proves her worth and gains prestige as well as security by producing children--preferably male--for her husband's family. Over time, with the death of older women and the coming to maturity of her offspring, she assumes the mantle of female authority in the household and homestead.

# ORGANIZATIONAL SPHERES IN BANGLADESH



## TARGET FOR EFFECTIVE DEVELOPMENT

DIVISION	..	..	..	..	..	..	..	..	..	4
DISTRICT	..	..	..	..	..	..	..	..	..	20
SUB-DIVISION	..	..	..	..	..	..	..	..	..	69
THANA	..	..	..	..	..	..	..	..	..	470
UNION	..	..	..	..	..	..	..	..	..	4,350
GRAM	..	..	..	..	..	..	..	..	..	68,385
GHAR	..	..	..	..	..	..	..	..	..	12,676,000

Especially for farming and low-income laboring families, children are an economic asset as well as a source of political support at maturity.\* Boys can assist their father and uncles; girls may be used to forge alliances with potential economic and political supporters. For the poor, children become useful at early ages, assisting the family in field labor, helping with craft work, and doing odd jobs for wealthier households.

Beyond the family and homestead, much social life takes place in the hamlet (para), which is often composed of a number of related kin-groups and has a distinctive social identity. Within the para, influential men exercise authority in the settlement of disputes and maintenance of social norms. Paras are loosely affiliated into villages (gram), which are relatively unimportant units for everyday life. Administration of national-level programs extends from the top downwards; most development programs reach only to the thana or, sometimes, to the level of unions; there is little on-going participation by villagers in any of these programs, since they do not often penetrate into the closely-knit life of the para and bari. Most people have little access to health programs; most children never enter school and many of those who do drop out after only a brief exposure.

### 3. Beneficiaries

The initial beneficiaries of this project are the Bangladesh Government's family planning service delivery system and private voluntary organizations engaged in family planning activities. The largest amount of project inputs (TFPO training, MCH/FP training materials, contraceptive commodities and surgical supplies, operations research) is intended to strengthen the government's capability to deliver family planning services. Likewise, by providing substantial support to PVOs, this project will increase their capacity to provide services. At the same time, the capabilities and careers of the family planning personnel involved in both governmental and private programs will be enhanced by this project's inputs. This personnel aspect has important ramifications for women, as women (e.g., FWVs and FWAs) are the key field workers. Efforts to improve their training, skills, and supervision may also improve, inter alia, their status in the community.\*\*

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\* See, for example, Mead T. Cain, "The Household Life Cycle and Economic Mobility in Rural Bangladesh", Population and Development Review, IV, Sept. 1978.

\*\* There was a concern in the PID approval cable regarding the actions that can be taken to promote female FWAs to FFA supervisory positions. Under the integrated program FWAs and FFAs work together as a female/male team. The FFAs no longer have supervisory responsibilities.

Strengthening the government and PVO family planning delivery system will enable them to reach with greater frequency and duration the ultimate project beneficiaries--men and women of reproductive age and their children. This target category is widely dispersed, and access, geographically and socially, is a key barrier. Over 90 percent of the population lives and works in rural areas. Communication and transportation are very poor. Many rural people, particularly women, have never been beyond their own or nearby village. For this reason, the extensive network of government family planning field workers at the local level has been established. Socially, access is limited as women tend to be secluded. Even within the household, younger married women are dominated by older women, particularly by their mothers-in-law. Female fieldworkers must reach these women in their homes. By making and maintaining personal contact, the barriers of purdah and seniority may be overcome. Male field workers are employed to contact and motivate husbands of eligible women. As males make the crucial decisions on most aspects of family life, effective male fieldworkers are essential. Unfortunately, even with increased numbers of field workers resulting from the recent integration of health and family planning workers, they are spread too thin to reach all eligible couples. Therefore community mobilization is also important.

Maloney and Aziz\* conclude that most rural people are generally apprehensive about the effects of population growth. They will turn this concern into action if fertility control is oriented to their world view, value system, and strategic concerns in local context. This can best be done by soliciting community leaders (usually at the para level or below) to advocate family planning as the moral duty of individuals to their community. Such community leaders would include religious leaders and para headmen. The early experiences of swanirvar were cited as examples of the potential for fertility control if community's concern can be generated; although the subsequent bureaucratization of swanirvar was also noted.

This project contains several components to generate community support for family planning: training for religious leaders; grants to communities for family planning projects; and support for family planning activities of small indigenous FVOs, many which are composed of community leaders.

For men and women of reproductive age, the ultimate beneficiaries, a number of immediate effects are likely. Ideas about family planning tend to diffuse by example. Dissatisfied users are usually the most vocal, although satisfied acceptors also provide models for behavior. Trained, well supervised field workers should increase the number of satisfied users and decrease the number and influence of detractors. Special project attention will be given to improvement of the logistics and services of the voluntary sterilization program, as it is highly sensitive to any adverse results. A nationwide followup survey of the sterilization campaign of 1977 found, for example, that "... one of the important lessons would seem to be that the information to the client and the

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\* Beliefs and Fertility, op. cit.

general management of the sterilization programme can be very important in the level of satisfaction, particularly as reflected by the male participants. Providing a high quality service may be an essential factor for the growing acceptance of sterilization, especially by men."\* In short, the better the service, the more likely that project results will diffuse to a wider audience.

#### 4. Social Impact: Equity

By improving the service delivery capacity of the government and expanding the role of FVOs, a massive effort will be made to reach the urban and rural poor. According to current government regulations, FVOs are to concentrate their efforts in urban areas, although they are not precluded from working in rural areas as well. By serving urban areas, the FVOs can reach the most destitute, the landless, who have left the rural areas in search of some sort of opportunity. Also, the family planning social marketing activity of this project will greatly increase the accessibility of contraceptives to all by using commercial distribution channels.

The Government, through its extensive field worker approach, is trying to cover every village, regardless of its accessibility. Inevitably, however, due to poor road conditions and transportation facilities, especially during the monsoon season, many less accessible villages will not be reached, even with substantial improvement in government services. There is some evidence to indicate that FWAs are selective in their home visiting. Quddus reported that manual workers and farmers were visited less than respondents of prestigious occupations such as business or service\*\*. This may be related to the similar high family status of the FWA and/or the greater ease of recruiting persons of high status to family planning. Improved training and supervision of the FWAs are included to insure that they visit all eligible couples, even the ones most difficult to motivate.

The voluntary sterilization portion of the project seems to benefit the other end of society--the very poor. Data indicate that the majority of those accepting sterilization come from this segment of society. Quddus found that those who are economically better off are less likely to choose sterilization as a birth control method. On the other hand, repeated studies of sterilization acceptors have found them to be, on average, older, with larger families, than the acceptors of other methods.\*\*\* This finding does not preclude the possibility that the acceptors are also poor, but it does indicate that family size concerns are important in the choice of sterilization.

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\* N. Nawab Ali, et al., 'Sterilization Campaign of 1977 - A National Long Term Follow-Up Survey.' (Bangladesh Fertility Research Program, Technical Report No. 25, July, 1979)p.21.

\*\* Quddus, Performance of FWAs. p. 19

\*\*\* Quddus, Performance of FWAs, and Ali et al., Sterilization Campaign of 1977

One interpretation of these research results is that the provision of sterilization services meets a demand of the very poor, who adopt family planning to limit rather than to space their children and who are dissatisfied with temporary methods. Though no one anticipated its popularity, sterilization acceptance has increased markedly in recent years. One objective of this project is to ensure high quality service.

The chief beneficiaries of this project, over time, will be women and children, who together constitute three-fourths of the population of Bangladesh. For women, to adopt a family planning method to control fertility is, in essence, a liberating act. With fewer or no more pregnancies, women are less at risk of pregnancy-related mortality and morbidity. With better health and fewer child care demands, women can take part in a greater number of economically productive activities. The number of children under 15 in Bangladesh is staggering. Most children do not receive adequate diet, clothing, and medical attention. Very few have any opportunity for education. Assuming family income remains relatively stable, the children of couples who have adopted family planning to limit their family size should be better fed, better educated, better clothed, and generally better cared for since the family income does not have to stretch as far.

#### 5. Spread Effects

The goal of the project is to reduce fertility in Bangladesh through increasing the prevalence of contraceptive use. This is to be accomplished through systematic improvements in the public and private delivery systems for contraceptives. In addition to the direct benefits derived from the project which are discussed above, a number of indirect "spread effects" may be anticipated to occur as well.

Diffusion of information, favorable attitudes, and effective practice of contraception is a function of the frequency and intensity of contact and communication with credible sources of information and the provision of appropriate methods. As the delivery system for contraceptive materials and information improves, and as family planning workers achieve credibility, the impact of their activities in local areas should increase geometrically as satisfied clients transmit information, advice, and favorable impressions to others. As initial gains are registered in an area, follow-on activities may be scheduled to build on and amplify these program efforts.

Assuming favorable impact of the project and reduced fertility, what consequences might be anticipated? First, there is strong likelihood of reduced child and maternal mortality, in response to more adequate birth spacing which allows for better infant care. Second, with fewer mouths to feed, nutrition, especially for infants and children, should improve--especially in lower-income families. And third, reduction in fertility will result in reduced pressures on social services now being initiated, such as health care centers.

## D. Economic Analysis

1. Economic Justification for Fertility Reduction Family Planning Projects in general are not suitable for cost benefit analyses, since they do not result directly in a product that can be readily quantified in monetary terms. Yet in Bangladesh, decline in population growth rate is acknowledged as a necessary step to economic growth. The implications of maintaining the current population growth rate for agricultural production requirements and employment were noted in the background section of this paper, and previously in the CDSS.

The long-term rate of growth in foodgrain production in Bangladesh has been about 1.5 percent, well below the population growth rate of 2.8 percent. Even if the rate of increase in foodgrain production can be increased to 4 percent and maintained at that level (something that has not been done for a significant length of time elsewhere in the developing world), it would be 1990 before Bangladesh reached technical self-sufficiency in foodgrains. But "technical self-sufficiency" assumes a perfectly even distribution of food throughout the population. It would be much longer than that--even on this optimistic assumption with respect to production - before Bangladesh could provide the poorest elements of its population a nutritionally adequate amount of foodgrains from its own resources.

Thus, production increases, while essential in their own right, can be neither a sure nor a reasonably swift route to meaningful foodgrain self-sufficiency. The necessity of reaching this goal at least partly through population control, the other side of the self-sufficiency equation, is clear from a brief look at the nutritional situation of the poorest groups. In a recent IBRD report, Cm Nijhawan\* estimated that by 1976 about 45 million people, 60% of the rural population, were "hard core" poor. (Hard core poverty consumption expenditure was that required to provide 1,805 calories per person per day, or 85% of the minimum WHO/FAO recommended average calorie standard for Bangladesh.) Similar trends held for the urban population. With Bangladesh's very high and increasing man-to-land ratio, concentration of land ownership and lack of opportunity for non-farm employment, the food gap hits the poor most severely. Under these circumstances, Bangladesh simply cannot afford the additional food gap which maintenance of a 2.8% growth rate represents.

## 2. Demand Versus Supply

Once it is accepted that declining population growth rates are necessary, there are two possible approaches:

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\* IBRD Report No. 2870-BD, "Bangladesh Current Economic Position and Short-Term Outlook", March 21, 1980, Annex II.

(1) Concentrate primarily on readily available supply of family planning services, assuming that existing demand justifies these services. At the same time, it is understood that many of the interventions on the service side also have a positive impact on demand.

(2) Concentrate primarily on projects aimed at increasing demand for family planning services, i.e., on general development activities which have a positive effect on fertility reduction.

As previous sections of this paper have indicated, there is evidence that unmet demand for family planning services does exist, at least enough to effect a contraceptive prevalence rate of 25 percent if family planning services are made readily available. To go much beyond this level, however, activities which explicitly create demand by attacking the causes of high fertility will be necessary. The stimulus to demand from the interventions of this project, such as MCH, community based experimental activities and IEC, while helpful, need to be supplemented by demand creating interventions.

Not all development activities will have a negative fertility impact. An example of the possibly perverse effect of other program efforts on the family planning program may be seen in USAID's overall agricultural strategy. Agricultural activities do not in themselves affect the traditional values and life-styles that determine current fertility levels. However, higher average per capita farm incomes, a primary objective of USAID's agricultural programs and a desirable goal in itself, appears likely to lead to rising fertility rates, at least in the short-term. Truly significant increases in income would eventually have a fertility reduction effect, but thus far increases of the desired magnitude have not been possible - in great part because of the high rate of population increase which has eroded such production gains as have been made.

