PD CAK 270

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

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

DOCUMENT CODE 3

2. COUNTRY/ENTITY: Bangladesh

3. PROJECT NUMBER: 388-0050

4. BUREAU/OFFICE: Asia [04]

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

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 09 DD 30 YY 88

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)
A. Initial FY 81 B. Quarter 5 C. Final FY 86

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

A. FUNDING SOURCE	FIRST FY 81 B. FX	C. L/C	D. Total	LIFE OF PROJECT FY 81-86 E. FX	F. L/C	G. Total
AID Appropriated Total	6,378	4,622	11,000	89,265	51,996	141,261
(Grant)	(6,378)	(4,622)	(11,000)	(89,265)	(51,996)	(141,261)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
Host Country	NA	NA	23,000	NA	NA	143,000
Other Donor(s)	NA	NA	34,100	NA	NA	168,000
TOTALS			68,100			452,261

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
FY 81-83 (1) PP	440	440		58,731				58,731	
FY82 (2) H	440	440		1,530				1,530	
FY84 (3) PP	440	440		4,605				4,605	
84-86 (4) PP	440	440				76,395		76,395	
TOTALS				64,866		76,395		141,261	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 460 | 570 | 740 | 968

11. SECONDARY PURPOSE CODE

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

A. Code	BRW	BUW	RPOP				
B. Amount	116,861	20,700	3,700				

13. PROJECT PURPOSE (maximum 480 characters)

The purpose of this project is to increase the prevalence of modern method contraceptive use of eligible couples to 28 percent by the end of CY 1987.

14. SCHEDULED EVALUATIONS
Interim MM 08 YY 82 | MM YY
Final MM 05 YY 86

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

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a 36 page PP Amendment.)

This amendment increases LOP funding from $64,866,000 to $141,261,000 and extends the PACD to the end of FY 88.

17. APPROVED BY
Signature: James A. Norris
Title: Director
Date Signed: MM 06 DD 21 YY 89

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

AID 1330-4 (8-79)

INSTRUCTIONS

The approved Project Data Sheet summarizes basic data on the project and must provide reliable data for entry into the Country Program Data Bank (CPDB). As a general rule blocks 1 thru 16 are to be completed by the originating office or bureau. It is the responsibility of the reviewing bureau to assume that whenever the original Project Data Sheet is revised, the Project Data Sheet conforms to the revision.

Block 1 -Enter the appropriate letter code in the box, if a change, indicate the Amendment Number.

Block 2 - Enter the name of the Country, Regional or other Entity.

Block 3-Enter the Project Number assigned by the field mission or an AID/W bureau.

Block 4 - Enter the sponsoring Bureau/Office Symbol and Code. *(See Handbook 3, Appendix 5A, Table 1, Page 1 for guidance.)*

Block 5 - Enter the Project Title *(stay within brackets; limit to 40 characters).*

Block 6 - Enter the Estimated Project Assistance Completion Date. *(See AIDTO Circular A-24 dated 1/26/78, paragraph C, Page 2.)*

Block 7A. - Enter the FY for the first obligation of AID funds for the project.
Block 7B. - Enter the quarter of FY for the first AID funds obligation.
Block 7C. - Enter the FY for the last AID funds obligations.

Block 8 - Enter the amounts from the 'Summary Cost Estimates' and 'Financial Table' of the Project Data Sheet.
NOTE: The L/C column must show the estimated U.S. dollars to be used for the financing of local costs by AID on the lines corresponding to AID.

Block 9 - Enter the amounts and details from the Project Data Sheet section reflecting the estimated rate of use of AID funds.
Block 9A. - Use the Alpha Code. *(See Handbook 3, Appendix 5A, Table 2, Page 2 for guidance.)*

Blocks 9B., C1. & C2. - See Handbook 3, Appendix 5B for guidance. The total of columns 1 and 2 of F must equal the AID appropriated funds total of 8G.

Blocks 10 and 11 - See Handbook 3, Appendix 5B for guidance.

Block 12 - Enter the codes and amounts attributable to each concern for Life of Project. *(See Handbook 3, Appendix 5B, Attachment C for coding.)*

Block 13 - Enter the Project Purpose as it appears in the approved PID Facesheet, or as modified during the project development and reflected in the Project Data Sheet.

Block 14 - Enter the evaluation(s) scheduled in this section.

Block 15 - Enter the information related to the procurement taken from the appropriate section of the Project Data Sheet.

Block 16 - This block is to be used with requests for the amendment of a project.

Block 17 - This block is to be signed and dated by the Authorizing Official of the originating office. The Project Data Sheet will not be reviewed if this Data Sheet is not signed and dated. Do not initial.

Block 18 - This date is to be provided by the office or bureau responsible for the processing of the document covered by this Data Sheet.

AUTHORIZATION AMENDMENT

Name of Country: Bangladesh

Name of Project: Family Planning Services

Number of Project: 388-0050

1. Pursuant to Section 104(b) of the Foreign Assistance Act of 1961, as amended, the Family Planning Services Project for Bangladesh was authorized on February 17, 1981. That authorization is hereby amended as follows:

a. Paragraph 1 of the authorization is deleted and the following is inserted in lieu thereof:

"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 non-governmental organizations in Bangladesh ("NGOs") involving planned obligations of not to exceed One Hundred and Forty-One Million, Two Hundred Sixty-One Thousand United States Dollars ($141,261,000) in Grant funds during Fiscal Year 1981 through 1986, 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. The planned life of project is from February 17, 1981 to September 30, 1988.'

b. A new paragraph 5 is added to the authorization as follows:

"5. Waiver

"Project Vehicles. I hereby waive the requirement of Section 636(i) of the Foreign Assistance Act of 1961, as amended, and the source ~~/~~ origin requirements of Handbook 1, Supplement B, Chapter 5, to permit the procurement of ninety-six vehicles by Population Services International, Inc. (PSI) and other NGOs to facilitate implementation of the Project.

"I certify that exclusion of procurement from Free World countries other than the Cooperating Country and Code 941 countries would seriously impede attainment of U.S. foreign policy objectives and objectives of the foreign assistance program."

c. A new paragraph 6 is added to the authorization as follows:

"6. Renewal of Authority of the Mission Director to Extend Life of Project (Project PACD) by One Year.

"The extension of the life of the project approved by this amendment to the authorization renews the authority of the USAID/Bangladesh Mission Director to extend the life of the project (project PACD) by one year."

(cont'd...2)

2. The authorization cited above remains in force except as hereby amended.

Signature _____
M. Peter McPherson
Administrator

Date: _____

Drafted:RLA/SCAllen:msj:skd
1/25/84

Clearances:P&H:JThomas _____
RLA:SAllen (draft) _____
PRO:WBoehm _____
CONT:RDeBruce _____
for DD:WJoslin _____
D:JANorris _____

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Glossary

BACE	Bangladesh Association for Commodity Education
BDG	Government of Bangladesh
BFPA	Bangladesh Family Planning Association
CBD	Community-based delivery of family planning services
CPR (derived)	Contraceptive prevalence rate derived from MIS service statistics and USAID-funded NGO data
CPR (survey)	Contraceptive prevalence rate estimated from national CPSs
CPS	Contraceptive Prevalence Survey
CYP	Couple Year of Protection
CuT	Copper-T, a type of IUD
FPSTC	Family Planning Services and Training Center
FWC	Family Welfare Center
ICDDR,B	International Center for Diarrheal Disease Research, Bangladesh
IEC	Information, Education and Communication
IPAVS	International Project of the Association for Voluntary Sterilization
IUD	Intrauterine Device
MCH	Maternal and Child Health
MIS	Management Information System, generally refers to the MIS Unit of the MOHPC
MOHPC	Ministry of Health and Population Control
NCPC	National Council for Population Control
NIPORT	National Institute of Population Research and Training
NGO	Nongovernmental Organization
NPCP	National Population Control Program
NRR	Net Reproduction Rate
OR	Operations Research
PSI	Population Services International
SMP	Social Marketing Project
TAF	The Asia Foundation
TFPO	Thana Family Planning Officer
VS	Voluntary Sterilization
VSST	WHO VS Surveillance Team
WHO	World Health Organization

I. SUMMARY

A. Overview

This amendment extends the project three years and increases the project authorization by $76.4 million. During the amendment period the project will focus on those activities which have proved to be most successful in achieving project objectives and will pursue those demonstrably worthwhile discrete activities identified during ongoing evaluations and assessments. During the FY 1983-86 period, we will collaborate with the other major Donors and the Government to develop a unified action plan for the future development of the National Population Control Program and for complementary Donor assistance. Recommended changes in the program will be reflected in the amendment to this project and in the new USAID project for FY 1987 funding.

B. Project Progress

The project has four principal elements: expansion of services, training, management information and (limited) demand creation activities. The project purpose is to be achieved by concentrating resources on improving and expanding the delivery of family planning services through the existing MOHPC system, the SMP and other NGO efforts:

-- The MOHPC implements a large public sector family planning program offering both clinical and domicilliary services and is responsible for coordinating all other population control efforts. The MOHPC has an extensive family planning services network which has the potential to effectively provide free services to the rural poor, particularly in remote areas. The MOHPC predominates in the delivery of VS (voluntary sterilization) and IUD services and has shown considerable growth in performance levels for these methods.

-- The SMP utilizes commercial marketing techniques to expand the availability of condoms, contraceptive pills and foaming tablets, selling its products at subsidized prices through 105,000 retail outlets. The SMP currently is test marketing an oral rehydration product and recently has received approval to test market an injectable contraceptive through graduate doctors.

-- Finally, NGOs use a wide range of approaches to delivery of services, including both clinic-based and community-based programs sometimes integrated with other development activities. These programs complement the MOHPC and SMP activities and presently serve primarily that segment of the population located in cities and large towns. The current project provides funds to five NGO "intermediary" agencies that support the activities of indigenous organizations. By June 1983, over 50 new NGO CBD subprojects at 95 locations had been initiated under the project -- serving 44 district and sub-divisional towns, as well as some limited rural populations.

It is important to note that the project is an integral part of the larger national program to reduce fertility. Although the SMP and other NGO activities are discrete projects, the MOHPC program (and therefore the project purpose) relies on the support of other Donors and government contribution for success.

The very preliminary results of the 1983 CPS, however, indicate a CPR (modern methods) of about 15% and it is now evident that the original project target of 25% will not be fully achieved. This is largely due to three factors: the target (for a number of reasons) was unrealistic; the MOHPC -- which was expected to be the predominant provider of family planning services under the national population control program -- did not perform as expected; and the CPS in Bangladesh seems to undercount condom use, an area of substantial growth. The BDG, in conjunction with the major Donors, is now attempting to redress problems in the MOHPC family planning program. However, this is expected to be a long-term effort. We have revised the project targets to realistic but still ambitious levels and extended the project by an additional three years.

C. Proposed FY 84-86 Add-on Activities

Based on USAID review of the project, results of the Midterm Evaluation, audit findings, and AID Policy Papers, the same project purpose and goal will be retained during the amendment period. The numerical CPR target, however, will be 28% by the end of CY 1987.

The basic strategy of the project also will be retained but the emphasis on each component within implementing agencies will be changed. Priority will continue to be given to the expansion of family planning services. However, we will concentrate our efforts on those activities showing evidence of the best performance -- the MOHPC clinical methods, the SMP and other NGO activities. Donor dialogue will continue with the BDG to identify major areas of improvement to achieve more effective implementation of the family planning program.

1. The Ministry of Health and Population Control Program

We will continue to support the delivery and, to the extent possible, continued expansion of family planning services by the MOHPC through VS, IUD and injectable reimbursement and commodities. The awards program will be expanded. Development of MCH materials, training and other institution building activities such as the local family planning project and operations research will be consolidated in a new Technical Resources, Research and Training budget category which will use pipeline FY 81-83 funds, but no new funding. This category will also be used for long and short-term consultants, evaluations and other discrete activities as they are identified.

2. The Social Marketing Project

The highly successful SMP will continue to expand its present activities with eight years of dramatic growth in condom sales and nearly universal geographic coverage. The SMP, at last, also seems to have developed an effective system for distributing pills which is expected to produce a significant growth in pill sales. It will increase the number of products -- one new brand of condom, one new brand of oral contraceptive, an injectable contraceptive and an oral rehydration product. The mass media campaign will be continued and evaluated.

3. Other Nongovernmental Organizations

We will continue to support the expansion of NGO sub-projects in urban areas developed during the original project. An important emphasis during the amendment period will be the promotion of NGO activities which augment the government program in rural areas. Another important aspect of our support to NGOs will be assistance in the development of sub-project management capability through short-term technical services and training. If the ICDDR,B Extension Project is successful, then we plan to assist the training of MOHPC fieldworkers in other thanas.

We will implement the new NGO MIS which will be used to evaluate the effectiveness of various NGO strategies. While current performance information indicates that NGO's generally can be an efficient means of providing family planning services, they use a number of diverse delivery methods -- all of which may not be equally productive.

D. Budget (Obligations By Fiscal Year)

	FY 81-83	FY 84-86	Total
	(in 000s)		
1. MOHPC	20,823	18,474	39,297
2. SMP	7,311	13,505	20,816
3. Other NGOs Grants/Contracts	9,541	18,041	27,582
4. Contraceptive Commodities	22,586	30,980	53,566
Total Authorization	60,261	81,000	141,261

II. Problem Analysis

A. Introduction

Unrestrained population growth continues to present one of the greatest impediments to improving social and economic conditions in Bangladesh. Since Independence, successive governments have consistently promoted, with considerable donor support, ambitious public sector programs to reduce fertility. Although the impact of these programs on the population growth rate largely has been disappointing, during the past ten years there have been some important achievements. The government has established a functioning, if not always effective, national system for delivery of family planning services. Further, there is a universal awareness of family planning and knowledge of at least one modern contraceptive method. While the contraceptive prevalence rate has, in fact, increased slowly, there is now evidence that an initial contraceptive prevalence rate of 35% could be reached provided that service delivery is improved and modern contraceptive methods are readily and regularly available.