USAID is examining specific development activities which will have a positive fertility reduction impact, and the recent studies on Beliefs and Fertility and Socio-Economic Determinants of Fertility were commissioned to provide information on this subject. Probable areas for project development include female employment and education. USAID's experience with women's projects thus far indicate that they are slow in implementation, are very staff intensive, and cannot go immediately into nationwide programming. Massive inputs will be required to make them work, and a high initial cost-benefit ratio cannot be expected.

While such projects are being developed, however, immediate fertility reduction gains can be made through providing nationwide access to contraceptive services. This will also ensure that once additional demand has been generated, access to services will be available to all who require them. Therefore this project follows the approach of ensuring a readily available supply of contraceptives.

### 3. Project Component Mix

There are several possible ways of increasing access to family planning services, and this project uses a combination of them: increased clinical service (sterilization), door-to-door delivery of contraceptives, distribution of contraceptives via normal private commercial channels, and innovative service delivery projects of private voluntary agencies. The following table V compares cost per continuous user for each of these methods. This is done in lieu of a cost benefit calculation, which, because of the difficulty in quantifying the benefits of a population program, cannot be done realistically. Cost per continuous user data, in conjunction with total contraceptive prevalence by project component as shown in Table IV, serves as a measure of cost-effectiveness of the various project components.

Table V. Annual Cost Per Continuous User

	<u>FY 81</u>	<u>FY 82</u>	<u>FY 83</u>
Sterilization	\$5.17	\$4.92	\$4.57
BDG Other Methods	\$30.19	\$27.80	\$24.28
Social Marketing	\$7.22	\$6.53	\$6.73
NCCs	\$10.19	\$8.14	\$8.14

Annex L describes how these figures were derived, using budgetary data from Annex G, information on other donors and NGOs from other sources, and user data from Table IV.

It should be noted that the per user costs shown above are not AID costs alone, but costs of the BDG and all other donors. The annual costs to AID per user would be much lower, particularly for BDG other methods.

The BDG services other than sterilization have a much higher cost per user than any other component. In part this is due to inclusion of some construction costs for health and family planning clinics. Since ongoing construction is far behind schedule, planned construction may not be implemented as extensively during 1981-83 as the budget would indicate.

Even taking this bias into consideration, however, BDG program costs are inordinately high, particularly when it is noted that the NGC programs are responsible for a large percentage of total acceptors. (Table IV shows contraceptive users attributable to BDG and NGCs.) This is not surprising.

Previous sections have stated that BDG family planning performance has been poor and have noted the reasons for it. The inputs which make BDG costs so high over the 1980-83 period are aimed at improving performance over the long term, and if estimated prevalence increases are correct, the annual cost/user will decrease significantly over the project period.

Based on past experience, the NGC costs and user rates appear reasonable. Below are some AID-funded PVC cost per user data, based on the most recent annual figures available. These figures are for total users, not continuous users. Concerned Women for Family Planning claims a 60% continuous user rate after 20 months. A conservative average continuous user rate for the PVCs below would be 33% of total users. The resulting cost per continuous user is in line with that estimated for the project.

PVO Family Planning Projects		
<u>Organization</u>	<u>Annual Cost/Total Users</u>	<u>Cost/Continuous User (at 33% continuation)</u>
Pathfinder Model Clinic	\$ 2.00	\$ 6.00
International Union for Child Welfare	\$ 2.00	\$ 6.00
Barisal Freedom Fighters	\$ 2.63	\$ 7.89
Narayanganj Women's Organization	\$ 5.36	\$ 16.08
Christian Health Care Project	\$ 2.60	\$ 7.80
Concerned Women for Family Planning	\$ 2.63	\$ 7.89

Clinic projects such as the Model Clinic and Christian Health Care do significant numbers of sterilizations, which would reduce costs per users somewhat.

Since cost per users are lower for NGOs than for the BDG and prevalence rates are generally higher, why not put more money into the NGOs and less into the governmental program?

The BDG service delivery system is now in place. It has resulted in some declines in fertility and it is the most important source of contraceptive services by current users. It is the only organization with the personnel and infrastructure to provide services nationwide. The success of PVOs in providing

family planning services is due in part to their size. Because they are small, they can concentrate their efforts intensively in the target area. It is not known to what extent they can expand their services rapidly and still retain their quality of services as well as their low cost per user rates.

In addition, this project has the flexibility to adjust funding among the various components dependent upon annual performance. In the government component, actual budget outlays for contraceptive commodities and for sterilization will be based on annual assessment of commodities distributed and services provided. The budget projections for the following years will then be adjusted upwards or downwards as required. Likewise, the sterilization budget will be a function of annual performance. The budget for training will be reassessed annually to take into account evaluations of previous training experiences and placement of BDC officials after training. The number of operations research grants will depend upon the number of high quality proposals offered. Operations research and prevalence surveys, while not readily adaptable to cost-effectiveness analysis, will be important in providing USAID and the BDG with information to evaluate the overall program and to recommend changes. Grants to NGOs will be negotiated annually and will be highly dependent on evaluation of the previous year's progress. Thus, for all components of this project, the arrangement of annual, incremental funding based on previous year's performance will enable USAID to maximize project effectiveness. Evaluations incorporated into individual grants and occasional assistance from centrally-funded consultants (APHA or CDC) are necessary if thorough annual assessments are to be made.

## Part IV Implementation Planning

### A. Administrative Arrangements

#### 1. The BEG

The Population Control and Family Planning Division (PC&FPD) of the Ministry of Health and Population Control will coordinate the implementation of the BEG component of the project. The organization chart of PC&FPD is shown in Figure 2.

For each year of this project, a Project Grant Agreement will be signed with the External Resources Division of the Ministry of Finance. All foreign exchange cost components will be subobligated through Project Implementation Orders. Local costs will be reimbursed to the Government through Account No. 4 in the Bangladesh Bank. Detailed procedures will be developed to reimburse the Government for local costs and will be made a part of each year's Project Grant Agreement. There are two existing models for disbursing local funds, the operations research grant and reimbursement of costs for sarees and lungis in the sterilization program. Both models have worked well and have sufficient controls in them.

There are acknowledged administrative difficulties, most of which are common throughout Government and are features of the social environment. Some improvements have been made during the course of the first population project, but many of them remain unresolved. Some of AID and other donor inputs, such as training and consultant services have contributed to improvements in the level of staff competency and continual improvement will be made during the life of this project.

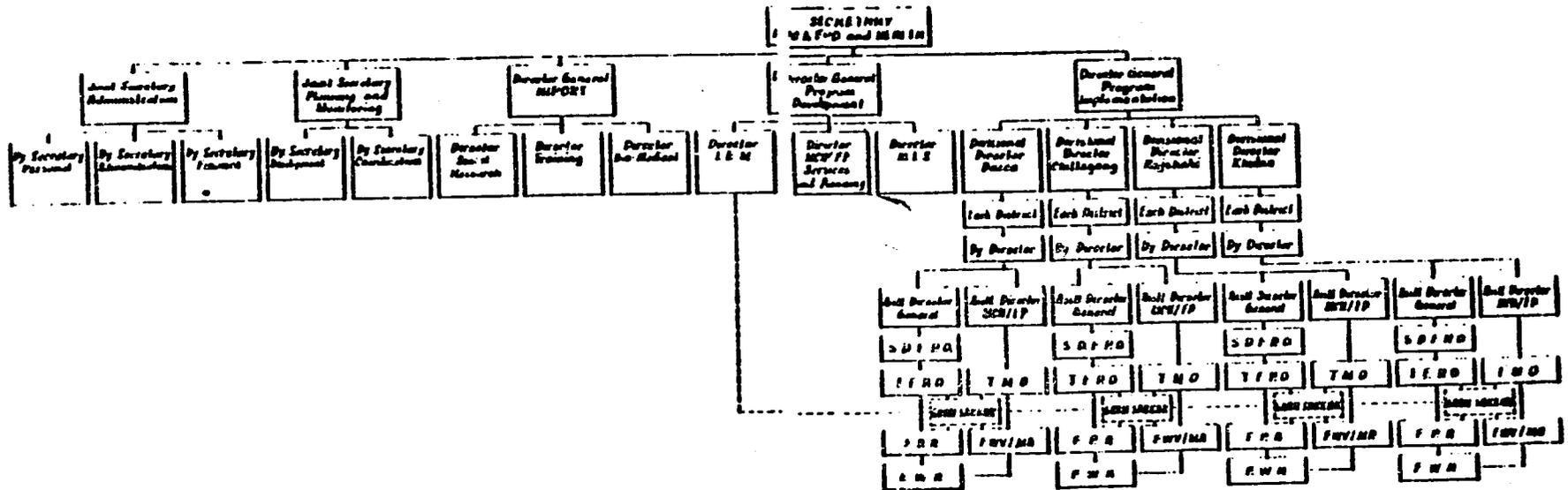
For problems related to the "system" there is little the donors can do, except to maintain candid discussion with the EDG regarding actions which might facilitate program implementation. Population officials have always been receptive to ideas and criticisms.

However, there are actions which can be taken by the EDG to minimize bureaucratic constraints, such as filling the many personnel vacancies in the program, developing more flexible procedures for the expenditure of funds, and becoming more aware of field level problems. None of these actions would require extraordinary authority.

As noted earlier in this paper President Zia is deeply committed to the population program. It is one of three pillars of his revolution and he and his Ministers speak often and forcefully to rural audiences on the need to accept family planning. The President is also becoming aware of the inadequacies of the program and short term improvements are evident when-

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### ORGANIZATION CHART OF NATIONAL FAIRLY PLANNING PROGRAM



ever he reaches into the bureaucracy. His sustained interest and more direct involvement in the program are necessary for longer term improvement.

Experience to date cautions against believing that administrative miracles will occur in the population program in the short term. Substantial improvements have been made in the past five years, but they have been slow. Donors and Government alike have vastly underestimated the time needed for the Government to organize and administer a national program of the size and magnitude needed to deliver services effectively in a rural setting. This project recognizes this fact and continues to support the Government, but at the same time increases the private sector's ability to provide services now.

## 2. Non-Governmental Organizations

NGOs working in family planning are registered either with the Ministry of Health or with the Ministry of Social Welfare or in some cases with both Ministries. These organizations, both foreign and domestic, are loosely organized into a Council of Voluntary Organizations which meets bi-monthly and which is chaired by the Secretary of Health and Population.

Under this project separate grant agreements will be signed between USAID and the NGOs. Each NGO receiving a grant will be fully responsible for the implementation of the activities described in the grant. Each NGO will be responsible for clearing its family planning activities with relevant Government Ministries and for keeping the Government informed, principally through the Council of Voluntary Organizations.

While these private agencies are not handcuffed by the Bureaucratic malaise and constraints of a Government system, and this is a principal reason for including them in this project, they in some cases have management and administrative limitations. The major constraint here, which is universal in Bangladesh, is the lack of experienced and skilled administrators to implement projects. In this project AID will work very closely with the NGOs receiving grants to improve their administrative capabilities. When necessary, grant agreements will include provisions for upgrading skills and hiring new staff with needed skills and experience. In addition, participant training funds have been reserved in this project for sending NGO managers to other Asian countries and in some cases to the U. S. for short term professional training courses.

## 3. USAID

USAID population staff in the Population, Health and Women Division (PHAW) is responsible for administering all aspects of this project.

Project implementation will be through Project Grant Agreements, and Project Implementation Orders. For NGOs with more than one project activity, each project will be reviewed and approved separately by USAID staff. While USAID's population support has grown both bilaterally (sterilization support in FY 78, operations research in FY 77, and social marketing in FY 80) and through the AID/W supported intermediaries, there are only two full time direct hire AID staff working in population. Clearly, given the complexity of this project's implementation process, the wide range of local costs involved, present staffing is not enough to implement this project, particularly if the longer term issue of how to increase demand for fertility control is to be addressed.