The imperatives for an effective expanded national population control program cannot be overstated. The present Bangladesh population of 96 million people is increasing at 2.4% per year and is expected to double, at this rate, in twenty-nine years. Without successful efforts to reduce this growth rate, mounting population pressures through the next century will adversely affect levels of health, nutritional intake, per capita income, population density, unemployment and other indicators of social welfare. The exponential impact of the present rate of population growth and the high social and economic cost against a limited resource base demand the introduction of innovative approaches to reducing fertility and an acceleration of efforts to improve the government's family planning program.

B. Present Progress of the National Population Control Program

1. Description of the overall program

A comprehensive national family planning policy began emerging in 1973 with the formulation of the First Five Year Plan. The plan proposed a strong government program to achieve a decline in fertility to replacement level by the year 2000. This demographic objective was subsequently accelerated in the Second Five Year and the 1982 Two Year Action Plan to achieve an NRR of 1 by 1990 by reducing the crude birth rate from 45 to 31 per thousand and the crude death rate from 17 to 13 per thousand by 1985. Basically, to accomplish this, the Government has established a broadly-based National Population Control Program to improve health care, increase public awareness of family planning, provide easy access to contraceptive methods and generate community

support for population planning through a system of community and clinic-based services and mass-media campaigns. The National Population Control Program is administered by a number of public and private organizations using a variety of approaches and reaching different segments of the population.

The Ministry of Health and Population Control implements a large public sector family planning program offering both clinical and domicilliary services and is responsible for coordinating all other population control efforts. The MOHPC has an extensive family planning services network which can be used to provide free services to the rural poor, particularly in remote areas. Although, the MOHPC has not been effective in the delivery of community-based services, the MOHPC predominates in the delivery of VS and IUD clinical services. The Ministries of Agriculture; Education; Information and Broadcasting; Labour and Industrial Welfare; Social Welfare and Women's Affairs; Rural Development and Cooperatives; and Planning also offer various service delivery, population education, research and IEC activities in what is called the "multisectoral program."

The Social Marketing Project provides universal geographic coverage for non-clinical contraceptive methods. It has successfully used commercial marketing techniques to expand the availability of contraceptive pills, condoms and foaming tablets. It has now initiated a pilot project to develop an effective marketing strategy for injectable contraceptives, through, at least initially, graduate doctors.

Finally, Nongovernmental Organizations use a wide range of approaches to delivery of services, including both clinic-based and community-based distribution and programs integrated with other development activities. These programs complement the MOHPC and SMP activities (e.g, NGOs may refer clients to government clinics). To date, these have been concentrated in district and sub-divisional towns where the MOHPC has been less active. AID is the principal Donor financing NGOs.

In 1982, approximately $60 million in total resources from all sources were available for population and MCH activities. Most of the resources were channelled through the MOHPC. The actual Government contribution from both the Annual Development Plan and the Revenue Budget is about 20 percent of this total. The remaining 80 percent is contributed by foreign donors for a variety of purposes (BDG project aid, commodities and NGO activities). The government generally has not had to contribute significantly to program costs because of the availability of generous donor financing. Government funds, accordingly, are allocated to those activities which are of little interest to foreign donors, e.g., salaries and other administrative support. See Annex A for further discussion of donor activities.

There are three major donors -- The International Development Association of the IBRD, The United Nations Fund for Population Activities and AID (the single largest bilateral donor). In addition, there are a number of multi and bilateral donors contributing, in aggregate, significant complementary funding for both family planning and related health-care activities.

Although the National Population Control Program is segmented by those discrete activities which individual donors are prepared to support and by some divergence of donor strategies, it is important to note that the donors have successfully cooperated generally to maintain a rational and interrelated effort.

2. Description of Present Problems in the Program

The Martial Law Administration continues to consider population control to be a critical factor in the development of Bangladesh's human and material resources and important progress has certainly been made in family planning acceptance since 1972. However, modern birth control methods, according to the 1981 CPS, were being used by 11% of the then 17 million eligible couples in Bangladesh -- an amount which is inadequate to have any significant impact on population growth. Very preliminary results of the 1983 CPS indicate that the CPR has increased to approximately 15% (see Table 1 for comparative CPR data and Table 2 for estimates of active users by method and implementing agency). Most of the increase in prevalence seems to be in voluntary sterilizations. It is important to note that this very limited number of acceptors is being reached despite evidence that a 35% CPR is now achievable given the present level of socio-economic development provided that quality family planning services are readily and regularly available.

It now appears that the government's medium-term family planning goals are almost certain to be unachievable within the present time frame. During 1982/83 only about 60% of the government's Five Year Plan targets were reached. This was largely due to the overly ambitious nature of the targets but, more importantly, also to organizational problems within the MOHPC (the single most important element of the government's national family planning effort) which impede the design and management of a successful program. The recent USAID mid-term evaluation of Project 388-0050 concluded that the MOHPC program remains perpetually restrained by fiscal rigidity, frequent organizational changes, administrative inefficiencies and inadequate field worker supervision and training. This evaluation, in fact, reiterates the conclusions of similar evaluations both by AID and other donors during the last eight years.

The MOHPC's family planning program in Bangladesh has suffered from recurrent and demoralizing organizational changes that shift emphasis from vertical (i.e. separated) to integrated implementation of health care and family planning activities. These changes have disrupted the already weak administration of the Population Control Wing and have provoked tension between the Health and Population Control Wings over the relative importance of health care as a critical element in promoting family planning. Program reintegration ordered in 1980 has not been completely implemented: the relative importance of fieldworker services (viz, family planning vs. MCH vs. oral rehydration vs. immunination vs. malaria control vs. health education) has been inadequately considered and at present 27 "core package" messages are expected to be delivered; field workers remain under-supervised; and logistical support (commodity supply, distribution and control) remains a serious deficiency.

Recent operations research projects conclude that inadequate supervision of field worker performance remains a central weakness of the MOHPC program. The present supervisory system does not reward either supervisors who promote field worker productivity or field workers who perform well. Consequently, it is frequently observed that field workers do not regularly visit villages and "simply don't work". A recent study has indicated that field workers make only 10 to 23% of required home visits. Since there is a direct correlation between the frequency of villager-field worker contact and family planning acceptance rates, this lack of field worker visits is a significant problem.

The proper distribution and control of family planning commodities has been an additional, persistent problem. Supply reporting is not complete and the obvious result has been unreliable distribution information, major difficulties with distribution control and inability to make valid procurement decisions. Accordingly, there is frequently either a shortage or a surplus of supplies. Additional, common problems include staff vacancies, inadequate training, undue transfer of trained personnel, inadequate storage facilities and insufficient transport allowance.

3. Donor Response

A group representing the principal Donors has been meeting since November 1982 to discuss possible measures to resolve the long-standing administrative constraints to implementation of an effective national population control program. As a result of these meetings a paper was drafted by the IBRD, UNFPA and USAID (and formally presented to the government in March 1983) which recommended, as an immediate measure, that the national population program be removed from direct government administration and placed under the auspices of a semi-autonomous population control board responsible for planning, financing and implementation of activities directly and through the government and NGOs. Population and family planning also was selected by the Bangladesh Consultative Group as a major agenda item for the 1984 Paris meeting.

In July 1983, the Secretary of MOHPC, in response to the Donors' discussion paper, announced the formation of a National Council for Population Control. This Council would be chaired by the CMLA, have eleven Ministers as members and an executive committee headed by the Minister of Health and Population Control. The Council, according to the Secretary, would have policy-making and coordinating (but not implementing) authority. In addition, the Secretary stated that, based on recommendations of the Donors' paper, some actions would be taken to add new interventions and eliminate constraints to improve the effectiveness of the program.

In September 1983, the Secretary of the MOHPC further announced a series of specific measures which he believed would resolve the problems in the MOHPC program and the Donors' concerns. These measures included a number of new interventions (principally a system of awards and penalties which promote improved field worker performance); an increase in compensation for clinic-based contraceptive methods; community awards for unions and upazilas (as well as NGOs) which achieve high acceptor rates; changes in certain bureaucratic regulations; changes in marriage age and maternity benefits; and a modified organization structure for the MOHPC based on a so-called "functional integration".

The Secretary rejected the Donors' recommendation for a semi-autonomous population control board with implementing functions stating that there had already been too many changes in the implementation of the program and it was now the time to consolidate responsibility and achieve stability. The Secretary reiterated the government's belief that the only effective way of delivering family planning services is through integration with MCH and primary health services at the Upazilla level and below. Instead of full integration, the government planned to undertake functional integration (see Figures 1-4 for old and new organization charts) which, the Secretary asserted, would resolve the problems of earlier integration efforts and offered a more pragmatic organization structure. While recognizing the wide range of problems facing the implementation of a successful program, he believed that these could be resolved through appropriate supervision. The USAID-financed Management Needs Assessment by Management Systems for Health in November-December 1983 generally agreed with the BDG position for the need for stability in program structure.

The BDG will need some time to identify human and financial resources and organizational changes necessary to improve the program and, during the next year, we expect the Donors to continue to encourage and support MOHPC efforts. During the amendment period, we will work to focus attention on systemic problems; continue to emphasize PD-3 and quality considerations in the VS program; improve the BDG logistics system; and on other identifiable issues as they develop. We plan to submit a new project for FY 1987 which reflects the government's changes in the program and coordinates with the new projects of the other Donors.

III. Family Planning Services Project

A. Original Purpose, Goal and Strategy

The Family Planning Services Project was designed as part of the national program to reduce fertility by increasing the prevalence rate of modern birth control methods. The purpose of the project is to increase the prevalence of contraceptive use to 25% (modern methods) as part of a larger goal to reduce population growth as a critical element in Bangladesh development.

The present AID project for addressing the population crisis is largely based on evidence that an estimated 35-40% of eligible couples would practice family planning if modern and reliable birth control methods are readily and regularly available. Accordingly, a strategy has developed in which family planning delivery systems are strengthened to meet this latent demand before activities which serve to create additional demand (i.e., which create a demand for smaller families or, alternatively, reduce the social and economic imperatives for large families) are extensively undertaken.

The project purpose is to be achieved by concentrating resources on improving and expanding the delivery of family planning services through the existing MOHPC system, the SMP and other NGO efforts. The project has four principal elements: expansion of services, training, management information and (limited) demand creation activities. It is important to note that the project is an integral part of the larger national program to reduce fertility. Although the SMP and other NGO activities are discrete projects, the MOHPC program (and therefore the project purpose) relies on the support of other Donors and government contribution for success.

B. Revised Purpose, Goal and Strategy

Since the CPR is expected to be 15% (modern methods) at the end of 1983, it is now evident that we will not reach the project purpose. Based on the conclusions of the Mid-Term Evaluaton (see Annex E), audit findings and our review of AID Policy Papers, the original purpose remains valid. The numerical CPR target, as discussed more fully in the Technical Analysis, will be 28% (modern methods) by the end of CY 1987.

The basic components and project strategy also will be retained; although, more emphasis will be placed on the expansion of family planning services through the SMP and other NGO activities. This emphasis and corresponding allocation of project funds (excluding commodities) among the MOHPC, the SMP and other NGOs was based on two important considerations: definition of the target populations and assessment of the ability and willingness of each implementing organization to reach the target populations rapidly and to meet CPR objectives.

Eligible couples who want family planning services are segmented according to two broad categories: location in urban or rural areas and family planning objective (i.e., those who want to limit their family size choose both permanent and non-permanent methods; those who want to space their children choose only non-permanent methods). The National Population Control Program primarily reaches those who want to limit their family size by use of permanent methods. Of the 15% of eligible couples accepting modern methods as estimated from the 1983 CPS, the proportion using permanent methods has increased from 44% in 1981 to an estimated 55% in 1983. The preliminary results of the 1983 CPS and service statistics further indicate that services to those eligible couples who want to space their children are inadequate.

In determining which organization could reach the various target populations most effectively, the principal criteria were organizational capacity and proven effectivness in expanding service delivery. The SMP and NGOs are the most cost-effective organizations providing services. However, the SMP provides primarily non-clinical family planning methods. Various NGOs provide a full range of services but, to date, they have concentrated their activities in district and sub-divisional towns and they do not, as yet, have the oganizational capacity to provide coverage in rural areas. The MOHPC does have the infrastructure to provide clinical and non-clinical services but it is less cost-effective and has had considerable difficulty in expanding its non-clinical services. Private doctors, traditional healers and pharmacists also provide family planning services but not of full range and not at significant levels. It is hoped that SMP will begin to energize these groups to become more active through its increasingly effective oral contraceptive marketing strategy and approved injectable contraceptive pilot activity.

We propose to support those areas where the MOHPC has a demonstrated ability. Accordingly, in addition to commodities, amendment funds will be used for the reimbursement of expenditures for the provision of clinic-based contraceptive services, as well as the community, fieldworker and NGO awards program. Contraceptive Prevalence Surveys and support to the FPSTC also will continue to be supported.

The recent evaluation of SMP (see Annex F for summary of findings) concluded that the tremendous growth in the national distribution of non-clinical contraceptives since 1976 can be largely attributed to SMP sales and that SMP now accounts for more than half of the distribution of all non-clinical contraceptives. Based on this evaluation, we plan to continue and expand this successful activity. Additions to our original SMP strategy include the sale of an injectable contraceptive (not provided by AID) through private physicians, the continuation of the mass media advertising of the benefits of smaller families and the marketing of primary health care products.

Other AID-funded NGO programs provide family planning services through local voluntary agencies which are not otherwise available through the national program. At present these services are largely provided in district and sub-divisional towns but we plan to expand NGO efforts in rural areas not reached by the MOHPC.

C. Project Activities

The following is a discussion of the present project and proposed activities to be funded under the amendment. Annex G contains a description of FY 1981-83 project activities that will not be continued or receive new funding under the amendment. Input/output tables are included in Annex H. N.B, the dollar amounts for each implementing agency exclude centrally procured commodities. The commodities funded under the MOHPC Grant and shown in the Input/Output Table will be utilized by both the MOHPC and NGOs but exclude those utilized by the SMP.

1. Contraceptive Commodities FY 81-83: $22.6 million
FY 84-86: $31.1 million

AID is the largest supplier of contraceptives to the national program, providing all the Condoms, Emko Foam, Neo-Sampoon tablets, Cu-T and, until recently, all the pills used in Bangladesh. In addition, drugs, and other supplies for the voluntary sterilization program have been financed on a limited, emergency basis.

The proper distribution and control of AID-financed and all other commodities through the MOHPC system, as noted above, has been a persistent problem. Aside from concerted donor efforts, we have also undertaken a number of additional measures to improve the logistics system. We successfully encouraged the government to permit NGO's to obtain their supplies directly from the central warehouse rather than from district stores. Since NGO's are significant distributors of pills and condoms, this immediately served to reduce demands on the government system. We encouraged the government and UNFPA advisor to begin yearly projections of supplies early enough to ensure adequate supplies on a timely basis -- this now is being done. In conjunction with UNFPA we initiated and ensured implementation of District and Thana Storekeeper training. We insisted on a physical inventory of supplies by the MOHPC in June 1983. The June inventory was not completed successfully and, therefore, a contract will be negotiated with a chartered accounting firm to undertake annual nation-wide inventories. All outdated commodities will be removed at this time. The government Auditor General is conducting an audit of the MOHPC logistics system, at our request, which is expected to be completed by early 1984.

Centrally-procured commodities will continue to include condoms. We are not planning to purchase further oral contraceptives for the MOHPC. As discussed more fully below, the oral contraceptive provided by AID has not been popularly received in Bangladesh. Other donors have expressed an interest in providing oral contraceptives and it appears from on-going discussions with them and the MOHPC that they will meet the BDG's oral contraceptive need.

2. MOHPC Program FY 81-83: $17.9 million
FY 84-86: $18.5 million

a. Voluntary Sterilizations FY 81-83: $11.5 million
FY 84-86: $10.6 million

Reimbursable expenses (see Table 3) include physicians and clinic staff fees, surgical apparel (new sari or lungi), food, transportation, lost wages and referral fee. This reimbursement is contingent upon continuous government demonstration of the absolutely voluntary nature of the sterilization program and competent technical supervision and surveillance.

Government officials have been equally concerned with voluntarism and quality of service. Informed consent forms have been issued and are being used, revised procedures for analgesia and local anesthesia have been adopted and retraining of physicians has begun. To confirm compliance with informed consent procedures and accurate reporting of sterilizations performed, an AID-financed chartered accounting firm is conducting quarterly audits. The Swedish International Development Agency, with WHO as the executing agency, is providing financing for expatriate physicians as part of an independent voluntary sterilization surveillance team (VSST). Since November 1982, reimbursements have been contingent upon receipt of monthly VSST reports.

The quality of the sterilization procedure has undoubtedly improved and is now probably the best surgical care available in Bangladesh. Physicians are generally well trained in VS procedures and supplies are now available. As a measure of progress the mortality rate (for both vasectomy and tubectomy) has fallen from an estimated 21 per 100,000 in 1979/80 to an estimated 6 per 100,000 in 1982/83. This compares to an estimated maternal mortality rate of 640 per 100,000 pregnancies. Since there are still deficiencies in the program, e.g., laboratory tests and pre-surgical examinations are not always performed, careful monitoring of VS activities will continue.

The number of voluntary sterilizations performed by both the BDG and NGOs has increased 190% from 135,791 procedures performed in 1979 to 394,239 performed in 1982. We expect 396,000 sterilizations to take place in 1983. (See Table 4 for the number of VS per month from 1979 to September 1983 and Figures 5 and 6.)

As long as the program continues to meet PD-3 guidelines we will reimburse the MOHPC for procedures performed. However we expect the government to increase its contribution from nothing in BDG FY 1983/84 to 20% in FY 1984/85, 40% in FY 1985/86 and 50% in FY 1986/87. The increased reimbursements effective November 1, 1983 are expected to result in an increased number of VS acceptors. This expected increase is reflected in our projections.

b. IUD Reimbursements FY 82-83: $0.6 million
FY 84-86: $3.1 million (see below)

In July 1982, the MOHPC requested AID assistance in strengthening their IUD program. The IUD which had been extensively used in 1965-70, had become generally unpopular due to inadequate fieldworker counselling and anamnesis during this period. However, a new IUD (the Cu-T) was being introduced to revitalize the program. It was hoped that women would perceive the Cu-T as better and more comfortable than the old Lippes Loop. Since IUDs generally are inserted at clinics by paramedics or physicians, the MOHPC planned to reimburse clients for the transportation costs and paramedics and physicians for the insertion procedure. We agreed to finance this program (using demand creation funds) for two reasons: it was consistent with the government's policy of making the other major clinic-based method -- voluntary sterilization -- a "no-cost-to-the client" method, and it was believed that offering an additional "no cost" temporary method would encourage use by potential family planning acceptors. Reimbursement for IUD insertion also assures that clinical methods are offered on a comparable basis. Since the introduction of the program, the average number of insertions per month has increased from 6,846 (July 1981 - June 1982) to 9,738 (July 1982 - June 1983).

IUD insertion is now a fully integrated, acceptable MOHPC intervention which we will continue to support as a service delivery activity. Project funds will be used to reimburse the client's initial visit, transportation costs, the referrers fee for the initial insertion and the MOHPC cost of the insertion. We also intend to reimburse the cost of a follow-up visit. The reimbursements are based on MIS service statistics but if the evaluation to be conducted in early 1984 shows discrepancies in the number of insertions or other problems such as multiple IUD insertions and payments to the same clients, appropriate adjustments will be made in this program.

c. Injectable Reimbursements FY 84-86: included in b. above

Injectable contraceptives are becoming an increasingly popular contraceptive method in Bangladesh. Since this type of contraceptive generally is injected at clinics by physicians and some paramedics, the MOHPC is considering reimbursement of clients for the transportation cost and paramedics for the injection procedure to balance the compensations

for the three clinic-based methods -- sterilization, IUD and injectable. AID will not supply injectable contraceptive commodities; however, we have agreed, in principle, to reimburse associated costs if the MOHPC implements the reimbursement scheme. The rationale for this reimbursement is the same as that for IUDs.

d. Performance Awards FY 81-83: $0
FY 84-86: $3.5 million

We have agreed, in principle, to finance as an innovative activity, an NCPC performance award scheme which rewards MOHPC fieldworkers, communities and non-governmental organizations whose service areas achieve predetermined targets. The criteria to be used in determining and measuring targets and the mechanisms for administering the scheme will be established by a committee representing the MOHPC and AID with the assistance of a consultant. The criteria will correspond to PD-3 guidelines. We will contract for an independent yearly evaluation of the Awards Program commencing in 1985 after the program has been operating for one year. We also expect to contract for an audit of the proposed award recipients activities prior to disbursing funds for the program. The award scheme is generally described below:

(i) MOHPC Field Force Awards: Poor fieldworker performance is largely due to poor training and supervision, but also to salary and benefit structure and civil service regulations which do not reward those who perform well or penalize those who do not. Supplemental performance awards (equivalent to one month salary), accordingly, will be given to all fieldworkers who exceed predetermined targets. Workers eligible for the award include all fieldworkers at the thana level and below, including the thana family planning officer. N.B, the MOHPC also plans to take disciplinary action against those fieldworkers who do not meet their targets for an eighteen month period.

(ii) Outstanding Achievement Awards: A national achievement award has been proposed by the MOHPC to recognize outstanding performance of fieldworkers, clinical staff, medical practitioners, program managers, and NGOs. The award will be in the form of a medal and certificate of merit. In addition, to promote improvement in the quality of VS services, a certificate of merit and, possibly, a cash award will be given to VS facilities which offer high quality care in hygienic surroundings.

(iii) Community and Organizational Awards: To encourage community leadership to assume more responsibility for the family planning program, an award will be given to any union which can exceed established family planning targets. The award of Tk.50,000 is to be utilized for a developmental project in the union. Twenty-one rural upazillas, one from each district, also will be selected for an award if the upazilla has

achieved established family planning targets. The award of Tk.100,000 is to be used for development activities of the Upazilla, as decided by the Upazilla Parishad. Ten NGOs which can demonstrate outstanding performance with innovative ideas will be awarded a certificate of merit and Tk.25,000 in cash to be used to further the activities of their projects.

e. CPS FY 81-83: $0.2 million
FY 84-86: $0.2 million

The 1983 survey, with MOHPC approval, is now being undertaken by an independent firm on a contract basis. The field work for the 1983 CPS began in October 1983 and the results are expected by the end of March 1984. The 1983 CPS is testing a complex methodology which is designed to determine whether women underreport some methods, particularly condoms, and therefore attempt to resolve the so-called condom-gap between CPS results and distribution figures. We will continue to conduct the CPS utilizing an independent Bangladesh research firm (see Evaluation Plan).

f. Activities To Be Conducted with Pipeline Funds

Pipeline funds from the Local Family Planning Project, MCH materials, training, printing, evaluation and operations research will be consolidated under a new budget category called "Technical Resources, Training and Research". As new discrete activities are proposed by the government or are identified in the management needs assessment or during project implementation, they will be supported with these funds. Funds will also be used for evaluations of the MOHPC program, consultants, training and research activities. In addition, pipeline funds for non-centrally-procured commodities will continue to be used to purchase surgical ligatures, Cu-T, Emko foam and possibly foaming tablets.

2. The Social Marketing Program FY 31-83: $7.3 million
FY 84-86: $13.5 million

The private-sector Social Marketing Program (SMP) has been successfully operating in Bangladesh since 1975 with Population Services International (PSI) as advisor. The program was initially funded by AID/W but is now included in the Family Planning Services Project. The SMP contraceptive retail sales program currently sells two brands of condoms and oral contraceptives and a foaming tablet (all supplied by AID) through 105,000 retail outlets at prices affordable by most of the population. It also recently began selling a safe delivery kit at cost for use by midwives and other medical personnel. The sales effort which provides universal coverage in both urban and rural areas is effectively promoted by an intensive advertising campaign and other marketing techniques.

The SMP performance continues to be characterized by a growth rate exceeding 25% per year for the past seven years (see Figure 7 for SMP performance and Figure 8 for comparative BDG performance). From January through June 1983 there were an estimated 967,000 active users of SMP products (see Table 2). In 1983, the SMP annual sales are estimated to be 82 million condoms, 1.75 million cycles of oral pills and 5.5 million foaming tablets. Based on MIS service statistics, the SMP sales represent 68% of condom protection, 21% of oral pill protection and 75% of foaming tablet protection nation-wide: 51% of all non-clinical protection provided by the national program.

The SMP condoms (Panther and Raja), in fact, are now the single most widely used non-clinical contraceptive method in Bangladesh. Until recently, however, growth in oral contraceptive sales had been largely disappointing. This was attributed to the initial marketing strategy in which pills were sold through commercial outlets without further counselling to clients. In 1980, with the introduction of Norminest which has a better image and a higher trade margin, a new campaign which provides the complementary services of medical representatives was started. The current strategy is centered on the medical practitioners who provide most of the medical care, including doctors, pharmacists and village practitioners. The new campaign appears to be successful and, for the first time since 1978, pill sales have begun to increase at a rate greater than that for condoms. In addition to its intensive advertising campaign, the SMP has added mobile units to show family planning films in semi-urban and rural areas. These films which have been popularly received are shown about 80 times per month to crowds ranging upwards of 3000 people.

The SMP remains a dynamic organization that has continued to demonstrate that an effective retail marketing effort can have a major impact in low income, rural areas at a low unit cost (see Economic Analysis). To maintain its market and enhance the acceptability of its contraceptive products, the SMP will add to its product line another low dose oral contraceptive (not funded by AID), a third condom brand, an injectable contraceptive (not funded by AID) to be marketed on a pilot basis to private doctors and an ORS product. Governing Council approval, which must be obtained for these activities, has been received for adding the ORS, condom and injectable contraceptive. To maintain substantial growth in brand-name contraceptive product marketing that has exceeded 25% per year over the past seven years and to expand into other product areas, additional investment is planned using amendment funds to expand the sales force (from 60 to 100) and to contact, supply and service more outlets in increasingly remote areas. Further, the management information system will be computerized to improve control over sales, inventory and finances. Mobile film units will be expanded to provide coverage in rural areas which are not at present adequately serviced by the mass media.

Moving beyond the traditional social marketing project into social advertising, Population Services International in FY 1983 contracted with a private U.S. advertising firm, Manoff International, to develop a mass media motivational campaign to increase the demand for family planning. This advertising campaign is not product-related but is directed at increasing demand for all methods of fertility control. Based on the results of a sophisticated market research experiment, messages were developed, pretested, and are now being broadcast over the radio. A baseline survey was conducted and a series of follow-up surveys will be done to measure the impact of this approach in increasing the demand for family planning. Newspaper ads, TV spots and short films are now being developed and tested.

One important area for review during the amendment period is the appropriate institutional structure for the SMP. Technically, the SMP does not exist as an independent legal entity but is solely the product of an agreement between the BDG and PSI with all of its funding, to date, provided by AID through relatively short-term contracts with PSI. While the short-term, project oriented nature of the SMP has permitted considerable flexibility particularly when setting and adjusting operating targets, it also can have negative impact e.g, when senior managers are being recruited: it is difficult to attract top-quality commercial sector people when the future of the organization is uncertain. Further, the BDG clearly perceives the SMP as an important part of its national family planning program. Accordingly, the merits of establishing the SMP as a permanent entity will be pursued.

Based on the evaluation of the SMP in October, 1983, it is planned to continue this important, successful activity indefinitely. Given the pivotal role that the present contractor has played and continues to play and the extraordinarily successful performance to date, a Cooperative Agreement, which more appropriately reflects the unique relationship between the SMP, PSI and the BDG, will be used to replace the present contract which expires in July 1984. A new scope of work and budget will be developed, approved by the SMP Council and the BDG, and negotiated by June of 1984. It is further planned to use a portion of SMP revenue to purchase a permanent facility for offices, warehouse and vehicles. This will reduce significantly the future costs of SMP operations.

4. <u>Other Non-governmental Organizations</u> FY 81-83: $7.7 million
FY 84-86: $18.0 million

Our strategy for support of other NGOs has been primarily to replicate two proven, cost-effective approaches: community-based distribution (CBD) programs implemented by indigenous voluntary agencies and NGO clinical projects specializing in the provision of high quality voluntary sterilization services. (See USAID strategy paper in Annex I.) The CBD programs are generally single-purpose or "vertical" outreach programs

characterized by an effective chain of supervision, use of female fieldworkers, offering a choice of contraceptive methods, and emphasizing systematic resupply and follow-up of acceptors. The clinical programs, implemented primarily by BAVS, emphasize counselling and medical standards. Most of these activities have taken place in urban areas in accordance with the MOHPC policy to restrict NGO CBD programs to district and sub-division towns where the MOHPC does not deploy fieldworkers. Rural programs have been supported when these are coordinated with MOHPC services and when family planning is integrated with other services.