In June 1980, the Mission submitted a SPAR for a public health physician with clinical family planning experience, especially sterilization experience. The primary responsibility of this physician is to assist in the implementation of sterilization support. Without a physician the Mission does not believe it wise to commit itself to such large support for sterilization. The physician should arrive in FY 81. In addition, one part-time spouse direct hire position has been set aside for a population and development officer to develop "demand-generating" activities. A qualified candidate has been identified and should arrive at post in early November, 1980.

Under an O. E funded personnel services contract (PSC), one additional population specialist will be hired for implementing and monitoring the NGO component of this project. Given the project's total value and complexity and the necessity of travelling to monitor the wide variety of project activities which will be supported under this project, a population staff of two population generalists, one physician, and one PSC is necessary to implement this project.

## B. Implementation Plan

USAID anticipates that it will take the greater part of FY 81 to develop and negotiate the many grant agreements described in this project. Grant agreements will be modified through amendments whenever necessary and implementation modifications will be made through Implementation Letters. The Project Paper should be approved by December 1980. The following shows the Implementation Plan by project input and type of activity.

### 1. The BEG

Project Grant Agreement covering contraceptive supplies, participant training, operations research, sterilization costs, and development

of MCH training materials - January/March 81. Separate grant agreements will be negotiated for the annual prevalence survey. The timing of this grant agreement will depend on negotiations with the EDG, although ideally actual survey work should be done during the winter months if possible.

## 2. NGOs

USAID will sign a three year grant agreement with each NGO according to the schedule below. This agreement will set forth overall targets and sub-project procedures. Funding will be obligated for one year only, however, and additional year funding will be obligated through annual grant agreement amendments, the amount dependent upon previous year's performance.

(a) Bangladesh Family Planning Association (EFFA) ...	April 1981
(b) The Pathfinder Fund	March 1981
(c) Population Services International (PSI)	Feb. 1981
(d) FFSTC	June 1981
(e) IPA VS	April 1981
(f) The Asia Foundation	April 1981
(g) CARE	Jan. 1981

## 3. Demand Generating Activities

Grant agreements and contracts will be negotiated with government and private sector organizations when appropriate activities have been identified.

### C. EVALUATION PLAN

1. Comprehensive Evaluation. At least six months before the end of the project an in-depth external evaluation will be conducted. The purpose of this evaluation will be to assess the performance of the project in meeting its purpose and to make recommendations for the completion of the project and for follow-on activities the mission might take in seeking to reduce population growth in Bangladesh. The composition of the evaluation team will be similar to the one assembled for the 1980 evaluation of USAID population activities (i.e., a combination of both AID/W and non-AID family planning and/or evaluation professionals, both male and female). This evaluation will be funded by the project. In addition to this comprehensive evaluation, other evaluation, surveillance, survey and review activities will assess performance of specific aspects of the project.
2. Annual Review. Both the BDG and the NGO components of the project will be reviewed annually by the USAID population staff and evaluation officer.
3. TFPO Training in Indonesia. This component will be evaluated in early 1981 by a Bangladeshi organization (probably from Dacca University) with the purpose of identifying ways to improve the impact of this ongoing training program. Funding for this evaluation has been provided by the current (FY 76-80) population project under which the training was initiated.
4. NGO Component. Each subgrant proposal under the NGO component of the project will be reviewed by USAID population staff prior to USAID approval.

Each NGO receiving support will be required to collect simple cost effectiveness information, especially for those subgrant activities that include services other than family planning. Grantees will be asked to use prevalence programming, as defined in the 1980 external evaluation, in all projects where it is applicable and feasible. Performance of the grantee will be systematically reviewed by USAID population staff prior to consideration of requests for subsequent year funding.

5. Sterilization Component. Special attention will be given to evaluating and monitoring all aspects of the sterilization program in order to insure that the highest quality services are established and maintained. Specifically, the following

will be done:

- a. With technical assistance of the Center for Disease Control in Atlanta (which will be funded by AID/W) a sterilization surveillance system will be established to monitor mortality and morbidity.
  - b. Periodic assessments of the quality of sterilization services will be conducted by four expatriate physicians (who will be funded by the World Bank) together with Bangladeshi counterpart staff. These assessments will be made against baseline data that is to be gathered in early 1981.
  - c. Through the use of quarterly sample audits, an independent Bangladeshi accounting firm will audit the local costs disbursements made by USAID. These audits will be funded by the project.
6. Prevalence Surveys. The purpose of the project, achievement of 25 percent contraceptive prevalence, will be measured by prevalence surveys conducted by an outside professional firm using funds provided by the project and at a time (or times) to be determined by USAID staff.

**D. Conditions, Covenants and Negotiating Status**

The following conditions/covenants will be included in all Project Grant Agreements between USAID and the BDG and between USAID and all NGOs receiving financial support under this project.

1. The Grantee will insure that none of the AID funds available under Agreements with AID are to be used to pay for the performance of abortions, as a method of family planning or to coerce any person to practice abortion.
2. The Grantee will insure that none of the AID funds available under Agreements with AID are to be used to finance involuntary sterilization(s) or to coerce anyone to have a sterilization.
3. The Grantee will insure that if sterilization services are provided under the terms of an AID grant no fees may be paid to clinical and/or non-clinical personnel to motivate clients to accept sterilization.
4. The Grantee will insure that if sterilization services are provided under the terms of an AID grant an informed consent form acceptable to USAID must be used for all clients receiving support.

The following conditions will be made a part of the Grant Agreement between USAID and the BDG.

1. Within 90 days of the signing of a Project Grant Agreement, which includes financial support for sterilization, the BDG will submit a comprehensive plan for a sterilization surveillance system which is acceptable

to USAID. No funds for the sterilization program will be released by AID until a sterilization surveillance system is approved.

2. The BDG will put into use immediately the Informed Consent Form for sterilization clients currently used by BAVS or a similar one acceptable to AID.

All elements of this project have been developed jointly with the BDG and with the NGOs. The BDG has agreed to all planned areas of assistance and has agreed to the conditions precedent listed above. On the basis of discussions with USAID in preparation for this project the BDG has made an important policy change. It has agreed not to charge for contraceptives and has reduced its proposed payments for sterilization in order to ensure that there is no financial advantage to acceptance of sterilization over other methods. There are no issues yet to be resolved between the BDG and USAID which would delay signing of the agreement for this project. No waivers are foreseen at this time although it is possible that PVO grantees may wish to purchase items such as cycles from non-American sources in future.

**UTILIZATION OF SPECIAL COMPUTER PROGRAMS  
TO CALCULATE FAMILY PLANNING PROGRAM EFFECTS**

Although family planning service delivery statistics are available from 1969, the quality of earlier data is questionable. Moreover, since the government program itself did not operate fully until late 1975, the impact of family planning on Bangladesh's population growth is examined only after 1975. A CONVERSE program was run for the 5 year period between 1975 and 1979. CONVERSE is a one-sex (female) component projection model, which assesses the impact of contraceptive acceptors on a country's female population and female vital rates.

For planning contraceptive services the TABRAP was tried for the 1980-90 year period, using different CBR targets based on actual population projections. TABRAP (Target Birth Rate Acceptor Program) is a computer programmed model which calculates the annual number and composition (by age and method) of contraceptive acceptors required to meet an annually specified CBR target over the target interval. For detailed information on TABRAP and CONVERSE, see Nortman, et al., 1977.

The following summarizes the assumptions and limitations involved in the programs. Unless specified, they apply to both TABRAP and CONVERSE.

1. Only the age group 15-44 of women were included in the calculation of program effects, while the number of acceptors is based on those 10-49 years old. Therefore, program effects were inflated due to the omission of ages 10-14 and 45-49 married women as a denominator

2. Due to the limitation of contraceptive methods to 6, tubectomy and vasectomy were combined as one method: sterilization. MR had to be omitted among the methods being introduced to Bangladesh. This was done not only because MR is the lowest profile method, but also because some part of it overlaps with other methods. This is much less true with other methods.

3. Many input data were borrowed from the 1970 Indonesian case, mainly because of the availability of these data. Also it is not unreasonable to substitute Indonesian data for Bangladesh since the two countries have several demographic characteristics in common, such as similar intercountry ranking by population size, religion, family planning program history. Four sets of Indonesian data were used: (a) proportion of acceptors by age group, not immediately discontinuing use by method, (b) method-specific overlap of use with post-partum amenorrhea, (c) annual rate of discontinuation by age and method, and (d) proportion of women sterile in each age group (for TABRAP only).

Appendix Table 15 presents the statistics for these.

4. Since data for Emko foams and injections for (a) and (c) above are available neither from Bangladesh nor from Indonesia, the following arbitrary assumptions are made based on their similarities with other methods: Emko was considered to have the same use-effectiveness as condoms, while the use-effectiveness of injections was estimated to be between IUDs and sterilization.

## Annex B

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

Life of Project:  
From FY 81 to FY 83  
Total U.S. Funding \$68,633,962  
Date Prepared: Sept. 15, 1980

Project Title &amp; Number: FAMILY PLANNING: 388-0050

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS																
<p>Program or Sector Goal: The broader objective to which this project contributes:</p> <p>Reduction in the rate of population growth as a critical factor in overall economic development.</p>	<p>Measures of Goal Achievement:</p> <table border="1" data-bbox="590 469 978 596"> <thead> <tr> <th></th> <th>FY 81</th> <th>FY 82</th> <th>FY 83</th> </tr> </thead> <tbody> <tr> <td>CBR</td> <td>42.0</td> <td>40.0</td> <td>37.8</td> </tr> <tr> <td>CDR</td> <td>16.0</td> <td>16.0</td> <td>16.0</td> </tr> <tr> <td>CCR</td> <td>26.0</td> <td>24.0</td> <td>21.8</td> </tr> </tbody> </table>		FY 81	FY 82	FY 83	CBR	42.0	40.0	37.8	CDR	16.0	16.0	16.0	CCR	26.0	24.0	21.8	<p>Demographic Surveys</p>	<p>Assumptions for achieving goal targets:</p> <p>Decreasing fertility through increased contraceptive use is the major factor contributing to a reduction in population growth rate (i.e. migration will continue to play a minor role and the death rate will not increase).</p>
	FY 81	FY 82	FY 83																
CBR	42.0	40.0	37.8																
CDR	16.0	16.0	16.0																
CCR	26.0	24.0	21.8																
<p>Project Purpose</p> <p>To raise the overall contraceptive prevalence rate from the current rate of 13% to 25% by the end of the project.</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <p>Annual contraceptive prevalence targets</p> <table border="1" data-bbox="763 745 978 827"> <thead> <tr> <th></th> <th>FY 81</th> <th>FY 82</th> <th>FY 83</th> </tr> </thead> <tbody> <tr> <td></td> <td>17.4%</td> <td>21.2%</td> <td>25.0%</td> </tr> </tbody> </table>		FY 81	FY 82	FY 83		17.4%	21.2%	25.0%	<p>Contraceptive prevalence Surveys.</p> <p>BDC and NGO Service Statistics.</p>	<p>Assumptions for achieving purpose:</p> <ol style="list-style-type: none"> <li>1. Improved training and supervision of family planning personnel will lead them to perform their jobs more efficiently and effectively.</li> <li>2. Community Support for family planning will grow and influence families to use birth control services.</li> <li>3. Important training and infrastructure activities financed by other donors will complement this project in a timely fashion.</li> <li>4. NGO supported family planning activities.</li> <li>5. Increased access to improved services is sufficient to effect increase in prevalence rate (i.e. an unmet demand exists)</li> <li>6. Religious leaders will support family planning thereby increasing its acceptability among the general population</li> <li>7. BDC program managers will utilize results of operations research to improve the F.P. service delivery system.</li> </ol>								
	FY 81	FY 82	FY 83																
	17.4%	21.2%	25.0%																