Disbursements have been slow due to the longer than expected time needed to obligate funds and initiate activities and to the lengthy BDG approval procedures for NGO projects. Grant Agreements were not negotiated and signed until the third and fourth quarters of FY 1981. Grantees then used most of 1981 and early 1982 primarily for planning and organizational activities. New programs funded under the project began to have significant levels of service outputs only in the second half of 1982. By June 1983, over 50 new NGO CBD subprojects at 95 locations had been initiated under the project grants -- serving 44 districts and sub-divisional towns, but also serving rural areas on a limited basis. (N.B, these figures do not include centrally funded projects.)

NGO activities under the project have made an impressive start in expanding services. Of approximately 203,000 CYP provided by AID funded NGO CBD projects from January to June 1983, 88,500 CYP were provided by new project-funded CBD activities. While VS services funded under the project have not expanded as rapidly as CBD services, NGO VS services continue to represent a significant percentage (approximately 18%) of national VS performance. Performance has been satisfactory noting that the majority of sub-projects have been operating for less than one year. Evaluations have indicated that significant increases in use of modern contraceptive methods can be achieved by single-purpose, vertical family planning projects which do not offer other health care or development interventions. A list of all activities funded under the project is included in Annex J and a summary of the 1982 NGO Evaluation is included in Annex K.

Projections of NGO outputs by agency are included in Table 5. It should be emphasized that centrally funded NGO activities remain an important part of the total AID assistance package and we anticipate that central funds will remain at current levels during the period covered by this amendment, and that outputs for these centrally-funded programs will remain at 1982 levels or increase.

We plan to modify our original strategy for the amendment period to encourage expansion of NGO services in rural areas. Most district and sub-divisional towns now have effective coverage by NGO CBD programs and the majority of district headquarters are served by NGO clinics. While gaps in urban coverage remain they are usually in areas where NGO intermediaries have been unable to identify local implementing agencies.

The need to train large numbers of NGO project staff is a corollary of the expansion of quality family planning services through NGOs and all intermediaries have expressed the importance of staff development and training. A provision for training is generally included in individual grant agreements. Table 6 indicates the major categories of personnel employed in AID NGO family planning programs and the locus and adequacy of existing in-country training institutions. The table indicates that while satisfactory local institutions have developed to meet pre and in-service training needs for field and clinical personnel, in-country training for all levels of program and project managers remains inadequate. We plan to support a training needs assessment for intermediary and NGO management personnel, and to identify effective in-country training alternatives. In the interim, however, we will continue to support short-term third-country training, particularly at the ACPCD in Bangkok, and on a limited basis, short-term U.S. training for key program personnel.

A potential demand creation community participation project is the plan for several NGOs to design projects which serve to activate the recently reconstituted (on paper) "Population Control Committees." These committees have been formed at the village, union and thana level. The function of the NGOs would be to ensure that these committees are formed, to train the committee members on their role and function as prescribed by the Government and to assist them in promoting the Government's population control efforts. Some examples of activities these committees might undertake are birth and death registration, motivation of fieldworkers and prospective clients, and monitoring of fieldworker activities.

Since the acceptor reporting systems developed by individual NGOs do not always follow a standard format, comparative analysis among individual NGOs and between NGOs and the government program has been difficult. Accordingly, we are financing a technical assistance contract for the development of an appropriate NGO management information system to provide performance data on a continuing basis. We plan to continue the services of the consultant through the amendment period. This new system is expected to be implemented during 1984.

Individual NGO activities are summarized below.

a. <u>International Project of the Association for Voluntary Sterilization</u> FY 81-83: $3.7 million
FY 84-86: $6.0 million

BAVS is the Bangladesh affiliate of IPAVS. It has filled an important role as a national training resource, a major provider of high quality VS services and a leader in establishing ethical and medical standards for the national sterilization program. It has been responsible for introducing a new anesthesia technique into the national program which has significantly reduced anesthesia-related deaths and provides training for MOHPC physicians. The project provides support through IPAVS for the continued expansion of BAVS' service and training activities.

It was anticipated that, contingent on strengthening of BAVS' management capability, the number of clinics would be expanded from 24 to 48, and that BAVS would perform 150,000 VS procedures during the project period. The number of clinics, however, has not increased as rapidly as originally planned. Twenty-eight clinics are now fully operational, and BAVS is in the process of establishing 6 more clinics. (All BAVS clinics except for the Dhaka clinic are now supported from project funds.) The reduction in the number of clinics planned has been due to delays in obtaining MOHPC approval for new clinic sites and IPAVS belief that the number of new clinics planned was overly ambitious. However, BAVS performed a total of 133,072 procedures from April 1981 thru June 1983, indicating that the original project paper target for BAVS will be exceeded.

BAVS conducts training programs for the MOHPC on the new anesthesia technique, emergency management, counselling and sterilization procedures. BAVS has also established the government standard for patient screening, evaluation of pre-operative sedative regimens and post-operative care. Project funds have been used to support these efforts and the participation of MOHPC physicians in BAVS regional medical workshops and a BAVS-organized refresher program. IPAVS is working with the government to strengthen initial training of MOHPC physicians in VS procedures. IPAVS assistance to the BDG and other NGOs will continue to focus on improving medical quality and counselling through training activities.

IPAVS's broad program objective for the period 1984-1986 is to expand and improve VS services in Bangladesh with special emphasis on medical quality and counselling. IPAVS will improve BAVS's internal efficiency and cost-effectiveness through in-service training and staff development and increase clinical performance through improved outreach and IEC efforts. IPAVS also proposes to support two additional clinics each year from 1985 to 1987, for a total of 40 clinics serving district and sub-divisional towns by the end of 1987.

b. Family Planning Services and Training Center FY 81-83: $0.6 mill.
FY 84-86: $1.0 mill.

Funding for FPSTC which was incorporated into the MOHPC Grant Agreement supports efforts to expand technical and financial assistance to 20 new indigenous PVOs. FPSTC-funded projects generally provide CBD services, including clinical referrals, and involve the local leadership in building broad community support for family planning. FPSTC subgrantees tend to be relatively small, local-level organizations located in district and sub-divisional towns and with only a few exceptions are managed and staffed by women.

FPSTC appears to administer its program effectively, providing extensive training and technical assistance to these local agencies. Although implementation of this activity was initially delayed by difficulty in establishing funding procedures, 18 subprojects now have been started in addition to the 20 funded directly by FPIA. While service outputs in 1982 were limited, they have increased significantly in the first half of 1983. The pace of activity is expected to continue to increase steadily and the progress of this activity is now considered satisfactory.

FPSTC will continue to provide funds and technical assistance to local-level NGOs to expand community-level family planning services. FPSTC's emphasis during 1984 will be to consolidate its program under the USAID grant and to increase service outputs by expanding the coverage of established projects. FPSTC also proposes to initiate new projects in rural areas on a pilot basis in 1984 and to expand rural activities further in 1985 and 1986.

c. Bangladesh Family Planning Association FY 81-83: $0.7 million
FY 84-86: $1.2 million

BFPA's broad goal is to complement the national population program by promoting the small family norm through IEC efforts and providing innovative, cost-effective community-based family planning services. BFPA emphasizes collaborative projects with other NGOs currently working in sectors other than family planning.

The major activities supported under the project are two innovative, community-based service delivery programs. One utilizes traditional rural healers in ten thanas to distribute contraceptives and to make clinical referrals. The other utilizes volunteers from local-level clubs and voluntary agencies to provide CBD and referral services in their communities. A variety of organizations are included under this project, including youth clubs and women's groups. Both the healers and volunteers receive a small monthly travel allowance, but provide their time on a voluntary basis. These programs appear to be cost-effective and to provide significant levels of family planning services.

BFPA has also funded two IEC activities under the project grant. It has produced an excellent color film, Samadhan (The Decision), directed by a leading Bangladeshi commercial film director. The film, which has an entertaining story-line combined with a family planning message, is being shown by BFPA's mobile film units as well as by other NGOs. BFPA has also sponsored a series of seminars for local-level opinion leaders under the grant to promote broader community support for family planning.

During the amendment period, BFPA will further expand services provided by traditional healers and voluntary agencies, as well as continue IEC efforts including film production and family planning workshops for

village-level opinion leaders. BFPA also proposes to develop new service delivery initiatives; it is currently exploring the feasibility of working with women's cooperative groups as well as with outreach workers of the Gramin Bank, a rural credit institution.

d. The Pathfinder Fund FY 81-83: $1.4 million
FY 84-86: $1.9 million

The grant to Pathfinder supports the expansion of clinical services, services for industrial populations, and community-based projects in District and Sub-Divisional towns. Pathfinder has focussed on expanding its successful model for community-based family planning services, utilizing local women's organizations and municipal councils as implementing agencies. Implementation of their eighteen new activities was adversely affected in 1982 by long initial delays in obtaining necessary BDG clearances. Because the majority of Pathfinder project-funded activities were only recently started, significant increases in service outputs are not expected until FY 83-84.

Under this project amendment, Pathfinder proposes to expand community-based family planning service programs, with increased emphasis on community participation. Pathfinder will continue to work primarily with women's groups and municipal councils in urban areas, and to involve women in management and implementation of these programs. Pathfinder will also attempt to introduce interventions such as Mother's Clubs for family planning acceptors in its mature CBD projects to improve continuation rates, increase acceptance, and enhance the status of women in their communities. Pathfinder is currently exploring with the BDG the potential for collaborative projects to improve family planning performance in rural thanas in the BDG program. While Pathfinder has not initiated any new clinical programs to date, during the amendment period Pathfinder plans to expand clinical services for the industrial and plantation sectors, with special emphasis on popularizing vasectomy.

e. The Asia Foundation FY 81-83: $1.2 million
FY 84-86: $2.6 million

The project provides funds for expansion of the nine subproject activities initiated under the PVO Co-Financing grant to TAF. It was anticipated that TAF would integrate vertical community-based family planning activities into other community development efforts of indigenous PVOs. TAF currently supports eighteen subprojects with well-established local level community organizations in both urban and rural areas.

During the amendment period, TAF will initially consolidate its recent rapid expansion of subgrant activities and strengthen monitoring and evaluation systems. TAF focus in 1984 will be on expanding the scope of established projects and improving their efficiency, rather than on

initiating new programs. However, TAF anticipates further expansion of its program in 1985 and 1986, and will develop new projects providing community-based contraceptive and clinical services (excluding sterilization) in rural areas. TAF will also seek to identify and to introduce other interventions to increase demand for family planning services as well as to enhance continued acceptance.

f. Family Planning International Assistance FY 81-83: $0
FY 84-86: $2.4 million

FPIA is the international division of the Planned Parenthood Federation of America. It receives assistance from AID's Office of Population, and has provided project and commodity support with central grant funds for family planning activities in Bangladesh since 1972. FPIA is the only major U.S. population intermediary in Bangladesh which is not currently funded under the Family Planning Services project.

FPIA recently consolidated its Bangladesh program; it currently supports a few large-scale projects with national-level NGOs, including FPSTC, Concerned Women for Family Planning, and the International Union for Child Welfare which support family planning services in urban and rural areas and complement BDG efforts to meet existing demand for family planning.

FPIA will continue to support its ongoing programs in Bangladesh with funds from its AID central cooperative agreement. Funds under the project amendment will be utilized for new programs. FPIA proposes to develop two large-scale and five smaller scale service delivery projects in rural areas in collaboration with established, national organizations that will provide community-based contraceptive and clinical referral services complementary to the BDG program. FPIA also proposes to work with newly created union-level population control committees to strengthen grass roots support and supervision for the government program. We will support an in-country FPIA presence with project funds, in order to ensure effective monitoring and technical support for these new initiatives.

g. ICDDR,B FY 81-83: $1.1 million
FY 84-86: $1.3 million

This project with the International Center for Diarrheal Disease Research, Bangladesh (ICDDR,B) is testing two hypotheses. One which is being tested in Matlab thana is that MCH services when added to family planning services can increase the demand for family planning. The second which is being tested in two other thanas is that government fieldworkers, by using the so-called Matlab-approach, can also duplicate the Matlab-CPR.

Contraceptive use in Matlab thana, the ICDDR,B research area, was negligible when an AID centrally-funded family planning project was launched to test the hypothesis that comprehensive family planning services can initiate a fertility change in a rural Asian setting. By 1980, the project area had a contraceptive prevalence rate of 32 percent and fertility was reduced by 25 percent. Over the 1982-1983 period the Matlab thana project was modified so that more intensive MCH services were offered in some areas and Cu-T home insertions were offered in all areas. During this period, prevalence increased from 32 to 40 percent. Preliminary analysis shows, however, that the prevalence increases in this period are not explained by MCH interventions and are only partially explained by family planning services innovations. Analysts attribute the rising prevalence to a combination of factors related to a comprehensive retraining and reorientation of the field staff over the 1982-1983 period. This suggests that further operational improvements in an already fully developed service can increase prevalence -- in this case by almost 8 percentage points in two years. It also demonstrates that the demand for quality family planning services may exceed 35% of eligible couples.

In the extension portion of the experiment, three research approaches are used: diagnostic research of the government system to identify administrative problems; operations research to evaluate service delivery after the ICDDR,B-MOHPC collaborative work and to correct problems; and demographic work to assess impact. As part of the experiment the ICDDR,B has been providing the MOHPC with two types of assistance or "interventions": training and counterpart personnel. Training of government workers is now being carried out in comprehensive family planning, oral rehydration therapy and tetanus toxoid. The ICDDR,B counterpart personnel serve as "change agents" by assuming key supervisory roles that are missing in the government system.

Baseline data have been collected in four thanas and important information has been obtained concerning five critical areas -- the quantity of field work; the quality of field work; supplies and facilities; integration of health and family planning; and leadership, supervision and decision making. These data are used to plan further interventions and are expected to be utilized by the government.