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Outputs:</p> <p>Training to Improve Service Delivery Program</p> <ol style="list-style-type: none"> <li>1. TFPOs and program managers receive upgrading training in family planning program management.</li> <li>2. FWV trainers receive technical training in MCH.</li> <li>3. Religious leaders receive training in relation of family planning to Islam</li> <li>4. Training materials produced for family planning field workers.</li> <li>5. Increase in frequency and quality of motivational radio broadcasts</li> </ol>	<p>Magnitude of Outputs:</p> <ol style="list-style-type: none"> <li>1. 360 TFPOs receive in-service training 3 BDG officials receive MAs 10 BDG/NGO program managers receive professional training.</li> <li>2. Faculty in 12 FWVTIs trained to train FWVs.</li> <li>3. 30-40 religious scholars receive training in Middle East.</li> <li>4. At least 5 sets of training materials for fieldworkers produced and in use.</li> </ol>	<ol style="list-style-type: none"> <li>1. Through 4. Project records (Controller's records, PIC/Ps., airplane tickets, etc.)</li> </ol>	<p>Assumptions for achieving outputs:</p> <ol style="list-style-type: none"> <li>1. BDG maintains its interest in providing training to supervisors and managers.</li> <li>2. Governments of neighboring countries continue to cooperate in providing training opportunities.</li> <li>3. Islamic scholars are willing to receive family planning training.</li> <li>4. Indigenous production capacity exists for expanded and improved family planning radio broadcasting.</li> </ol>

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><b>Outputs</b></p> <p>Expansion of contraceptive services</p> <ol style="list-style-type: none"> <li>1. Contraceptives and supplies distributed through BDG and private systems.</li> <li>2. Increased numbers of high quality voluntary sterilization.</li> <li>3. NGOs increase family planning activities in rural areas.</li> </ol> <p><b>Management Information</b></p> <ol style="list-style-type: none"> <li>1. Annual prevalence surveys conducted.</li> <li>2. Operations research studies undertaken</li> </ol>	<p><b>Magnitude of Outputs:</b></p> <ol style="list-style-type: none"> <li>1. See Table IV, Output Section</li> <li>2a. At least 1,625,000 voluntary sterilization performed.               <ol style="list-style-type: none"> <li>b. Sterilization surveillance system operating.</li> <li>c. NGOs increase intensive coverage of family planning services to 10% prevalence of use.</li> </ol> </li> </ol> <p>Annual national prevalence survey conducted in each fiscal year.</p>	<p>1. Through 3. Project records (Bills of Lading, PIC/Cs, Service statistics, reimbursement reports, independent audits, project evaluations.)</p> <p>1 and 2 Project Records (award agreement, controller's records.)</p>	<p><b>Assumptions for achieving outputs:</b></p> <ol style="list-style-type: none"> <li>1. The BDG and other donors continue to provide necessary support to keep supplies moving to the field level.</li> <li>2. Demand for voluntary sterilization remains high.</li> <li>3. Surveillance system is adequate to ensure high quality VE program.</li> <li>4. NGOs have capability and interest to implement family planning programs in response to USAID resources.</li> </ol> <p>1. Qualified researchers are available and willing to design and carry out useful operations research programs.</p>
<p><b>Inputs:</b> (See project budget)</p> <p>USAID</p> <ol style="list-style-type: none"> <li>a) Training</li> <li>b) Expansion of Services</li> <li>c) Management Information</li> <li>d) Grants to NGOs</li> </ol> <p>BI-C:</p> <p>NGCs:</p>	<p><b>Implementation Target (Type and Quantity)</b></p> <p>See Detailed budget in Annex C.</p> <p>See Financial Analysis and plan Pt. III, B.</p> <p>See Project Description, PT. I, B.</p>	<p>Project records (Grant Agreements, PICs, Controller's records)</p> <p>Annual Development Plans and Grant Agreements.</p> <p>NGO financial statements and grant agreements.</p>	<p><b>Assumptions for providing inputs:</b></p> <p>USAID, BDG, and NGOs are able to provide planned inputs in a timely fashion.</p>

Annex C

Contraceptive Requirements for Centrally  
Procured Contraceptives

	<u>81</u>	<u>82</u>	<u>83</u>	<u>Total</u>
1. Pills	15,700,000	17,650,000	21,900,000	55,250,000
2. Condoms	106,766,000	115,000,000	130,000,000	335,000,000

Pills are in monthly cycles and condoms are in pieces. These commodity requirements take into consideration AID/W's contract periods as well as present in-country supplies.

Annex D

A Review of Study Objectives and Reported Findings  
of Completed Operations Research Projects  
1978-1980

Research Project	Summary of Study Objectives and Reported Findings
<p><u>Title</u></p> <p>Evaluating Family Planning Program Effectiveness and Efficiency: A Case Study of Operation Research Project.</p> <p><u>Principle Investigator(s) and Organization</u></p> <p>M. A. Sattar Associate Professor Department of Statistics Rajshahi University</p> <p><u>Dates</u></p> <p>May 13, 1978-April 13, 1979</p>	<p>The objectives of this study were:</p> <ul style="list-style-type: none"> <li>- To promote both the diffusion of knowledge about family planning and changes in attitude to family planning.</li> <li>- To undertake comprehensive motivational activities to increase the rate of practice of modern contraception.</li> <li>- To persuade all enlisted eligible couples to adopt more effective, modern techniques of family planning.</li> </ul> <p>The study was undertaken to follow up about 300 eligible couples of two villages in Rajshahi. The study period was 12 months.</p> <p><u>Major Findings:</u></p> <p>(Note: No baseline survey was conducted before implementation of the project).</p> <ul style="list-style-type: none"> <li>- Crude Birth Rate, Crude Death Rate, General Fertility Rate, and Infant Mortality Rate were 53, 12, 258 and 80 per 1000, respectively, in the study area, and the Total Fertility Rate was 8.</li> <li>- Pills and condoms were popular methods of contraception at the end of the project.</li> </ul>

- Of contraceptive users, 43% use pills, 26% condoms, 7% tubectomy, 3% injection, and 4% IUD.
- During the study period, the rate of increase of pill users was greater than that of condom users.
- 21% of female acceptors had only one child.
- The number of female acceptors decreased as education of their husbands increased.

**Title**

**Sterilization Campaign of 1977. A National Long Term Follow-up Survey.**

**Principle Investigator(s) and Organization**

**Atiqur Rahman Khan  
Syed Waliullah  
M. Nawab Ali  
Douglas H. Huber**

**Bangladesh Fertility  
Research Program**

**Dates**

**May 17, 1978-Nov. 16, 1978**

**The main objectives of the study were:**

- To investigate motivational aspects of the sterilized clients - i. e., to ascertain factors that prompted adoption of sterilization as a method.
- To determine the current level of satisfaction with the method.
- To measure the attitude and readiness of the clients to work as motivators for sterilization.
- To identify associated factors that influence the life of the sterilized clients, such as sex life, psychological aspects, social atmosphere and other related variables.
- To ascertain the perception of community members about the sterilization program.
- To compare findings of this study with those of other national studies.

A total of 1000 sterilized cases (500 vasectomy and 500 tubectomy) were selected for interview with an equal number of controls. From each selected thana, 25 vasectomy and 25 tubectomy clients were selected for interview.

Major Findings:

- Mean ages of the tubectomy and vasectomy clients were 31.8 and 32.3 years, respectively.
- Mean parity was 4.4 for vasectomy clients and 4.3 for tubectomy clients.
- Age of the youngest living child was 3.7 years for vasectomy clients and 3.2 years for tubectomy clients.
- Clients were mostly from lower socio-economic status. 71% of the vasectomy clients were landless.
- Both tubectomy and vasectomy clients had less previous experience with contraceptive use than the general population.
- Condom was used by only 22% of men in post-vasectomy period and 44% reported that they did not receive any condoms.
- Majority of clients consulted with their spouses before being sterilized.
- Over 90% of clients indicated that they would have had the sterilization even if the taka and clothing were not provided.

- The one year pregnancy rate was 1.5% for vasectomy and 1% for tubectomy clients.
- 90% of clients remained satisfied with their operation one year later.

**Post-Operation Problems:**

- Pain was most common problem for both vasectomy and tubectomy clients.
- Physical weakness and swelling was a common problem for men.
- Infection was common for women.

**Long Term Problems (at one year):**

- 43% of the both sexes reported that they had decreased capacity for work.

**Title**

A Study of the Less Expensive Family Planning Service Delivery System.

**Principle Investigator(s) and Organization**

Dr. Anwarullah Chowdhury  
Associate Professor  
Department of Sociology  
University of Dacca.

**Dates**

May 16, 1978-May 17, 1979

- \* BDG provides special resources for education, community development, health and family planning to achieve community participation in development and family planning.

**The main objectives of the study were:**

- To identify a less expensive delivery system of family planning services.
- To identify the most effective and most popular methods of family planning.

The study was conducted in one Z. P. G. (Zero Population Growth)\* village in DND (Dacca, Narayanganj, Demra) area and a non-Z. P. G. village in an adjoining area. The total number of respondents in the Z. P. G. and non-Z. P. G. areas were 370 and 200, respectively.

Major Findings

- Contraceptive user rate was 27% in the Z. P. G. area and 22% in the non-Z. P. G. area at the time of the survey.
- Oral Pills were the most popular method of contraception in both areas.
- Acceptors did not receive adequate contraceptives from Z. P. G. program personnel.
- Supplies of contraceptives were irregular in Z. P. G. centers.
- Motivational activities were infrequent in both the Z. P. G. and non-Z. P. G. areas.
- The amount of expenditure incurred in the Z. P. G. program was too high for the results achieved.

Title

Female Depot Holders (FDH)  
at Village Level

The main objective of the study was to increase the acceptor rate by establishment of FDH.

Principle Investigator(s)  
and Organization

P & M Consultants Limited  
Dacca

One experimental and one control union were selected from Dacca District. A survey was conducted in both the unions before the establishment of FDH system. Sixteen FDHs were recruited in the experimental union. The experiment continued for seven months after which a terminal survey was conducted. The two surveys were compared to determine changes in contraceptive use in the experimental and control unions. The total number of respondents in the experimental and control unions were 3282 and 3115, respectively.

Dates

June 1978-September 1979

Major Findings:

- During the experimental period, the rate of increase of new acceptors of oral pill and condom in experimental and control unions were 7.9 and 5.0 percent, respectively.
- Before FDH project total pill and condom contraceptive use was 3.7% eligible couples. Seven months after implementation this rate had increased to 11.6% eligible couples.
- Three alternative delivery systems were proposed for each union. The additional cost of operation of adding FDH was 22%, whereas the additional costs for the increase of 3 or 6 FWAs were 36.5% and 72% respectively.

Title

Location Analysis and Evaluation of Service Delivery System for Union Family Welfare Centers (FWC) in Bangladesh

Principle Investigator(s) and Organization

Proggani Consultants Ltd.

Dates

Oct. 6, 1978-Aug. 31, 1979

The main objectives of this study were:

- To identify the present status of maternal and child health care and family planning services in selected rural areas.
- To evolve optimal location criteria for the establishment of union family welfare centers (i. e. , primary health and family planning clinics).

The study was conducted in 16 villages in 4 unions of 2 districts. 1402 households were selected for interview. There were three different sets of questionnaires: for all married women (in the household) of age less than forty years; for information about social institutions in the selected villages; and for the staff of the union family welfare centers (FWC).

Major Findings:

- 93% of the respondents had knowledge about the activities of union FWCs.
- 12% of the respondents had visited their FWC.
- 38% of current contraceptive users did not receive any follow-up services.
- Most of the FWCs had inadequate equipment and supplies of contraceptives, medicines and vitamins.
- The F. P. workers faced no resistance from Hakims, Kabirajs or village quacks during field work, but religious leaders sometimes tried to create problems.

Title

Performance of Family Welfare Assistants (FWAs)

Principle Investigator(s) and Organization

Abul Hasnat Golam Quddus  
Department of Sociology  
University of Chittagong

Dates

Oct. 1978-July 1979

The objective of the study was to evaluate the performance of family welfare assistants (FWAs).

The study was divided into two parts: the evaluation of actual performance of FWAs as field workers, and the evaluation of reliability of official records maintained by them.

The study was undertaken in 68 villages in 14 thanas in Chittagong District. A total of 845 female respondents and 68 FWAs were interviewed.

Major Findings:

- 10% of the respondents were current users of contraceptives.
- In general, oral pill users were richer, younger, and had fewer children than ligation acceptors.

Annex D  
Page 8

- Over 50% of the respondents were aware of the existence of FWAs.
- 43% of the respondents were visited by FWAs at least once.
- FWAs were the main source of knowledge and service delivery of F. P. methods.
- The majority of the FWAs neglected MCH services due to inadequate knowledge about MCH advice and services, and they did not consider MCH services as a part of their duties.
- FWAs' record keeping was poor due to lack of proper training and understanding about the importance of utilization of data.
- As age and number of children were found to influence the acceptance or rejection of a permanent method, it was felt that both sexes did not accept sterilization for monetary incentive.
- Estimated cost of averting a pregnancy was Taka 1,077.