If the ICDDR,B's extension project intervention successfully increases the CPR in the two experimental thanas, then the intervention will be expanded in 1985. Emphasis will be on transferring the service delivery component through training. It is also anticipated that training of change agents from the MOHPC and NGOs will take place during this phase to hasten the spread of this intervention.

h. BACE/Female Secondary Education Scholarships FY 82-83: $0.2 mill.
FY 84-86: $0.3 mill.

We are financing a pilot female secondary scholarship program with an indigenous NGO, the Bangladesh Association for Community Education (BACE). The rationale for supporting the project is the relationship between female secondary education and decrease fertility, and the underlying assumption that economic rather than social constraints impede increased female participation in secondary education.

The program provides scholarships to all girls who enroll in secondary schools in rural Shaharasti Thana, Comilla. Although scholarships have been provided only for the past eighteen months, preliminary enrollment statistics indicate that the scholarships have been associated with (1) a significant increase in Class VI enrollments in 1982 and 1983, and, therefore, greater continuation rates from primary to secondary school, (2) lower dropout rates during the academic year, and (3) higher continuation rates from one academic year to the next.

Continued support for this pilot activity may lead to follow-on activities; however, it is still too early to predict the next level of assistance.

i. CARE FY 81-83: $0.5 million
FY 84-86: $0.2 million

We are financing the Faculty Training Program for the existing twelve Family Welfare Visitors Training Institutes. At present less than half of the training positions at the institutes have been filled. The Faculty Training Program (under the auspices of NIPORT) is intended to initially train the 60-80 field trainers immediately required by the institutes and to establish a continuing program for the professional development of the FWVTI faculty.

CARE, under the AID grant, has been assisting NIPORT to develop an appropriate curriculum and conduct the initial six month training programs. The activity, which began in June 1981, was considerably delayed until NIPORT named a project officer and appointed faculty. To date, 16 trainers have completed the program and an additional 18 trainers are now enrolled. It now appears that the program is progressing. If the planned evaluation confirms the reports of progress and plans from CARE then we plan to extend the project by one year to complete the programmed training.

j. Family Health International/Bangladesh Fertility Research Program
FY 81-83: $0.1 million
FY 84-86: $0.1 million

Given the frequency and intensity of complaints about the AID-supplied NORIDAY oral contraceptive pill and the almost universal preference of Bangladeshi women (or at least their service providers) for Combination-5, USAID commissioned a double blind study (in which neither client nor service provider knew the brand of pill offered to the client) to determine whether reported side effects of NORIDAY are physiologically or psychologically based. If AID-supplied pills are physiologically inappropriate then the supply of these pills through the Social Marketing Project will be reconsidered. In addition, a new low-dose oral contraceptive is also being tested for suitability for Bangladeshi women. FHI, with AID assistance, has developed a protocol which the BFRP will implement in four centers. We have also agreed to fund approximately forty percent of the institutional costs of the BFRP in an effort to strengthen viable bio-medical research centers in Bangladesh.

III. Project Analyses

A. Technical Analysis: Project Targets

The original Family Planning Services Project was expected to increase the Bangladesh contraceptive prevalence rate from 13.6% of currently married women (using both traditional and modern methods) in 1979 to 25% (using only modern methods) in 1983. It is now evident, however, that project targets were too ambitious and based on an inadequate database.

The project paper projected a national CPR of 25% modern method use by the end of FY 1983 to be measured by yearly national contraceptive prevalence surveys. The 1981 CPS measured modern method use at 11% during the summer of 1981 and the very preliminary results of the 1983 CPS, combined with data from the baseline PSI mass media survey, indicate the CPR to be about 15% modern method use at the end of CY 1983. This rate is considerably below that projected in the project paper.

Prevalence by implementing agency was to be derived from MIS service statistics because accurate prevalence rates by source of supply can not be obtained from a national prevalence survey. Table 7 gives the planned and actual prevalence by implementing agency derived from MIS service statistics. The sum of the planned amounts in column 1 exceeds the project goal of 25% because MIS service statistics, which are based on a combination of distribution and performance figures, tend to give higher estimates of contraceptive use, particularly of condoms. Column 2 indicates prevalence as of June 1983. This amount, 19%, falls far short of the overall projected total, 30%. The table serves to underscore the differential achievement of target by implementing agency. The SMP, for example, far exceeded its projected condom prevalance targets, while the MOHPC fell far short in its non-clinical program. Interpretation of the prevalence attributable to NGOs is more problemmatical. Data provided by USAID-funded NGOs indicate a 2.3% prevalence by June 1983. The MIS service statistics indicate only 2.4% overall attributable to NGOs. As non-USAID funded NGOs must contribute more than 0.1% , this finding provides further evidence that MIS service statistics seriously under-report the contributon of the NGOs.

In addition, regardless of the numerical level of project targets and outputs, the project implementation schedule proposed an accelerated pace for project activities which could not be attained. The project, which was expected to begin in November 1980, actually did not begin until June 1981. The latest tranche of the MOHPC grant was obligated in June of FY 1983 and is expected to continue present activities through September 1984. Accordingly, as of June 1983, only two years of activity actually had been completed and the project was nine months behind schedule.

The purpose of this project amendment is to increase contraceptive prevalence of modern methods to 28% by December 1987, from an estimated 15% in December 1983. The proportion of traditional method use is difficult to estimate. We will assume that the 1983 rate of about 4% continues. If this is true, then the overall prevalence may be about 32% by December 1987.

Table 8 presents our projected prevalence rates (based on a series of assumptions) to be measured by independent contraceptive prevalence surveys. Annex M contains the assumptions and calculations from planned outputs. The projections are made to 1987, the period of time when project inputs will be utilized.

We expect a slight increase in prevalence of oral pills because of the increased supply of the more acceptable Combination-5 and the wide expansion of our NGO CBD projects. Also, the SMP's new low-dose product and new marketing strategy are showing large sales increases. The condom prevalence is problemmatic. Based on our inputs and projected use we would expect it to rise to almost 10% by 1986. However, as the measurement tool will be an independent CPS, we have lowered the projected condom prevalence. This is because we have evidence from an independent study we commissioned through PSI that women, particularly rural women, underreport condom use. In this study, four categories of respondents were interviewed: eligible women, couples (both husbands and wives interviewd separately), and husbands of non-interviewed eligible women. The sample was drawn from urban and rural areas where there would be a higher probability of finding condom users. In the urban sample, there was remarkable congruity among the four categories of respondents, with about 30 percent of each group reporting current condom use. In the rural sample, there were discrepancies, with eligible women (the resondents of national contraceptive prevalence surveys) reporting the lowest current use of condoms. (Condom prevalence was found to be 2.8% among the eligible women; 4.5% among the wives of the couple-sample; 7.0% among the husbands of the couple sample; and 4.1% among the husbands of non-interviewed eligible women.) Due to the select nature of the sample, these results cannot be used to estimate national prevalence or to compare with results of prior CPS's. They do indicate, however, that the methodological approach of the CPS may result in underreporting of certain methods, particularly condoms. The design of the 1983 CPS has been modified to include a subsample of husbands of non-interviewed eligible women and couples (husband-wives) to obtain more data about possible underreporting and to obtain national prevalence estimates. For the prevalence projection in Table 8, we have adjusted the condom rates proportionately downward to ensure comparability with past surveys which have interviewed only female respondents. See Annex M for the condom prevalence we expect from service statistics and the adjustments made.

The BDG targets for contraceptive prevalence of the Second Five Year Plan (as revised in May 1982) are given in Table 9. These are stated according to the July-June BDG fiscal year. We will assume the contraceptive prevalence is that of the end of the FY year in June. Thus, the comparison of BDG and USAID targets given in Table 9 has a six month gap.

This Table highlights the overly ambitious BDG targets. Although both USAID and the BDG attribute the highest proportion of prevalence to VS, the BDG objective seems far too ambitious given present program progress. The BDG oral pill target is also seriously overstated since pill use has generally stagnated in recent years. The BDG condom prevalence projections may be possible. Interestingly, USAID, based on data from past CPSs, has projected more traditional method use. Overall, the BDG and USAID targets diverge with the discrepancy increasing over time. We understand that the BDG intends to lower these targets in the Third Five Year Plan to achieve an NRR of 2 rather than of 1 by 1990 (approximately 35% CPR).

Progress by method in terms of implementing agency will be derived from MIS service statistics and data supplied by USAID-funded NGOs. Decrement tables will be used to estimate the number of active users of VS and IUD. Standard CYP assumptions (unadjusted for agency efficiency) will be used to estimate users of non-clinical methods. The estimate of the denominator, the number of eligible couples, is taken from Table M-1. Based on the planned outputs by agency, we estimate the following prevalence by method:

Agency/Method	December 1986	December 1987
1. BDG (MOHPC plus other ministries and some NGOs)		
Sterilizations	11.2%	12.7%
Oral Pills	2.3%	2.3%
Condoms	1.4%	1.4%
IUD & Other	2.4%	3.2%
(Sub-total)	(17.6%)	(19.6%)
2. SMP		
Condoms	8.7%	10.0%
Oral Pills	0.9%	1.0%
Other	0.4%	0.5%
(Sub-total)	(10.0%)	(11.5%)
3. NGOs (USAID-funded)		
All Methods	5.0%	6.1%
4. Total CPR (derived)	32.6%	37.2%
5. Estimate of Eligible Couples	19.6 million	20.0 million

N.B, the CPR (derived) for 1986 and 1987 exceed the project goals because, in Bangladesh, service statistics tend to give a higher estimate of contraceptive use, particularly for condoms than independent surveys of eligible women.

B. Financial Analysis & Plan

A summary cost estimate and financial plan is given in Table 10. The costing of outputs is given in Annex H, Input-Output Tables. Estimated project costs of $81 million are to be financed from the AID grant and disbursed over a three year period. N.B, $4.6 million of this amount already has been authorized. Actual FY 81-83 obligations and projected FY 84-86 obligations are given in Tables 11 and 12.

A relatively large pipeline is required for the NGO program due to the long delay between USAID obligations to actual expenditures by subprojects. Grant funds are normally obligated to NGOs mid-way through each fiscal year. The Grantees then subobligate these funds with indigenous PVOs for activities during the following twelve month period. Individual indigenous NGOs subsequently expend these funds over the life of their projects, usually twelve months. It is therefore expected that FY 83 funds, which were obligated in the latter part of the fiscal year following receipt of allotments, will continue to be expended by subprojects through the first half of CY 1985.

The funding mechanism described above requires that NGO financial requirements under the project be estimated on the basis of projected annual expenditures, as well as projected annual subobligations. The NGO pipeline at any given time includes (i) funds that have been committed for approved, ongoing subgrants but have not yet been fully expended and (ii) uncommitted and/or unprogrammed funds. The NGOs require a certain pipeline of these uncommitted funds in order to make new commitments to continue ongoing subprojects as well as to initiate new subprojects to expand the program. As the program expands, a larger pipeline becomes necessary. The estimated obligation and pipeline levels are necessary for prudent project management. To reduce either would negatively affect project implementation.

C. Social Analysis

The social imperatives and ramifications of this project have been adequately discussed in this and the original project paper. It should be under-scored, however, that while the cultural norm in Bangladesh -- typical of traditional, agrarian and economically insecure societies -- is to have many children, there appear to be few compelling cultural impediments (either Bengali or Islamic) to accepting the principle of family planning. As noted above, an estimated 35 to 40% of all eligible couples are willing to adopt modern contraceptive measures provided that they are regularly and readily available.

In terms of beneficiaries, the project has a direct positive impact on women. There is an important dual relationship between the status of women and fertility. Since women who bear and raise many children suffer from poorer health and are generally precluded from employment, our family planning activities clearly promote our cross-sectoral Women in Development objective of improving the physical quality of life of Bangladesh women. At the same time development activities which support and sustain improved status, mobility and economic opportunities for women can have a dramatic long-term impact on fertility reduction in Bangladesh. The Family Planning Services Project recognizes this dual relationship primarily by helping eligible couples (particularly the women members) to have greater control over their fertility but also by testing a potentially important demand creation initiative -- female education (see Section II) -- which directly improves the status of women. Further, since family planning fieldworkers are women, a significant secondary impact of the project has been the development of important role models -- respected women who work and earn money outside of the home.

AID NGO family planning programs in Bangladesh also have played an important role in strengthening a large number of local women's organizations employing a significant number of women in visible management positions. The CBD programs also provide employment as fieldworkers to a large number of women, many of whom have not previous employment history. These projects represent an important opportunity for involving women in planning and implementation of programs that provide services to other Bangladeshi women. We will actively encourage intermediaries to increase, to the extent possible, the numbers of women managers in NGO projects.

D. Economic Analysis

In the original project, the cost-effectiveness criterion that was used to compare alternative programs was the "cost per continuous user" criterion. The total family planning program costs from all sources were divided into four major components: Sterilization; BDG services other than sterilization; Social Marketing Project; and other NGO services. Once annual costs by component had been derived, they were compared with annual contraceptive usage by component to derive annual cost per continuous user.

For the amendment, an alternative cost-effectiveness criterion will be employed to demonstrate the relative position of program components vis-a-vis each other with the components being defined in terms of the following organizational categories: (i) Social Marketing Project, (ii) USAID-funded NGO's, and (iii) a "residual" category encompassing the Bangladesh Government and non-USAID funded NGO's. The residual category is used chiefly because incomplete information prevents a more disaggregated analysis.

The "new" cost-effectiveness criterion that we have used is the "cost per total couple years of protection criterion." The procedure for estimating CYP's essentially consists of using the standard CYP measures for non-clinical methods (e.g, one CYP equals 100 condoms, 13 cycles of oral contraceptives). For clinical methods, the measure was modified to include protection provided in the future. Based on available data, an IUD insertion was estimated to provide 2.45 CYP and a sterilization 7.75 CYP. To distinguish this approach which attributes benefits to the future from the standard methodology, the CYP calculated in this analysis are labelled "Total Couple Years of Protection" or TCYP. The following table gives us the final figures for comparison between the three components:

1) USAID-funded NGOs --	
Estimated adjusted* cost	$4,180,963**
Estimated TCYP	692,885
Cost per TCYP	$6.04
2) Social Marketing Program --	
Estimated adjusted cost	$5,143,028
Estimated TCYP	804,826
Cost per TCYP	$ 6.39
3) Residual --	
Estimated adjusted cost	$43,390,941
Estimated TCYP	3,601,988
Cost per TCYP	$12.05

*Taking account of current costs borne by the government and imputed to NGOs.
**All figures are in current dollars.

It is clear from the above that, with reference to the cost per TCYP criterion, both the NGO and SMP approaches to family planning are more cost effective than the Residual Program which consists primarily of the government program. The table further indicates that the AID-funded NGOs and the SMP are, on cost per TCYP basis, roughly 50% more efficient as the residual. It should be noted, however, that there may be a tendency for NGOs to work in easier areas than the government programs do and/or to effectively draw off clients who otherwise would have used services provided through the government program. It also should be noted that there is a wide variation in cost per TCYP within NGOs. However, due to different durations of NGO activities, cross-referrals and widely different mix of types of FP activities undertaken by the individual NGOs, a strict comparison between NGOs may be premature, as discussed more fully in Annex N.

We may take our analysis a bit further into a cost-benefit type framework as follows: if one of the aims of a development strategy is to increase per capita income, then we could compare the per capita income effect of an increase in capital stock (i.e., an investment) with the per capita income effect of an expenditure in a family planning program that reduces the rate of growth of the population. Using this (admittedly crude) premise, it is shown in Annex N that the benefits of family planning interventions in Bangladesh are equivalent to $50 per CYP.

Thus, for those family planning interventions that have a temporary impact only (e.g, pills and condoms), the benefit of providing services to a couple for a year is $50. For those interventions that also have an impact in the future (e.g, sterilizations and IUD insertions), the calculation is more complicated. Using a 15% discount rate to assess the present discounted value of future couple years of protection yields a calculated benefit of $222 per sterilization and $91 per IUD insertion. These benefits are all well in excess of the costs of even the least cost-effective elements of the family planning program in Bangladesh.

E. Administrative Analysis

The implementing organizations and their capabilities are discussed in Section VI (Implementing Agencies) and the following other sections:

MOHPC:	Sections II & III
SMP:	Section III
Other NGO's:	Section III

IV. Implementation Plan

A. Implementation Agencies

As noted above, the project will continue to follow the implementation procedures established in the original project paper: The Population Control Wing of the Ministry of Health and Population Control will administer its component, PSI through the SMP will administer its component and various intermediary NGOs will administer the non-governmental sub-projects. In addition, a number of appropriate non-governmental research organizations will be identified to undertake demand creation studies, operations research and national contraceptive prevalence surveys.

B. Monitoring Plan

Monitoring will continue to be performed by USAID staff who will be in frequent, if not daily, contact with MOHPC officials, NGO representatives and short-term advisors. In addition, a public health physician, an NGO coordinator, a research/evaluation advisor and logistics advisor are responsible for providing full-time project assistance:

1. MOHPC performance will be measured by MIS services statistics and the logistics reporting system. In addition, the Voluntary Sterilization Surveillance Team forwards their monthly reports. An independent chartered accounting firm will conduct a yearly inventory of project supplies at the district, thana and fieldworker level. Similarly chartered accounting firms will conduct four quarterly audits per year of the VS program and an annual audit of the Awards program.

2. SMP performance will be measured by quantitative data supplied from SMP sales reports and MIS service statistics.

3. NGO performance will be measured by routine progress reports, the improved USAID NGO-MIS (see Section III) and MIS service statistics.

C. Implementation Schedule

See Annex O.

D. Evaluation Plan

Evaluations are planned for the three major project programs (MOHPC, SMP and NGOs) as well as for the overall project progress. The type, timing and mechanisms of these evaluations are discussed below.

1. MOHPC

a. Reimbursements and Awards

A yearly evaluation of the IUD reimbursement program will be conducted. The fieldwork for the first evaluation will commence in early CY 1984. If an injectable reimbursement program is approved by the National Council for Population Control, its evaluation will be added to the yearly IUD evaluation. USAID will contract for an independent yearly evaluation of the Awards Program commencing in 1985 after the program has been operating for one year. USAID also expects to contract for an audit to be conducted of the proposed award recipients activities prior to disbursing funds for the program. The VS chartered accounting firm quarterly audits will continue.

b. Management Capability

In November-December 1983, a management needs assessment of the Ministry of Health and Population Control's family planning program was conducted to identify institution building inputs and factors to be addressed through policy dialogue with the Government of Bangladesh. The report is now in process. The outcome of the policy dialogue conducted during the three year amendment period will impinge directly on the development of the follow-on FY 87-90 project.

c. Overall

USAID will contract with a five to six member team to conduct an overall, comprehensive evaluation of USAID's support to the BDG program. The team will include at least two senior BDG, preferably MOHPC officials. The evaluation should be conducted in the winter or spring of FY 1986. The final report should contain recommendations for the completion of the FPS project and for the design of the follow-on FY 87-90 project.

USAID also plans to be involved in the IBRD appraisal team in January, 1984. This team will be reviewing the total National Population Control Program and conducting a needs assessment which will identify necessary government and all donor inputs for the period 1985-1990.

2. Social Marketing Project

An external evaluation will be scheduled for the summer of 1985. In addition, the research/evaluation PSC will assist in designing and analysing various studies conducted by the contractor, PSI, in conjunction with the SMP program.

3. Non Government Organizations

a. Internal Evaluation

Data on performance and costs have been gathered from each intermediary for FY 82 and 83. In FY 84 USAID will evaluate the data collection and evaluation systems currently used by each NGO grantee; review the existing data on performance and cost-effectiveness; and design a data collection system to measure, in a uniform manner, the performance and cost effectiveness of the USAID-funded NGO grantees on an annual and on-going basis. This system will utilize the micro-computer to be installed in the P&H Division in FY 84.

b. External Evaluation

USAID will contract for a two-person team to evaluate the overall direction and strategy of USAID's NGO program. The team will also assess actual versus planned performance and make recommendations for improvements. This evaluation will conducted in the winter or spring of FY 86.

In addition, several special studies will also be conducted in FY 84. The Pathfinder Fund will conduct mini-contraceptive prevalence surveys in project areas with high contraceptive prevalence reported from their project records. In FY 85, a comprehensive evaluation of the impact of BACE's secondary education scholarship program for females will be conducted.

4. Overall Project

The project purpose will be measured by independent contraceptive prevalence surveys in late CY 83, CY 85 and CY 87.

Table 1

Comparative CPR (Survey) Data: Percentage of Currently Married Women Under 50 Years of Age Using Contraception by Method in 1975, 1979, 1981 and 1983 (Estimate)

Method	BFS[1] 1975	CPS Year 1979[2]	1981[3]	1983[4]
Modern Methods[5]				
Oral Pill	2.7	3.6	3.5	3.5
Condom	0.7	1.5	1.6	1.9
IUD	0.5	0.2	0.4	0.9
Tubectomy	0.3	2.4	4.0	6.5
Vasectomy	0.5	0.9	0.8	1.7
Injection	-	0.2	0.4	0.3
Vaginal Method	.a	0.1	0.3	0.3
(Subtotal)	(4.7%)	(8.9%)	(11.0%	(15.0%)
Traditional Methods				
Abstinence	1.1	0.8	1.2	0.3
Safe Period	1.0	2.2	3.9	1.7
Withdrawal	0.6	0.2	1.8	1.2
Other	0.3	0.6	0.7	1.0
(Subtotal)	(3.0%)	(3.8%)	(7.6%)	(4.2%)
Total CPR	7.7%	12.7%	18.6%	19.2%

[1]Source: Bangladesh Fertility Survey (BFS), 1975. Data derived from Table 2.4.5 and Table 4.4.1.

[2]Source: 1979 National Contraceptive Prevalence Survey (CPS).

[3]Source: 1981 National Contraceptive Prevalence Survey (CPS).

[4]Source: Very preliminary results of the 1983 National Contraceptive Prevalence Survey combined with final results of PSI's baseline mass media survey.

[5]The proportion of use of nonpermanent modern methods has decreased from 83% in 1975 to 63% in 1979 to 56 percent in 1981 to 45% in 1983 (estimate). Conversely, the proportion of users using sterilization has increased from 17% in 1975 to 55% (estimate) in 1983.

[a]This method is included in 'other'.

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Table 2

Estimated Active Users by Method and by BDG Ministries, SMP and NGO from CY 1981, CY 1982 and January-June 1983 Source: MIS Service Statistics and USAID Decrement Tables

Method	1981 (Midyear EC = 17.2 million) BDG (in 000)	SMP (in 000)	NGO (in 000)	Total (in 000)	1982 (Midyear EC = 17.6 million) BDG (in 000)	SMP (in 000)	NGO (in 000)	Total (in 000)	1983 (Mid Semester EC = 18.0 million) BDG (in 000)	SMP (in 000)	NGO (in 000)	Total (in 000)
Vasectomy[1]	186	-	30	216	235	-	66	301	249	-	74	323
Tubectomy[1]	482	-	115	597	692	-	169	861	781	-	190	971
Condom	365	512	56	933	359	635	34	1078	325	783	51	1159
Oral Pill	504	73	50	627	482	85	55	622	453	139	69	661
IUD[1]	100	-	5	105	142	-	11	153	164	-	19	183
Injectable	13	-	9	22	3	-	13	16	6	-	18	24
Foam	10	-	3	13	12	-	1	13	13	-	1	14
Foam Tablet	3	43	-	46	6	35	-	41	15	45	-	60
Total	1005	628	268	2561	1931	805	349	3085	2006	967	422	3395
% of EC (Prevalence)	9.7	3.6	1.6	14.9	10.9	4.6	2.0	17.5	11.1	5.4	2.4	18.9
% of Total	65.1	24.2	10.7	100.0	62.3	26.3	11.4	100.0	58.7	28.6	12.7	100.0

[1]Number of active users at the end of year for Vasectomy, Tubectomy, and IUD for 1981 and 1982 end of June for 1983.

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Table 3

Approved Voluntary Sterilization Reimbursements and Compensation Rates for the FY 81-83 and FY 84-85 Periods (in Taka)

Item	FY 81-83		FY 84-85	
	Vasectomy	Tubectomy	Vasectomy	Tubectomy
Service Providers				
Doctor's fees	18	18	20	20
Supporting clinic staff	8	10	15	15
Client Reimbursements				
Food Cost	16	48	175	175
Wage loss	50	25		
Transportation	30	35		
Referral Fees				
MOHPC Fieldworker compensation for non routine services	10	10	15	15
Surgical Apparel				
Saree/lungi	25	50	To be based on current market retail value	

Table 4

Total Sterilization Performance by Month and Year from 1979 to Latest Available Month, Source: MIS Service Statistics

Month	1979	1980[1]	1981[1]	1982	1983
January	3,352	19,717	22,282	22,266	29,702
February	2,429	26,710	27,234	33,644	35,274
March	8,767	24,596	20,908	38,111	36,861
April	8,388	14,161	23,358	36,926	24,364
May	10,200	2,711	22,624	35,555	22,472
June	11,688	8,275	19,570	34,019	15,922
July	14,088	14,909	10,383	21,001	16,223
August	5,793	[a]	16,744	27,974	24,022
September	15,890	17,390	17,731	37,028	31,098
October	23,028	27,769	28,953	54,684	62,399[b]
November	17,480	23,654	27,696	30,775	70,612[b]
December	14,688	16,102	15,308	22,256	37,099[b]
Total	135,791	195,994	252,791	394,239	406,048[b]

[1] From September 1980 through December 1981, the performance is based on the middle of the month to the middle of the next month.

[a] The performance for August 1 through September 15 was 17,390.

[b] October-December 1983 performance results received as project paper was being finalized. They are not incorporated in the text.

Table 5

Summary of USAID-Funded NGO Service Delivery Projected Outputs by Year

		IPAVS	FPSTC	BFPA	Pathfinder	TAF	FPIA	Total
Year-end Active Users (Temporary Methods)								
July-December -	1983	-	21,000	40,000	44,000	60,000	-	165,000
CY	1984	-	35,000	60,000	93,000	120,000	3,000	311,000
CY	1985	-	49,000	80,000	124,000	180,000	30,000	463,000
CY	1986	-	60,000	100,000	160,000	220,000	58,000	598,000
CY	1987		70,000	110,000	175,000	230,000	100,000	685,000
CYP (Temporary Methods):								
July-December -	1983	-	16,000	30,000	30,000	45,000	-	121,000
CY	1984	-	28,000	45,000	69,000	90,000	1,000	233,000
CY	1985	-	42,500	60,000	108,000	150,000	16,000	376,500
CY	1986	-	55,000	75,000	142,000	200,000	44,000	516,000
CY	1987		65,000	105,000	167,500	225,000	80,000	642,500
VS Referred:								
July-December -	1983	-	1,824	4,000	2,200	3,028	-	11,052
CY	1984	-	3,960	8,000	9,200	6,000	500	27,660
CY	1985	-	4,524	10,000	9,200	8,500	4,500	36,724
CY	1986	-	4,800	15,000	10,700	10,000	9,100	49,600
CY	1987		5,000	17,500	12,000	12,000	12,000	58,500
VS Performed								
July-December -	1983	33,600	-	-	-	-	-	33,600
CY	1984	82,000	-	-	9,600	-	-	91,600
CY	1985	95,000	-	-	14,400	-	-	109,400
CY	1986	110,000	-	-	19,200	-	-	129,200
CY	1987	120,000			21,000			141,000

Table 6

Status of In-Country Training for Categories of NGO Personnel.