Title

Family Planning Workers  
and Service Delivery in  
Rural Bangladesh.

Principle Investigator(s)  
and Organization

M. Anisuzzaman  
Prof. of Political Science  
Chittagong University

Dates

Feb. 15, 1979-Oct. 31, 1979

The main objectives of the study were:

- To ascertain the socio-economic background of the fieldworkers.
- To ascertain the level of education and job training of the fieldworkers.
- To assess the orientation of the field staff to family planning as a concept and as a profession.
- To examine how the fieldworkers are perceived by the villagers, particularly by rural married couples of reproductive age.
- To determine the extent of services delivered by the fieldworkers.
- To identify specific problems faced by these workers in their present work environment.
- To indicate the prospects these workers foresee in the near future in matters of service delivery.

The study was conducted in six villages in six unions from four thanas in four divisions. About 15% of the married couples and a total of 35 FPAs, FWAs, and FWVs were interviewed.

Major Findings:

1) F. P. Workers

- 77%, 14%, and 9% were married, unmarried and widowed, respectively.

Annex D  
Page 10

- 48% married FWAs and FPAs were not using F. P. methods.
- 86% reported that religious leaders opposed the family planning program.
- 94% desired refresher training.
- On average, each worker was responsible for F. P. activities for 9 villages.

2) Villagers

- 44% were current users of F. P. methods.
- Most common methods currently used were pills, then condoms, then sterilization.
- 53% acceptors got supplies of contraceptives from F. P. workers, 23% from commercial sources, and 11% from a F. W. C. (Family Welfare Center).
- 75% of the acceptors who received contraceptives from the F. P. workers had a follow-up visit after using contraceptives.
- 64% of the respondents reported that the F. P. workers visited once a month.

## ANNEX E

### Other Donor Involvement in MCH Services

#### Service Delivery

To improve, inter alia, the delivery of MCH services, the World Bank group is funding the construction, furnishing, and equipping of 700 new FWAs and 19 THCs. Likewise, the UNFPA is funding the renovation of 100 existing FWAs. Both the World Bank and the UNFPA are continuing their salary support to the FWAs. The UNFPA will completely upgrade the staffing, equipment, and facilities of one demonstration district (Tangail) in order to expand the scope and quality of MCH/FP services. In this way, it plans to assess the current government service delivery model - i.e., to test it once it has been fully implemented.

#### Training

The World Bank group supports training mainly through its support for the building, equipment, and operating costs of training facilities. It is funding four model clinics which train medical students in MCH/FP, eight Family Welfare Visitor Institutes, and four Medical Assistant schools. It also supports the facilities of 19 FWA training teams and gives some support to NIPORT.

The UNFPA is providing extensive support to NIPORT (which has recently incorporated the Training Unit of PC&FP) to strengthen the training at all levels. Their NIPORT activities focus on management training at the TFPO level and above, FWV training at the 11 training institutes, and the organization of training teams for the refresher training for FWAs and FPAs at 20 District Centers. CARE is also involved with the training of FWVs, and has posted 5 national nurse-educator consultants at FWV training institutes.

UNICEF also has an array of training programs. In conjunction with the WHO, it has supported the training of Medical Assistants (MAs). It initiated the ambitious program to train traditional birth attendants (TBAs) and to provide them with kits. UNICEF also plans to train auxiliary nurse midwives (ANMs) to serve as nurse at THCs. Short term training/orientation sessions for FWWs are being funded by UNICEF so that the FWWs may participate effectively in the communicable disease control programs. UNICEF is supplying teaching aids for THCs to be used in the training of FWWs, VHWs, TBAs, and Palli Chikitsak.

WHO is providing technical assistance to the 11 FWV training institutes, 40 FWA training schools, as well as to the Medical Assistant training program,

### Supplies

The UNFPA is focusing its efforts to ensure the more efficient procurement and distribution of supplies and equipment. It is also supplying medicines, particularly pediatric preparations.

The World Bank and UNICEF are providing the major proportion of the needed basic drugs and D&DS kits. UNICEF is also supplying basic hospital/clinical diagnostic kits and reagents for the Thana Health Centers. UNICEF provides the high potency vitamin A capsules for children (0-6) and for locating mothers, as well as the ingredients and supplies for the oral rehydration salt packets.

### Communicable Disease Control

As a part of the Expanded Programme on Immunization, the WHO is providing expertise, short term consultancies, and training required to support the establishment of a viable cold chain system. UNICEF has supported the establishment of a Central Cold Storage at TEMO, Dacca, and is implementing the establishment of a cold chain in static health centers at district, thana, and union levels. In addition to supplying vaccines, supplies, and equipment for the BCG campaign, vaccines and supplies will be imported by UNICEF for DPT, TT, Polio and Measles.

### Nutrition

The World Food Program has provided food assistance for malnourished pregnant and lactating mothers and for malnourished children under Special Project, "Vulnerable Group Feeding Programme", of the PC&FP Division.

**ANNEX F**

**Family Planning Services**

**Project Location** : Bangladesh  
**Project Title** : Family Planning Services (388-0050)  
**Funding** : FY 81 Grant  
**Life of Project** : 3 years  
**IEE Prepared by** : Vivikka Mouldrem  
**Date** : Aug 15, 1979  
**Environmental Action Recommended** : Negative Determination

**Concurrence:**

Frank Kimball  
Mission Director  
Date Aug, 15, 1979

Assistant Administrator's Decision:

Approved: \_\_\_\_\_  
Not Approved: \_\_\_\_\_  
Date: \_\_\_\_\_

**I. Nature, Scope and Magnitude of Environmental Impacts**

**A. Description of the Project**

The Family Planning Services Project will continue the support of the Bangladesh national family planning program begun in the Population and Family Planning Project (388-0001), through training of program personnel, particularly field worker supervisors, contraceptive commodity support, support to voluntary sterilization, and operations research. This will supplement assistance to other aspects of the program by other donors. In addition, this project will provide funds to several non-government family planning organizations to enable them to expand their service delivery efforts.

**B. Direct Environmental Consequences**

None.

**C. Indirect Environmental Consequences**

If this project is successful in contributing to a reduced fertility rate in Bangladesh, its environmental consequences will be favorable, in that it will slow down the increase of pressure on the environment resulting from overpopulation. These pressures including pollution and misuse (overuse) of agricultural land and water resources, deforestation and urban migration with all of its consequences. There are no negative indirect environmental consequences of this project.

**II. Recommendation for Environmental Action**

A negative determination is requested on the basis that there is judged to be no foreseeable negative environmental consequences resulting from the implementation of the project.

Budget for BDG Project

Foreign Exchange\*  
(Dollars)

	<u>81</u>	<u>82</u>	<u>83</u>	<u>Total</u>
<b>1 . Participant Training</b>				
a) TFPC Training	100,000	800,000	600,000	1,500,000
b) Professional/ Academic		90,000	90,000	180,000
c) Religious/NGC		100,000	125,000	225,000
<b>2 . Commodities</b>				
a) Pills	600,000	4,000,000	4,500,000	9,100,000
b) Condoms	3,900,000	5,962,000	\$6,305,000	16,167,000
c) Medical Kits	100,000	200,000	150,000	450,000
d) EMKC Foam		215,000	200,000	415,000
e) Neo-Sampoo	100,000	860,000	1,300,000	2,260,000
f) Life saving equipment	350,000	200,000	150,000	700,000
<b>Total:</b>	<u>5,150,000</u>	<u>12,427,000</u>	<u>13,420,000</u>	<u>30,997,000</u>

Budget for Government Component

	<u>Local Costs</u> (In Dollars)			
	<u>81</u>	<u>82</u>	<u>83</u>	<u>Total</u>
<b>1. Sterilization</b>				
a) Physicians fees	316,556	-	-	316,556
b) Supporting staff	153,530	356,960	430,680	941,170
c) Field Workers compensation	79,139	184,000	222,000	485,139
d) Food Cost	683,760	1,589,760	1,918,080	4,191,600
e) Transport	542,101	1,260,400	1,520,700	3,323,201
f) Surgical Apparel	743,900	-	-	743,900
g) Wage Loss	680,595	1,582,400	1,909,200	4,172,195
h) Audit	35,000	60,000	60,000	155,000
<b>Total Sterilization</b>	<b>3,234,581</b>	<b>\$5,033,520</b>	<b>\$6,060,660</b>	<b>14,328,761</b>
Operations Research	100,000	400,000	400,000	900,000
<b>3. M.C.H.</b>	<b>65,000</b>	<b>165,000</b>	<b>150,000</b>	<b>380,000</b>
<b>4. Prevalence Surveys</b>	<b>50,000</b>	<b>150,000</b>	<b>170,000</b>	<b>370,000</b>
<b>5. Local Family Planning</b>	<b>50,000</b>	<b>400,000</b>	<b>100,000</b>	<b>850,000</b>
<b>Grand Total:</b>	<b>3,499,581</b>	<b>6,148,520</b>	<b>\$7,180,660</b>	<b>16,828,761</b>

Budget for NGO Component  
(All Costs Shown in Dollars)

	<u>FY 81</u>	<u>FY 82</u>	<u>FY 83</u>	<u>TOTAL</u>
1. BFPA	120,419	178,586	186,700	485,705
2. Pathfinder	200,000	834,088	1,350,000	2,384,088
3. Social Marketing	1,130,000	2,870,000	2,300,000	6,300,000
4. FPSTC	100,000	350,000	350,000	800,000
5. BAVS	500,000	1,100,000	1,500,000	3,100,000
6. Asia Foundation		700,000	800,000	1,500,000
7. CARE	<u>200,000</u>	<u>325,000</u>	<u>225,000</u>	<u>750,000</u>
<u>TOTAL</u>	2,250,419	6,357,674	6,711,700	15,319,793
Demand Creation	<u>100,000</u>	<u>670,126</u>	<u>900,000</u>	<u>1,670,126</u>
GPAND TOTAL	2,350,419	7,027,800	7,611,700	16,989,919



From: Dr. Muhammad A. Mannan,  
Deputy Secretary.

External Resources Division  
Ministry of Finance  
Sher-e-Bangla Nagar  
Dacca-7  
ANNEX H

D.O. No. .... 10. EPD/USA(P)-10/75 (Vol-III)

Date: December 21, 1980

#801

Dear Mr. Kimball,

Please refer to our letter of even number dated December 1980 wherein we made a request to extend the US Assistance to the Population Control and Family Planning Activities in Bangladesh on grant term basis upto September 30, 1983. The cost estimate for this activity during the life of the project has been estimated to be \$ 68,534,000.

The Government, therefore, requests USAID to provide an amount of \$ 68,534,000 for the Population Control and Family planning activities in Bangladesh during the life of the project.

With regards,

Yours sincerely,

( Muhammad A. Mannan )

Mr. Frank S. Kimball,  
Director,  
USAID Mission in Bangladesh,  
11th Floor, Huba (4th floor)  
Motijheel C/A, Dhaka.



*R.H.W.*

APPLY	1/12
DUR:	
INFO	
DIB	✓
D/OIR	✓
TRO	✓
RDE	
RNO	
P/AGR	
PHAW	
TRO	
CONF	✓
CLB	
ENO	
PER	
FVL	
RAA	✓
ASD	
APPLY/IAN	
Inv'l	
Date	
File	

BEST AVAILABLE DOCUMENT

## COUNTRY CHECKLIST

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FAA Sec. 116. Can it be demonstrated that contemplated assistance will directly benefit the needy? If not, has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? **It can be demonstrated.**
2. FAA Sec. 481. Has it been determined that the government of recipient country has failed to take adequate steps to prevent narcotics drugs and other controlled substances (as defined by the Comprehensive Drug Abuse Prevention and Control Act of 1970) produced or processed, in whole or in part, in such country, or transported through such country, from being sold illegally within the jurisdiction of such country to U.S. Government personnel or their dependents, or from entering the United States unlawfully? **No.**
3. FAA Sec. 620(b). If assistance is to a government, has the Secretary of State determined that it is not controlled by the international Communist movement? **Yes**
4. FAA Sec. 620(c). If assistance is to government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) debt is not denied or contested by such government? **No**
5. FAA Sec. 620(e)(1). If assistance is to a government, has it (including government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities? **No**

A.