Training Needs/Staff Category	Local Institutions Providing Training	Assessment of Locally Available Training	Recommendations
A. Management - intermediary program staff - national NGO managers - field/local-level NGO managers	Institute of Business Administration (IBA)-Center for Population Management and Research (CPMR); Bangladesh Management Development Center(BDMC); Village Education Resources Center (VERC); Agricultural Development Agencies in Bangladesh (ADAB); Concerned Women for Family Planning (CWFP); Family Planning Services and Training Center (FPSTC)	Appropriate in quality and sophistication for field-level managers only; inadequate for intermediary staff and national-level managers. Capacity severely constrained by sporadic availability of courses and extensive involvement of most training institutions outside the population sector.	Conduct training for field-level managers in-country with limited third-country training; continue third-country and limited U.S. training for national-level and intermediary program managers. In long-term, develop local capability to conduct higher-level management training in-country.
B. Clinical (Voluntary Sterilization) - physicians - nurses/paramedics - counsellors	BAVS National Training Center; Mohammedpur Fertility Services and Training Center	BAVS meets own internal clinical training needs and together with Mohammedpur Clinic has limited capacity to provide quality training to BDG and other agency personnel. BAVS proposes to further improve training and expand capacity during project add-on period.	Continue to conduct virtually all clinical training in-country thru BAVS with limited exceptions (e.g., third country observation tours for BAVS senior physicians and trainers); assist BAVS in strengthening training and expanding capacity.
C. Community-Based Distribution (CBD) - field workers - field supervisors	Concerned Women for Family Planning(CWFP); Bangladesh Family Planning Association (BFPA); Christian Health Care Project (CHCP); Family Planning Services and Training Center (FPSTC); National Institute Pop.Research and Training NIPORT/MOHPC District Training Teams.	Significant progress over past two years in institutionalizing training to meet field-level needs; training resources are satisfactory in quality and adequate to meet demand. Training can be further improved.	Continue to conduct training in-country; strengthen existing institutions through technical assistance, training of trainers, inventory and development of training materials, etc.
Family Welfare Visitors(FWV)/ paramedics	Family Welfare Visitors Training Institutes; Nursing Schools; Kumudini Hospital; Gonoshastho Kendro.	Skilled paramedics require long-term training; FWVTIs provide 18 mos. training and guarantee employment with MOHPC. Other agencies meet internal needs only. There is therefore a shortage of skilled paramedics available for employment in NGO CBD projects.	Explore possibility for conducting special three-month courses at FWVTIs and other agencies to train paramedics for NGO CBD programs in IUD, and injectable services.

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Table 7

Planned and Actual Prevalence of Contraceptive Use by Implementing Agency and Method Derived from MIS Service Statistics

Implementing Agency / Method	Table IV of Project Paper September 1983	MIS Service Statistics June 1983
BDG		
Sterilization	9.7%	5.7%
Oral Pills	5.7	2.5
Condoms	4.0	1.8
IUD and other	0.5	1.1
(Subtotal)	(19.9%)	(11.1%)
SMP		
Condoms	2.8	4.4
Oral Pills	1.2	0.8
Other	0.6	0.2
(Subtotal)	(4.6%)	(5.4%)
NGO		
All Methods	5.7%	2.4%[b]
Total CPR (derived)	30.2%[a]	18.9%
Estimate of eligible couples/(MWRA)	17,381,983	18,000,000[c]

[a]The sum exceeds the project goal of 25% prevalence because MIS service statistics, which are based on a combination of distribution and performance figures, tend to give higher estimates of contraceptive use, particularly of condoms, than do independent contraceptive prevalence surveys.

[b]From USAID-funded NGO data, the amount of prevalence attributable to their performance is 2.3%. It is evident that MIS Service Statistics underreport NGO performance.

[c]Revised estimate of eligible couples based on 1981 census results. (The project paper refers to married women of reproductive age, MWRA, which is the same measure)

Table 8

Contraceptive Prevalence Rate (Survey) Estimates for Project Paper Amendment Period

Method	December 1983	December 1984	December 1985	December 1986	December 1987
Oral Pill	3.5%	3.6%	3.9%	4.3%	4.7%
Condom[a]	1.9	2.3	2.7	3.2	3.6
IUD	0.9	1.0	1.8	2.6	3.3
Vasectomy	1.7	2.2	2.8	3.3	3.9
Tubectomy	6.5	7.7	8.9	10.3	11.7
Injectable	0.3	0.4	0.5	0.6	0.7
Emko/foam tablet	0.3	0.3	0.3	0.3	0.3
Modern Methods	15.1%	17.5%	20.9%	24.6%	28.2%
Traditional Methods[b]	4.2%	4.2	4.2%	4.2	4.2
Total	19.3%	21.7%	25.1%	28.8%	32.4%

[a]Using estimated distribution data, unadjusted for less efficient BDG condom distribution, we would expect 6.8% in 1983, 8.0% in 1984, 9.2% in 1985, 10.7% in 1986 and 12.1% in 1986. Adjusting for the less efficient BDG program, we would expect 6.0% in 1983, 7.3% in 1984, 8.5% in 1985, 10.0% in 1986, and 11.4% in 1987.

[b]We will assume that traditional method use remains at about 4 percent. It may decrease as more couples choose modern methods. However, at the same time, more couples may be becoming interested in child spacing/limitation and utilise traditional methods until they are motivated to use more effective methods.

Table 9

Comparison of BDG and USAID Contraceptive Prevalence Targets for 1983-1985

	BDG[1] June 1983	USAID[2] Dec. 1983	BDG[1] June 1984	USAID[2] Dec. 1984	BDG[1] June 1985	USAID[2] Dec. 1985
Estimated Contraceptive Prevalence (difference)	28.4 (9.2)	19.2	33.0 (11.3)	21.7	37.5 (12.4)	25.1
Prevalence by Method:						
Sterilization	9.9	8.2	12.9	9.9	16.1	11.7
Oral Pill	8.8	3.5	9.2	3.6	9.4	3.9
Condom	6.0	1.9	6.6	2.3	6.8	2.7
IUD	2.0	0.9	2.3	1.0	3.0	1.8
Total	26.7	14.5	31.0	16.8	35.3	20.1
Other Methods[3]	1.7	4.8	2.0	4.9	2.2	5.0

[1]BDG prevalence rates derived from Revision of Section XVII-32, Tables 17.3 and 17.4 issued by the Planning Commission in May 1982

[2]Taken from Table 8

[3]Other methods include traditional methods (withdrawal, rhythm, abstinence), Emko/foam tablet, injectables and MR (for the BDG).

Table 10

Financial Plan: Pipeline Analysis (in 000s of US Dollars)

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Component	Pipeline on 6/30/83	FY 84 Planned Obligation	1/4 FY 83+ FY 84 Est. Expenditure	Projected Pipeline on 9/30/84	FY 85 Planned Obligation	FY 85 Planned Expenditure
A. MIUPC Grant						
1. Funded Activities						
a. Reimbursements - Voluntary Sterilization	6,752	2,495	5,288	3,959	5,123	5,278
- IUD/Injectables	456	710	602	564	1,132	864
b. Demand Creation (Awards)	-	1,033	1,033	0	1,179	1,179
c. Contraceptive Prevalence Surveys	128	50	0	178	0	150
d. FPSTC	522	200	255	467	400	300
2. Pipeline Funds from FY 81-83						
a. Technical Resources, Training, and Research	1,308 (+508)[a]	0	436	1,452	0	541
b. Medical Kits, Clinic Supplies, Contraceptive Commodities	(3,792)[b]	0	935	2,857	0	1,139
Subtotal	13,538	4,488	8,549	9,477	7,834	9,451

	Projected Pipeline on 9/30/85	FY 86 Planned Obligation	FY 86 Planned Expenditure	Projected Pipeline on 9/30/86	Remarks (LC=Local currency FE=Foreign Exchange)
A. (Contd)					
1.					
a.	3,804	3,010	5,072	1,742	(LC) 20% reduction on BIG FY 84/85; 40% in BIG FY85/86; 50% in BIG FY86/87; and 60% in BIG FY87/88.
	832	1,258	1,110	980	(LC) Four month pipeline on 9/30/86.
b.	0	1,299	1,299	0	(LC)
c.	28	185	50	163	(LC)
d.	567	400	400	567	(LC)
2.					
a.	911	0	504	407	(FE/LC)( )[a] Reprogrammed from Commodities
b.	1,718	0	1,300	418	(FE) ( )[b] Amount reduced by ( )[a]
Subtotal	7,860	6,152	9,735	4,277	

Table (Continued)

Financial Plan: Pipeline Analysis (in 000s of US Dollars)

BEST AVAILABLE DOCUMENT

Component	Pipeline on 6/30/83	FY 84 Planned Obligation	1/4 FY 83+ FY 84 Est. Expenditure	Projected Pipeline on 9/30/84	FY 85 Planned Obligation	FY 85 Planned Expenditure
B. PSI/SMP Contract	4,076	6,697	4,993	5,780	3,647	4,550
C. NGO Grants/Contracts						
1. IPAVS	2,205	2,500	1,650	3,055	1,300	1,900
2. The Pathfinder Fund	1,014	200	539	675	800	600
3. The Asia Foundation	1,117	700	820	997	900	865
4. BIPA	478	250	278	450	500	400
5. ICDDR,B	475	1,000	800	675	300	602
6. CARE	226	225	291	160	0	160
7. RACE	100	80	90	90	100	100
8. HII/BFRP	69	21	50	40	40	45
9. 1983 CPS/PSC's/Evaluators	255	780	193	842	105	390
10. IPIA	-	600	50	550	800	400
11. Demand Creation	-	-	-	-	500	100
Subtotal	5,939	6,356	4,761	7,534	5,345	5,562

(Contd.)	Projected Pipeline on 9/30/85	FY 86 Planned Obligation	FY 86 Planned Expenditure	Projected Pipeline on 9/30/86	Remarks (LC = Local Currency (FE = Foreign Exchange)
B.	4,877	3,161	4,500	3,538	Two year funding in FY 84 (FE/LC)
C.					
1.	2,455	2,200	2,200	2,455	(FE)
2.	875	900	800	975	(FE)
3.	1,032	1,000	900	1,132	(FE)
4.	550	500	500	550	(LC) Expansion of project, direct funding to Population Council for technical assistance.
5.	373	0	373	0	(FE)
6.	0	0	0	0	(FE)
7.	90	100	90	100	(LC)
8.	35	0	20	15	(FE)
9.	557	390	390	557	(FE/LC) Including MD, Logistics and Research/Evaluation Advisor. Two year funds in FY 83, 1 year in FY 86
10.	950	1,000	800	1,150	(FE)
11.	400	250	300	350	(FE/LC) Super NGO working with BDG thana, union/village committees
Subtotal	7,317	6,340	6,373	7,284	

Table (Continued)

Financial Plan: Pipeline Analysis (in 000s of US dollars)

BEST AVAILABLE DOCUMENT

Component	Pipeline on 6/30/83	FY 84 Planned Obligation	1/4 FY 83 FY 84 Est. Expenditure	Projected Pipeline on 9/30/84	FY 85 Planned Obligation	FY 85 Planned Expenditure
D. Centrally Procured Commodities						
1. MHPC						
- Condoms	0	333	333	0	2,006	2,006
2. SHP						
- Condoms	0	7,832	7,832	0	7,812	7,812
- Oral Contraceptives	0	294	294	0	356	356
Subtotal	0	8,459	8,459	0	10,174	10,174
E. Grand Total						
MHPC Grant	13,538	4,488	8,549	9,477	7,834	9,451
PSI/SHP Contract	4,076	6,697	4,993	5,780	3,647	4,550
MD Grants/Contracts	5,939	6,356	4,761	7,534	5,345	5,562
Centrally Procured Commodities	0	8,459	8,459	0	10,174	10,174
Total	23,553	26,000	26,762	22,791	27,000	29,737

	Projected Pipeline on 9/30/85	FY 86 Planned Obligation	FY 86 Planned Expenditure	Projected Pipeline on 9/30/86	Remarks (LC = Local Currency (FE = Foreign Exchange)
D. (Contd)					
1.					
	0	1,925	1,925	0	FE
2.					
	0	10,028	10,028	0	FE
	0	394	394	0	FE
Subtotal	-	12,347	12,347	0	
E.					
	7,860	6,152	9,735	4,277	FE/LC
	4,877	3,161	4,500	3,538	FE/LC
	7,317	6,340	6,373	7,284	FE/LC
	0	12,347	12,347	0	FE
Total	20,054	28,000	32,955	15,099	

Table 11

Actual FY 81-83 Obligations of the Family Planning Services Project by Component and Year

ponent	1981	1982	1983	Total
MOHPC GRANT				
1. Voluntary Sterilization	3,234,581	1,757,762	6,500,000	11,492,343
2. Training	100,000	344,000	0	444,000
3. Operations Research	100,000	200,000	0	300,000
4. Local Family Planning	50,000	200,000	0	250,000
5. MCH Materials	65,000	200,000	150,000	415,000
6. CPS	50,000	100,000	0	150,000
7. Printing	0	15,000	0	15,000
8. Evaluation	0	50,000	0	50,000
9. Demand Creation	100,000	556,000	0	656,000
10. Family Planning Services and Training Center (FPSTC)	100,000	350,000	200,000	650,000
11. Commodities (contraceptives, equipment and supplies)	450,000	3,358,000	2,592,895	6,400,895
Subtotal	4,249,581	7,130,762	9,442,895	20,823,238

Table 11 (Continued)

Component	1981	1982	1983	Total
B. PSI/SMP Contract	1,130,000	4,180,918	2,000,000	7,310,918
C. NGO GRANTS/CONTRACTS AND TECHNICAL ASSISTANCE				
1. IPAVS	500,000	1,577,550	1,690,000	3,767,550
2. Pathfinder	200,000	798,000	400,000	1,398,000
3. ICDDR,B	0	504,677	641,925	1,146,602
4. CARE	200,000	325,000	0	525,000
5. BFPA	75,000	300,000	300,000	675,000
6. The Asia Foundation	117,432	525,000	550,000	1,192,432
7. Helen Keller International	0	100,000	21,505	121,505
8. BACE	0	54,700	100,000	154,700
9. 1983 CPS	0	0	161,787	161,787
10. FHI/BFRP/Oral Pill trial	0	0	69,348	69,348
11. SMP Evaluation	0	0	34,957	34,957
12. Management Needs Assessment	0	0	56,015	56,015
13. Personal Services Contractors	27,987	43,393	166,568	237,948
Subtotal	1,120,419	4,228,320	4,192,105	9,540,844

Table 11 (Continued)