6. FAA Sec. 620(a), 620(f), 620E; FY 79 App. Act, Sec. 108, 114 and 606. Is recipient country a Communist country? Will assistance be provided to the Socialist Republic of Vietnam, Cambodia, Laos, Cuba, or Angola? Will assistance be provided to Afghanistan or Mozambique without a waiver?

- a. No
- b. No
- c. No

7. FAA Sec. 620(i). Is recipient country in any way involved in (a) subversion of, or military aggression against, the United States or any country receiving U.S. assistance, or (b) the planning of such subversion or aggression?

No

8. FAA Sec. 620 (j). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction, by mob action, of U.S. property?

No

9. FAA Sec. 620(1). If the country has failed to institute the investment guaranty program for the specific risks of expropriation, inconvertibility or confiscation, has the AID Administrator within the past year considered denying assistance to such government for this reason?

OPIC bilateral agreement was signed Jan. 15, 1975

10. FAA Sec. 620(o); Fishermen's Protective Act of 1967, as amended, Sec. 5. If country has seized, or imposed any penalty or sanction against, any U.S. fishing activities in international waters:

N/A

a. has any deduction required by the Fishermen's Protective Act been made?

b. has complete denial of assistance been considered by AID Administrator?

11. FAA Sec. 620; FY 79 App. Act, Sec. 603.  
(a) Is the government of the recipient country in default for more than 6 months on interest or principal of any AID loan to the country?  
(b) Is country in default exceeding one year on interest or principal on U.S. loan under program for which App. Act appropriates funds?

- a) No
- b) No

12. FAA Sec. 620(s). If contemplated assistance is development loan or from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget which is for military expenditures, the amount of foreign exchange spent on military equipment and the amount spent for the purchase of sophisticated weapons systems? (An affirmative answer may refer to the record of the annual "Taking Into Consideration" memo: "Yes, as reported in annual report on implementation of Sec. 620(s)." This report is prepared at time of approval by the Administrator of the Operational Year Budget and can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

N/A

13. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have they been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

No

14. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the AID Administrator in determining the current AID Operational Year Budget?

Not in arrears

15. FAA Sec. 620A, FY 79 App. Act, Sec. 607. Has the country granted sanctuary from prosecution to any individual or group which has committed an act of international terrorism?

No.

16. FAA Sec. 666. Does the country object, on basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. there to carry out economic development program under FAA?

No

17. FAA Sec. 669, 670. Has the country, after August 3, 1977, delivered or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards? Has it detonated a nuclear device after August 3, 1977, although not a "nuclear-weapon State" under the nonproliferation treaty?

No

**B. FUNDING CRITERIA FOR COUNTRY ELIGIBILITY**

**1. Development Assistance Country Criteria**

a. FAA Sec. 102(b)(4). Have criteria been established and taken into account to assess commitment progress of country in effectively involving the poor in development, on such indexes as: (1) increase in agricultural productivity through small-farm labor intensive agriculture, (2) reduced infant mortality, (3) control of population growth, (4) equality of income distribution, (5) reduction of unemployment, and (6) increased literacy? **Yes**

b. FAA Sec. 104(d)(1); ILC Act of 1979. **Yes**  
If appropriate, is this development (including Sahel) activity designed to build motivation for smaller families through modification of economic and social conditions supportive of the desire for large families in programs such as education in and out of school, nutrition, disease control, maternal and child health services, agricultural production, rural development, assistance to urban poor, and through community-based development programs which give recognition to people motivated to limit the size of their families?

PROJECT CHECKLIST

A. GENERAL CRITERIA FOR PROJECT

1. FY 79 App. Act Unnumbered; FAA Sec. 653 (b); Sec. 634A. (a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the project; (b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that figure).

(a) Project was included in FY 81 Congressional Presentation Annex II, Asia Programs, p.28. Congressional Notification will be prepared to explain increased cost.  
(b) Yes

2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,000, will there be (a) engineering, financial, and other plants necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

(a) Yes

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

None required

4. FAA Sec. 611(b); FY 79 App. Act, Sec. 103. If for water or water-related land resource construction, has project met the standards and criteria as per the Principles and Standards for Planning Water and Related Land Resources dated October 25, 1973?

N/A

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

N/A

6. FAA Sec. 209. Is project susceptible of execution as part of regional or multilateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. No
7. FAA Sec. 601(a). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions. (a) No (b) Yes (c) No (d) N/A (e) No (f) No
8. FAA Sec. 601(b). Information and conclusion on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise). N/A
9. FAA Sec. 612(b); Sec. 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, utilized to meet the cost of contractual and other services. (a) N/A (b) N/A
10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? No
11. FAA Sec. 601(c). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes
12. FY 79 App. Act Sec. 608. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar, or competing commodity? N/A

**B. FUNDING CRITERIA FOR PROJECT**

**1. Development Assistance Project Criteria**

**a. FAA Sec. 102(b); 111; 113; 281a.**

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

- (a) Beneficiaries of this project will be primarily the rural poor and women
- (b) N/A
- (c) Self-help will be promoted under this project whenever feasible
- (d) As this project is intended to increase family planning and MCH services, participation of women will play a critical role

(e) N/A

**b. FAA Sec. 103, 103A, 104, 105, 106, 107.**

Is assistance being made available: (include only applicable paragraph which corresponds to source of funds used. If more than one fund source is used for project, include relevant paragraph for each fund source.)

[104] for population planning under sec. 104(b) or health under sec. 104(c); if so, extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems and other modes of community research.

This project builds upon the BDG's recently integrated health and family planning delivery system and includes activities to improve paramedical training, particularly for maternal and child health

c. [107] Is appropriate effort placed on use of appropriate technology? **Yes**

d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or has the latter cost-sharing requirement been waived for a "relatively least-developed" country)? **Yes**

e. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to the Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"? **No**

f. FIA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental and political processes essential to self-government. **Yes. See Part II, B., 1.**

g. FIA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase or productive capacities and self-sustaining economic growth? **Yes**

~~TOP SECRET~~

PHAW

13 OCT 79

AMEMBASSY DACCA

ACTION: AID

INFO : AMB DCM CHR

UNCLASSIFIED

RECD: 09 OCT 79

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Classification

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FM SECSTATE WASHDC  
TO AMEMBASSY DACCA PRIORITY 2522  
BT  
UNCLAS STATE 26227Z

ANNEX J

ADM AID

E.O. 12958: N/A

TAGS:

SUBJECT: POPULATION/FAMILY PLANNING II (388-0250)  
PID REVIEW

1. SUBJECT PROJECT APAC MEETING SCHEDULED OCT. 19.
2. PROJECT COMMITTEE (PC) MEETING HELD SEPTEMBER 24  
EVOKED GENERAL INTEREST AND ENDORSEMENT OF PROPOSED  
PROJECT.

DISCUSSION INCLUDED FOLLOWING ASPECTS:

3. ISSUES FOR APAC:

(A) THE PVO CO-FINANCING II PID STATES THAT THE PVO  
PROJECT WILL "...SUPPORT AS A FIRST PRIORITY THE NON-  
GOVERNMENTAL ORGANIZATION ELEMENT OF THE MISSION POPULATION  
STRATEGY AS FOUND IN THE 1981-CDSS." THE POPULATION/FAMILY  
PLANNING PID ALSO STRESSES THE INVOLVEMENT OF PVOS AND  
STATES ON PP 13-14 THAT POPULATION FUNDING WILL BE USED TO  
FUND THE ASIA FOUNDATION (TAF) TO USE IT AS A VEHICLE TO  
FUND INDIGENOUS PVOS TO PROVIDE FAMILY PLANNING SERVICES  
IN THE CONTEXT OF THEIR OTHER DEVELOPMENT ACTIVITIES.  
PC WOULD LIKE TO KNOW WHY IT IS NECESSARY TO HAVE

ACTIVITIES IN POPULATION IN TWO PROJECTS WITH TWO  
PROJECT MANAGERS. IS THIS A CASE OF OVERLAP? IT  
APPEARS FROM PID THAT TAF WILL BE USED UNDER BOTH  
PROJECTS FOR PVO PROJECT FUNDING. IF SO, HOW DOES  
TAF ROLE DIFFER IN THE TWO DIFFERENT PROJECTS.

(B) THE POP/FP PID PROPOSES MISSION FUNDING AND  
MANAGEMENT OF SUCH ACTIVITIES AS THE BANGLADESH  
ASSOCIATION FOR VOLUNTARY STERILIZATION, OPERATIONS  
RESEARCH, FAMILY PLANNING SOCIAL MARKETING: ALL  
PROJECT ACTIVITIES THAT HAVE BEEN CENTRALLY FUNDED  
AND MANAGED BY AID/W. IN ADDITION TO THESE PROJECT

ACTION TO	
REPLY DUB	10/15
INFO	
DIR	
D/DIR	
PRO	
RDE	
AGR	
PHAW	
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CONT	
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(2)

ACTIVITIES THE PID PROPOSES TO EXPAND SUPPORT TO THE FAMILY PLANNING SERVICES AND TRAINING CENTER AND THE BANGLADESH FAMILY PLANNING ASSOCIATION. PC BELIEVES IT IS A POSITIVE EVOLUTION TO BILATERALLY FINANCE PROJECT ACTIVITIES THAT HAVE HERETOFORE BEEN FINANCED UNDER CENTRAL GRANTS AND TO EXPAND THE POPULATION PROGRAM TO INCLUDE ADDITIONAL PVOS. WE BELIEVE THE MISSION SHOULD REVIEW STAFFING OF THE POPULATION DIVISION TO SEE IF IT IS ADEQUATE TO TAKE ON ALL THESE ADDITIONAL PROJECT ACTIVITIES. IF SO, PLEASE CLARIFY HOW THE MISSION INTENDS TO MANAGE ALL THESE DIVERSE ACTIVITIES AT CURRENT STAFF LEVELS.

(C) IF USAID LIMITS ITS ASSISTANCE TO THE BDC PRIMARILY TO SUPPORT OF COMMODITIES, TRAINING AND STERILIZATION, DOES THIS MEAN WE ANTICIPATE OTHER PROGRAM WEAKNESSES PREVIOUSLY IDENTIFIED IN CBSS AND PID WILL BE ADEQUATELY ADDRESSED BY OTHER DONORS? GIVEN AID'S CHANGING PROJECT FOCUS, HOW WILL COORDINATION WITH OTHER DONORS BE CARRIED OUT? HOW ARE ADMINISTRATIVE AND MANAGEMENT PROBLEMS OF PROGRAM BEING ADDRESSED?

4. PLEASE RESPOND TO ABOVE ISSUES PRIOR TO APAC MEETING.

5. THE FOLLOWING TOPICS, WHILE NOT ISSUES FOR APAC, SHOULD BE ADDRESSED AS DESIGN ITEMS IN THE PROJECT PAPER.

(A) FUNDING FOR CONTRACEPTIVES: DS/POP SAYS THE MISSION-PROJECTED REQUIREMENTS FOR THE BILATERAL PROGRAM AND THE SOCIAL MARKETING PROGRAM EXCEED THE AMOUNT BUDGETED FOR CONTRACEPTIVES IN THE PID. PLEASE OUTLINE IN PP THE REQUIREMENTS FOR BOTH PROGRAMS.

(B) DESCRIPTION OF HOW PROJECT COMPONENTS WHEN PUT TOGETHER WILL ACHIEVE THE TWENTY-FIVE PERCENT CONTRACEPTIVE PREVALENCE RATE STATED AS THE PURPOSE BY THE END OF THE PROJECT: INCLUDE IN PP STRATEGY THE VARIOUS ELEMENTS REQUIRED TO MEET THIS PREVALENCE RATE, ASSIGNING, WHERE POSSIBLE, SPECIFIC TARGETS THAT TOGETHER WILL ACHIEVE THIS PREVALENCE RATE.

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CONT'D PAGE 3.....

OPTIONAL FORM 1511 (Formerly FS-412) January 15 Dept. of S.

# TELEGRAM

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(3)

(C) PRIVATE VOLUNTARY STERILIZATION AND BDG STERILIZATION SUPPORT: INCLUDE IN PP A BREAKDOWN OF PROPOSED COSTS FOR ITEMS IN BOTH THE PRIVATE AND BDG PROGRAM THAT AID WILL BE FUNDING.

(D) ROLE OF WOMEN: PC NOTES THAT ALL FAMILY WELFARE ASSISTANTS ARE FEMALE AND ALL FAMILY PLANNING ASSISTANTS (SUPERVISORS) ARE MALE. WHAT ACTIONS ARE BEING OR CAN BE TAKEN TO PROMOTE SIGNIFICANT NUMBERS OF FEMALE FAMILY WELFARE ASSISTANTS TO FAMILY PLANNING ASSISTANTS SUPERVISORY POSITIONS? VANCE

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**Bangladesh Government Voluntary  
Sterilization Informed Consent Form**

- a. I willingly give consent to have sterilization operation although I know there are temporary methods (oral pill, condom, I.U.D. etc.)
- b. I know it is a type of surgical operation and it has some risk. The risk and the procedure of surgical operation were explained to me by the doctor.
- c. The doctor also explained to me that after this operation I will not have any more child but sexual capability remains the same.
- d. I willingly take this decision not from any fear or any other conditions.
- e. My husband/wife, gardians give full consent for this operation.
- f. I know it is a permanent method, once performed can not be easily reversed.

I willingly put on my signature/thumb impression on the consent form for performing my operation.

Signature/thumb impression of client

Village: \_\_\_\_\_

Union: \_\_\_\_\_

Thana: \_\_\_\_\_

Dist. \_\_\_\_\_

**Witness :**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Signature and designation of operating doctor**

**In addition, the following clause is now being added to the consent form.**

**I understand that I can change my mind any time and not have a sterilization operation and if I do change my mind I will not be deprived of medical treatment or other facilities.**

### Cost-Effectiveness Calculations

What follows is an attempt to divide total family planning program costs from all sources into four major components of the program: (1) Sterilization; (2) BDG services other than sterilization; (3) Social Marketing; and (4) NGO services. Once annual costs by component have been derived, they can be compared with annual contraceptive usage by component to derive annual cost per continuous user by component. This is meant to give some indication of relative cost-effectiveness of each component.

AID, BDG and other donor inputs all must be reviewed to apportion their costs among the four components listed above. AID inputs are reordere first in Part A which follows. To do this, it was necessary to estimate how AID contraceptive commodity costs are distributed between the BDG program, Social Marketing and NGOs. Part B goes through this process.

BDG-financed costs are divided into direct costs, i.e. costs directly attributable to either sterilization or other services, and indirect costs, i.e. management, training, supervision and other costs which are not method specific. Part C calculates these direct, and indirect costs.

Part D estimates the annual apportionment of other donor costs between sterilization and indirect costs.

Adding the annual indirect costs (i.e. non-method specific) of the BDG program financed by AID, the BDG and other donors, total indirect costs of the BDG program are derived in Part E. Then this total annual indirect cost is attributed to sterilization or other methods in the same proportion as the number of clients served annually between the two components.

Enough information is now available to prepare Part F, total annual costs by component. By comparing this with Part G, annual contraceptive usage, the estimates of annual cost per continuous user which are found in the economic analysis section of the Project Paper were calculated.

Part A. AID Project Costs

	<u>FY81</u>	<u>FY82</u>	<u>FY83</u>
1. Social Marketing:			
Social Marketing Grant	1,130,000	2,870,000	2,300,000
2. Demand Creation	100,000	670,126	900,000
3. Other NGOs:			
BFFA	120,419	178,586	186,700
Pathfinder	200,000	834,088	1,350,000
FFSTC	100,000	350,000	350,000
TAF		700,000	800,000
Training		100,000	125,000
Sterilization:BDG costs (inc. equipment)	3,584,581	5,233,520	6,210,660
BAVS**	500,000	1,100,000	1,500,000
5. BDG Other Services:			
Training	100,000	890,000	690,000
Operations Research	100,000	400,000	400,000
Maternal & Child Health	65,000	165,000	150,000
Prevalence Surveys	50,000	150,000	170,000
Local Fam. plan	50,000	400,000	400,000
CARE grant ***	200,000	325,000	225,000
6. Commodities	4,700,000	11,237,000	12,455,000
7. Evaluation			50,000

\*\* Although BAVS is an NGO, BAVS and BDG sterilization programs are considered together because they work hand in hand and because use attributable to sterilization was figured for the country as a whole and not separated into BDG vs NGO.

\*\*\* CARE grant is included in BDG services because it provides services directly to the BDG and does not carry out independent family planning activities

Part B. Commodity Distribution between BDG, Social Marketing Project and NGOs

From Table IV, contraceptive prevalence by method and organization (BDG, NGO, Smp) can be used to estimate distribution of commodity costs among organizations.

<u>Organization &amp; Method</u>	<u>FY81</u>	<u>FY82</u>	<u>FY83</u>
	<u>Continuous users</u>	<u>Continuous users</u>	<u>Continuous users</u>
BDG: Pills	823,076	926,923	1,000,000
Condoms	500,000	511,000	711,000
Other	75,000	85,000	90,000
<b>Total</b>	<b>1,398,076</b>	<b>1,522,923</b>	<b>1,801,000</b>
SMF: Pills	80,000	115,000	189,615
Condoms	400,000	489,000	489,000
Other	85,000	115,000	115,000
<b>Total</b>	<b>565,000</b>	<b>719,000</b>	<b>793,615</b>
NGOs: Pills	302,850	502,425	555,000
Condoms	232,700	277,200	395,000
Other	34,450	45,375	50,000
<b>Total</b>	<b>650,000</b>	<b>825,000</b>	<b>1,000,000</b>
<b>Total contraceptive use attributable to:</b>			
Pills	1,285,926	1,544,348	1,744,615
Condoms	1,132,700	1,277,200	1,595,000
Other	194,450	245,375	255,000

Assuming percentage distribution between pill, condom, other, and sterilization use is approximately the same as the BDG program, NGO mix was determined by taking the appropriate percentage of total NGO prevalence provided Table IV, as follows

	<u>FY81</u>	<u>FY82</u>	<u>FY83</u>
Pills	58.9%	60.9%	55.5%
Condoms	35.8%	33.6%	39.5%
Other	5.3%	5.5%	5.0%

<u>Method</u>	<u>FY81</u>		<u>FY82</u>		<u>FY85</u>	
	<u>%use attri- butable to:</u>	<u>Cost</u>	<u>%use attri- butable to:</u>	<u>Cost</u>	<u>%use attri- butable to:</u>	<u>Cost</u>
<b>Pills:</b>	100.0%	600,000	100.0%	\$4,000,000	100.0%	\$4,500,000
BDG	64.0%	384,000	60.0%	2,400,000	57.3%	2,578,500
SMP	6.2%	37,200	7.5%	300,000	10.9%	490,500
NGO	29.8%	178,800	32.5%	1,300,000	31.8%	1,431,000
<b>Condoms:</b>	100.0%	3,900,000	100.0%	5,962,000	100.0%	\$6,305,000
BDG	44.1%	1,719,900	40.0%	2,384,800	44.6%	2,812,030
SMP	35.3%	1,376,700	38.3%	2,283,446	30.7%	1,935,635
NGO	20.6%	803,400	21.7%	1,293,754	24.7%	1,557,335
<b>Other:</b>	100.0%	100,000	100.0%	1,075,000	100.0%	1,500,000
BDG	38.7%	38,700	34.7%	373,025	35.3%	529,500
SMP	43.0%	43,800	46.9%	504,175	45.1%	676,500
NGO	17.5%	17,500	18.4%	197,800	19.6%	294,000

## Commodity Cost of All Methods by Organizations

	<u>FY81</u>	<u>FY82</u>	<u>FY83</u>
BDG	\$2,142,600	\$5,157,825	\$5,920,030
SMP	1,457,700	3,087,621	3,102,635
NGO	999,700	2,791,554	3,282,335

**Part C: BDG Costs: Direct Costs**

To divide the costs of the BDG budget between sterilization and other methods, costs will be divided into two components; direct costs (salaries) and indirect costs (administration, training, supervision, overall program management and infrastructure). The former can be divided fairly easily between sterilization and other methods by estimation of the time involved by family planning workers in providing sterilization services vs other services. The latter (administrative costs) is not method specific. Division of "administrative costs" between sterilization and other methods will be described later.

**Direct Costs of Sterilization**

Tubal ligation requires direct services of a doctor, an FWV or attendant, and an FFA. Vasectomy requires services of a doctor, an FWV or attendant, and an FFA.

Cost per ligation and vasectomy, therefore, are calculated as follows:

MD Time/Sterilization = 30 min.  
 MD Total Time/Mo. = 170 hrs.  
 MD Salary\*/Mo. = Tk. 1200  
 MD Cost/Sterilization = Tk. 3.6

FWV or attendant Time/Sterilization = 1 hr.  
 FWV Total Time/Mo. = 170 hrs.  
 FWV Salary\*/Mo. = Tk. 510  
 FWV Cost/Sterilization = Tk. 3

\* Includes benefits

FWA\*\* Time/Sterilization = 12 hrs.  
 FWA Salary/Mo. = Tk. 360  
 FWA Cost/Sterilization = Tk. 25

FFA\*\* Time/Sterilization = 8 hrs.  
 FFA Salary/Mo. = Tk. 420  
 FFA Cost/Sterilization = Tk. 20

Cost / ligation = 31.6  
 Cost / vasectomy = 26.6

The estimated number of sterilizations performed annually are as follows:

	<u>Ligation</u>	<u>Vasectomy</u>	<u>Total</u>
FY81	345,950	61,050	407,000
FY82	469,200	82,800	552,000
FY83	566,100	99,900	666,000

Therefore total BDG direct costs for sterilization are

	<u>Ligation</u>	<u>Vasectomy</u>	<u>Total</u>
FY81	Tk.11,070,400	Tk.1,648,350	Tk.12,718,750 or \$ 847,920
FY82	Tk.15,014,400	Tk.2,235,600	Tk.17,250,000 or \$1,150,000
FY83	Tk.18,115,200	Tk.2,697,300	Tk.20,812,500 or \$1,387,500

Direct BDG Costs for Other Methods

Direct BDG costs for all other methods consist of the salaries of all family planning field personnel who deliver services: FWAs, FFAs and FWVs, less the portion of their salaries attributable to sterilization motivation and services. The latter is less than the total direct costs attributable to sterilization because it excludes the cost of the doctors' salaries.

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\*\* Assumes 3 clients usually brought at one time and includes time required for motivation.

	<u>FY81</u>	<u>FY82</u>	<u>FY83</u>
<b><u>FWA Salaries:</u></b>			
Total <sup>1</sup>	Tk. 58,320,000	58,320,000	58,320,000
Less part attributable <sup>2</sup> to sterilization	<u>- 8,648,750</u>	<u>- 11,750,000</u>	<u>- 14,152,500</u>
Salary attributable to other methods	49,671,250	46,590,000	44,167,000
<b><u>FPA Salaries:</u></b>			
Total <sup>3</sup>	Tk. 32,760,000	32,760,000	32,760,000
Less Sterilization <sup>4</sup>	<u>- 1,221,000</u>	<u>- 1,656,000</u>	<u>- 1,998,000</u>
Other Methods	31,539,000	31,114,000	30,762,000
<b><u>FWV Salaries:</u></b>			
Total <sup>5</sup>	Tk. 22,644,000	22,644,000	22,644,000
Less Sterilization <sup>6</sup>	<u>- 1,221,000</u>	<u>- 1,656,000</u>	<u>- 1,998,000</u>
Other Methods	21,423,000	20,988,000	20,646,000
<b>Total FPA/FWI/</b>			
FWV Salaries attributable to other methods	Tk. 102,633,250 \$ 6,842,200	Tk. 98,692,000 \$ 6,579,500	Tk. 95,575,500 \$ 6,371,700

<sup>1</sup> Tk.360/mo x 12 mo x 13,500 FWAs

<sup>2</sup> Tk.25/ligation x no. ligations annually

<sup>3</sup> Tk.420/mo. x 12 mo. x 6,500 FPA's

<sup>4</sup> Tk.20/vasectomy x no. vasectomies annually

<sup>5</sup> Tk.510/mo. x 12 mo. x 3,700 FWVs

<sup>6</sup> Tk.3/sterilization x no. sterilizations annually

## BDG-Funded Program Costs

	<u>FY81</u>	<u>FY82</u>	<u>FY83</u>
Total BDG FF Budget	\$ 23,000,000	\$ 25,300,000	\$ 25,400,000
Less Sterilization Direct Costs	847,900	1,579,500	1,387,500
Less Other Services Direct Costs	6,842,200	6,579,500	6,371,700
Equals Total Direct Costs	\$ 15,309,900	\$ 17,570,500	\$ 17,640,800

Part D. Other Donor Contributions to the BDG Program

The two other significant donors to the BDG family planning program are the IBRD consortium and UNFPA. Because limited budgetary data are available, other funds cannot be accurately divided between sterilization and other costs. For the purpose of this exercise, the following assumptions are made.

1. Over the three year period, the IBRD consortium will spend \$ 75,000,000 and UNFPA will spend \$ 27,400,000. Since this is entirely government-to-government assistance, all of it will be channeled to the BDG program.
2. IBRD will contribute \$ 8,500,000 for medicines used in sterilization. This will be divided among the three project years in the same ratio as numbers of sterilizations performed.
3. Approximately 60% of the total IBRD project will finance construction of Thana Health Centers and Union Family Welfare Centers. Since these are used half for family planning and MCH work and half for health work, only half their total cost will be included as family planning costs; i.e.  $\$ 75,000,000 \times .60 \times .50 = \$ 22,500,000$  will be excluded from the total.
4. All UNFPA costs and IBRD costs other than health costs of construction and sterilization medicines will be included in indirect costs of the BDG program (i.e., \$ 71,400,000).
5. These indirect costs will be apportioned annually over the three years.

Other Donor Costs of BDG Program

	<u>FY81</u>	<u>FY82</u>	<u>FY83</u>
Sterilization (IBRD)	2,129,000	2,887,000	3,484,000
Indirect Costs	23,800,000	23,800,000	23,800,000

**Part E. Total Indirect Costs of BDG Program**

For the purposes of this analysis, total administrative costs will be apportioned among methods according to the number of clients served annually. For sterilization, number of clients is number of sterilizations performed. For other methods, number of clients is number of continuous users. Because other methods require continuous motivation, follow-up and resupply of current users where sterilization does not, administrative costs for other methods may be somewhat higher than for sterilization, but in absence of a good basis on which to weight each method, no weights will be applied.

Sterilization Clients	407,000 (23%)	552,000 (27%)	660,000 (27%)
Other Method Users	1,398,076(77%)	1,522,923(73%)	1,801,000(73%)

<u>Source of funds</u>	<u>FY81</u>	<u>FY82</u>	<u>FY83</u>
BDG	\$ 15,309,900	\$ 17,570,500	\$ 17,640,800
Other Donors	23,800,000	23,800,000	23,800,000
AID	<u>1,580,000</u>	<u>1,635,000</u>	<u>1,915,000</u>
TOTAL	\$ 40,689,900	\$ 43,005,500	\$ 43,355,800
Indirect Costs of Sterilization	\$ 9,358,700	\$ 11,611,350	\$ 11,706,100
Indirect Costs of other methods	31,331,200	31,394,150	31,649,700

**Part F. Cost by Component****1. TOTAL COSTS OF STERILIZATION**

	<u>FY81</u>	<u>FY82</u>	<u>FY83</u>
BDG Direct Costs	\$ 847,920	\$ 1,150,000	\$ 1,387,500
Indirect Costs *	9,358,700	11,611,350	11,706,100
AID Direct Costs	3,499,581	6,148,520	7,180,660
IBRD-Medicines	<u>2,129,000</u>	<u>2,887,000</u>	<u>3,484,000</u>
Total	\$ <u>15,835,201</u>	<u>21,796,870</u>	<u>23,758,260</u>

## 2. TOTAL COSTS OF BDG OTHER METHODS

	<u>FY81</u>	<u>FY82</u>	<u>FY83</u>
AID Commodities	\$ 5,050,000	\$11,437,000	\$ 12,605,000
BDG Direct Costs	6,842,200	6,579,500	6,371,700
Indirect Costs	<u>31,331,200</u>	<u>31,394,150</u>	<u>31,649,700</u>
Total	\$ 43,223,400	\$ 49,410,650	\$50,626,400
3. Social Marketing	\$ 1,130,000	\$ 2,870,000	\$ 2,300,000
4. Other NGOs			
AID Costs	\$ 1,120,419	\$ 4,411,700	\$ 9,029,793
NGO's own resources*	<u>2,560,000</u>	<u>2,560,000</u>	<u>2,560,000</u>
Total	\$ 3,680,419	\$ 6,971,700	\$11,589,793

\* From all sources, except in cases where the grant is supplementing non family planning development programs to add family planning motivational service elements. For many of these organizations FF is an add-on to other services unrelated to FF.

## Annual Contraceptive Usage

	<u>FY81</u>	<u>FY82</u>	<u>FY83</u>
BDG Sterilization **	3,663,000	4,968,000	5,994,000
BDG Other (Table IV)	1,398,076	1,522,923	1,801,000
Social Marketing (Table IV)	565,000	719,000	793,615
NGOs (Table IV)	650,000	825,000	1,000,000

\*\* Based on actual number performed during year x9, since conservatively, a person undergoing sterilization receives 9 years of protection (ie, will reach age 45 in nine years).

PROCUREMENT PLAN

Under this project, a total of 29.5 million has been earmarked for procurement of contraceptive supplies, medical kits, and life saving equipment for the sterilization program. These commodities will be ordered on PIO/Cs and A.I.D./W will be requested to designate either GSA or other appropriate Government procurement agencies to procure and ship them. Ninety-five percent of these commodities are contraceptives. The determination of quantity, type of contraceptive, and shipping schedules, will be made on an annual basis in accordance with the Agency's central procurement policies and procedures for contraceptives. Specifications for medical kits and life saving equipment for the sterilization program will be developed with the assistance of consultants from CDC, once the exact type and quantity of equipment has been determined.

After the commodities arrive in Chittagong in Bangladesh, they will be stored in one of three central warehouses located in Chittagong, Khulna, or Dacca. From these warehouses commodities are trucked on a monthly basis to the Deputy Directors for population in all 20 districts. From there, commodities are delivered to Thana Family Planning Officers where fieldworkers receive their monthly supplies. The supply management and logistics system used in the Bangladesh family planning program was designed with the assistance of CDC. CDC will continue to provide management assistance to the program through the life of this project. In addition, UNFPA has funded a long term logistics advisor who will be in Bangladesh for at least the first two years of the project.

The Social Marketing Project will maintain its own reporting and supply system while all other non-governmental organizations funded in the project will receive A.I.D. supplied commodities from the BDG.

December 1, 1980

MEMORANDUM

TO : DS/DAA/HRD, Stephen Joseph  
FROM : DS/POP, J. Joseph Spidel  
SUBJECT: Bangladesh Population Project Paper - Family Planning Services,  
388-0050; Compliance with PD-70.

I have discussed the Bangladesh Project Paper with Mike Jordan and based on information contained in the Project Paper and supplemented by Mike Jordan's recent field visits, we have come to the following conclusions.

**Informed Consent** - The Government of Bangladesh has agreed to prepare an informed consent form which complies with PD-70 guidelines. AID has agreed to support the cost of printing this form. The initial form which has been translated is believed to be in compliance with the exception that the patient's option to withdraw consent anytime prior to the operation is not adequately spelled out in the current form. This will be amended in subsequent versions of the form, and implementation of informed consent procedures as required by PD-70 will make a condition precedent prior to implementing the new family planning services project. Implementation of informed consent procedures, therefore, does not appear to present a difficulty with respect to approval of the project paper.

With regard to ready access to other methods of a common location, this has not been well documented in the PP. Perhaps this too should be a condition precedent prior to implementing the new program.

**Incentive Payments** - Payment of the doctor's fee has been increased from 15 to 20 taka, or from \$1.00 to \$1.33 per tubectomy or vasectomy. Physicians are paid on a per-case basis for the surgery performed, however they do not motivate clients. The possibility of payment on a per-session basis has been discussed with the Government of Bangladesh, but their terms of reference for a session are weighted heavily to procedures performed. The increase in payment is consistent with increased cost of living and does not represent any significant increase in recompense per procedure in real terms. Assuming the revised PD-70 guidelines are approved and doctors continue to have no role in motivation of patients, as in Nepal, continuation of case payment is justified. However, even so, it would seem appropriate to urge the mission to continue to seek alternative means of reimbursing physicians. It should also be noted that a per-case payment of government physicians is justified to some extent in that all physicians are allowed their private practice from 2:00 p.m. on and therefore would be eligible for per-case payment for rendering other services in the private sector.

Fees going to supporting clinic staff of 10 taka (\$.65) per tubectomy and 8 taka (\$.53) per vasectomy go to paramedics or nurses who assist in surgery and routine post-operative care. This staff is not involved in motivation of clients. The differential payment for tubectomy vs vasectomy is justified by the Mission on the basis that more intensive care is required for tubectomy clients compared to vasectomy clients.

Fieldworker compensation of 5 taka (\$.33) is offered for each tubectomy or vasectomy. This amount is unchanged from previous years and requires that the fieldworker accompany their clients to the clinic and remain with them to provide such services as fetching food and carrying for their children.

Food costs of 48 taka (\$3.20) for tubectomy and 16 taka (\$1.06) for vasectomy are justified as the average cost of providing food to clients and is given to the patients so that relatives and fieldworkers assisting them at clinics can purchase food for them during the procedure and convalescence. This amount is unchanged from previous levels in the program.

The transportation costs of 35 taka (\$2.33) per tubectomy and 30 taka (\$2.00) per vasectomy is the average cost of client travel to and from the sterilization center. The same amount is given to all patients for the sake of administrative simplicity. A greater fee is provided to tubectomy patients because a greater number of relatives, children, etc., travel with them.

Compensation for wage loss of 40 taka (\$2.66) per tubectomy and 60 taka (\$4.00) per vasectomy has been re-examined by the Government of Bangladesh and reduced compared to what was previously proposed. The Mission feels this is a real representation of the value of lost wages to ensure that this compensation is not perceived as an incentive. Patients will be told not to work for four days and compensation is based on four days lost labor. The differential in pay reflects differences in pay levels for men and women.

Reimbursement for the procurement of surgical apparel - Since there are no laundry facilities at service centers, the Mission has argued that provision of new lungi costing 30 taka (\$2.00) for men undergoing vasectomy and a new sari for women costing 50 taka (\$3.30) for women undergoing tubectomy diminishes the chances of infection. In my view, this element of the program is less easily justified than the other costs described above. However, the cost associated with procurement of these garments has been supported by USAID during the past three years of the first population project and was cleared by the GC and AID/W as appropriate support in light of PD-70.

Based on the arguments presented by the Mission and Miss Jordan, it would appear that the package of recompense to acceptors represents legitimate expenses which would be incurred by participation in the voluntary

sterilization program. We also understand that the Mission and the Government of Bangladesh are undertaking an operations research program in which some of the elements of this package will be offered to IUD acceptors in an attempt to understand if VS services are made more attractive to the acceptor than other contraceptives services. It would seem reasonable to not hold up implementation of this sterilization program, but to modify the IUD program as required in light of any new information.

An element of PD-70 requires that VS services be of high quality. Since a number of deficiencies relating to quality of VS services have been identified, the following actions will be taken.

1. Purchase and provision of emergency lifesaving equipment to all Government of Bangladesh clinics through IPAVS.
2. Continuing investigation through the offices of CDC of sterilization deaths.
3. A study of the Fishburne protocol for anesthesia will be undertaken.
4. A national conference to review reports and recommendations relating to safety of sterilization. The decisions of this conference will be the basis of new training programs for physicians.
5. Establishment of a competent surveillance system relating to safety of sterilization will be made a condition precedent for support of sterilization under the project.

Conclusion - Assuming the above plans are implemented, in my judgment, conditions required by the revision version of guidance to implementation of PD-70 would be met. Although there are other issues relating to the proposed project paper, assuming careful and well-supervised implementation of the plans relating to sterilization, issues relating to PD-70 should not be a bar to approval of the project paper.

cc: DS/POP, P. Baldi  
ASIA/TR, M. Jordan  
DS/POP/ASIA-NE, W. Johnson

DS/POP:JJSpeidel:nmk