Component	1981	1982	1983	Total
D. CENTRALLY-PROCURED COMMODITIES				
1. Pills and Condoms	4,500,000	8,920,975[a]	8,815,000	22,235,975[a]
2. USAID-obligated CuT	0	0	350,000	350,000
Subtotal	4,500,000	8,920,975[a]	9,165,000	22,585,975[a]
E. SUMMARY				
1. MOHPC Grant	4,249,581	7,130,762	9,442,895	20,823,238
2. PSI/SMP Contract	1,130,000	4,180,918	2,000,000	7,310,918
3. NGO Grants/Contracts and Technical Assistance	1,120,419	4,228,320	4,192,105	9,540,844
4. Centrally procured Commodities	4,500,000	8,920,975[a]	9,165,000	22,585,975[a]
Grand Total	11,000,000	24,460,975[a]	24,800,000	60,260,975[a]

[a]Subsequently AID/Washington reports show that $128,000 has been deobligated from central procurement

Table 12

Proposed FY 84-86 Obligations to the Family Planning Services Project
(in 000s)

Component	FY 1984	FY 1985	FY 1986	Total
A. MOHPC Grant				
1. Reimbursements				
a. Voluntary Sterilization	2,495	5,123	3,010	10,628
b. IUD/Injectables	710	1,132	1,258	3,100
2. Demand Creation (Awards)	1,033	1,179	1,299	3,511
3. Contraceptive Prevalence Surveys	50	0	185	235
4. FPSTC	200	400	400	1,000
Subtotal	4,488	7,834	6,152	18,474
B. PSI/SMP Contract	6,697	3,647	3,161	13,505
C. Centrally Procured Commodities				
1. MOHPC				
a. Condoms	333	2,006	1,925	4,264
2. SMP				
a. Condoms	7,832	7,812	10,028	25,672
b. Orals	294	356	394	1,044
Subtotal	8,459	10,174	12,347	30,980

Table 12

Proposed FY 84-86 Obligations to the Family Planning Services Project
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Component	FY 1984	FY 1985	FY 1986	Total
A. MOHPC Grant				
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a. Voluntary Sterilization	2,495	5,123	3,010	10,628
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3. Contraceptive Prevalence Surveys	50	0	185	235
4. FPSTC	200	400	400	1,000
Subtotal	4,488	7,834	6,152	18,474
B. PSI/SMP Contract	6,697	3,647	3,161	13,505
C. Centrally Procured Commodities				
1. MOHPC				
a. Condoms	333	2,006	1,925	4,264
2. SMP				
a. Condoms	7,832	7,812	10,028	25,672
b. Orals	294	356	394	1,044
Subtotal	8,459	10,174	12,347	30,980

FIGURE 1

1980:Pre-Integration MOHPC Organizational Chart from Ministerial to Field Worker level

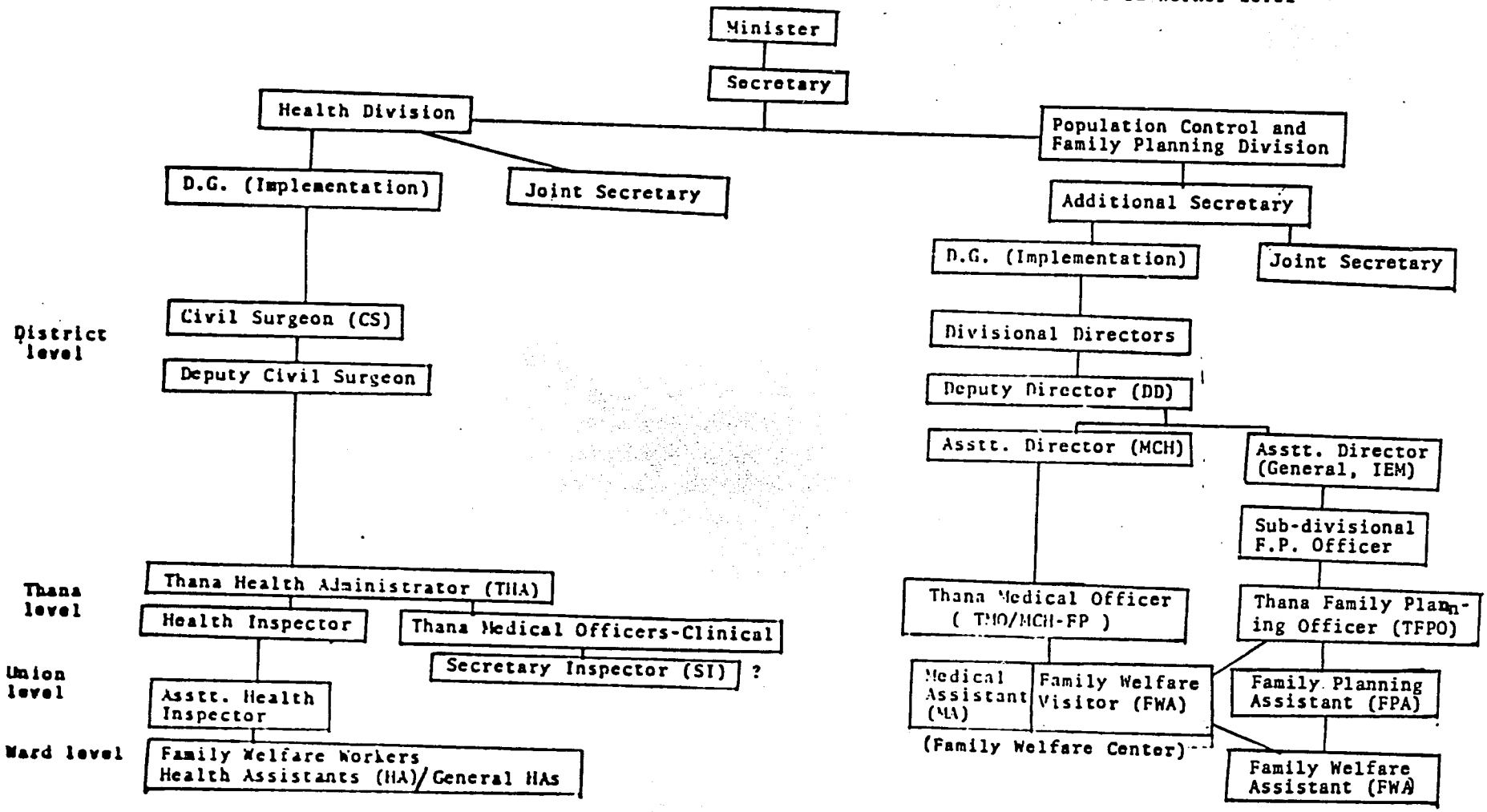

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Figure - 2

1981: First Integrated MOHPC Organizational Chart from Ministerial to Field Worker level.

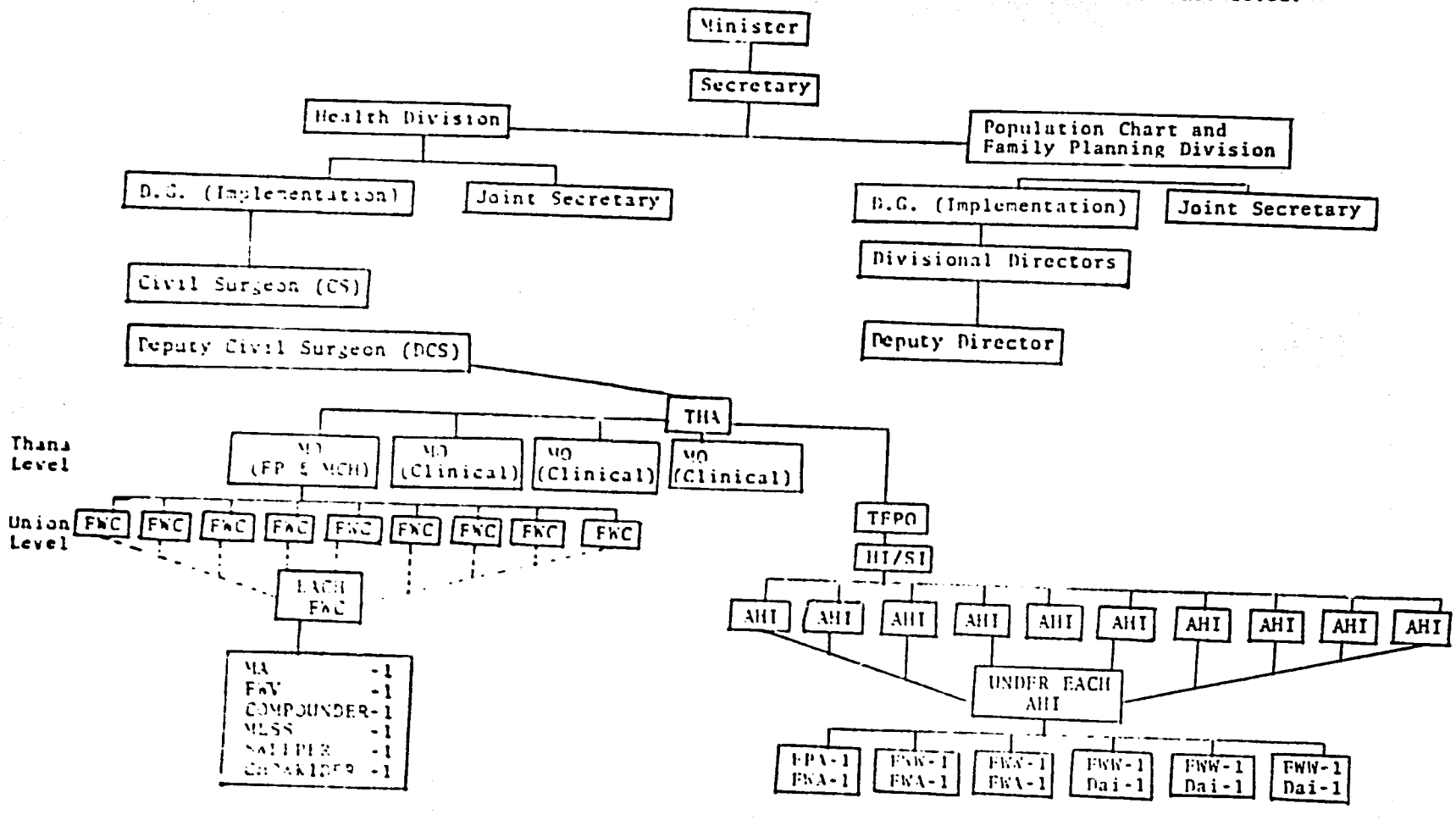

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Figure - 3

1982/83: Second Integrated MOHPC Organizational Chart from Ministerial to Field Worker level.

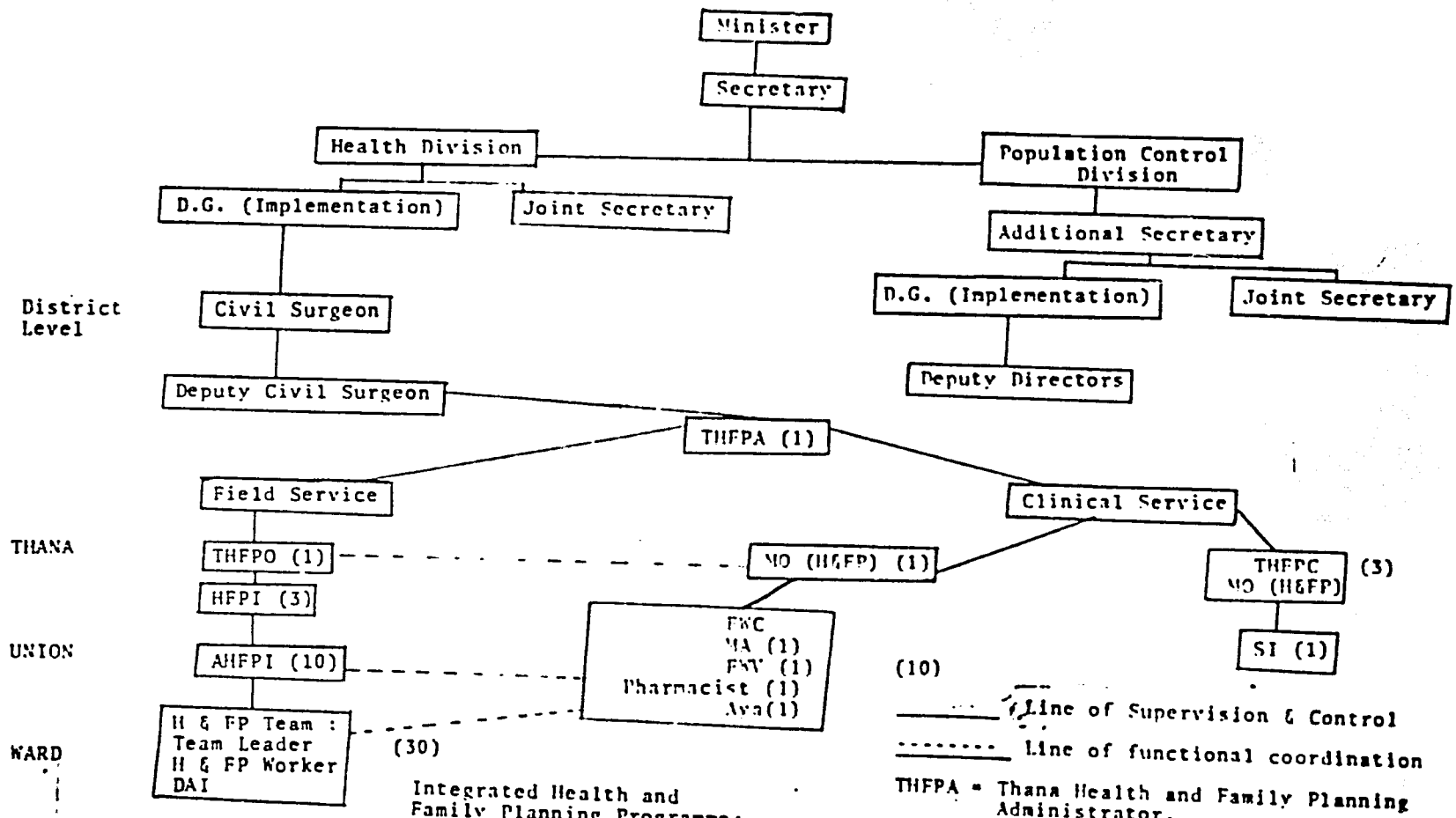

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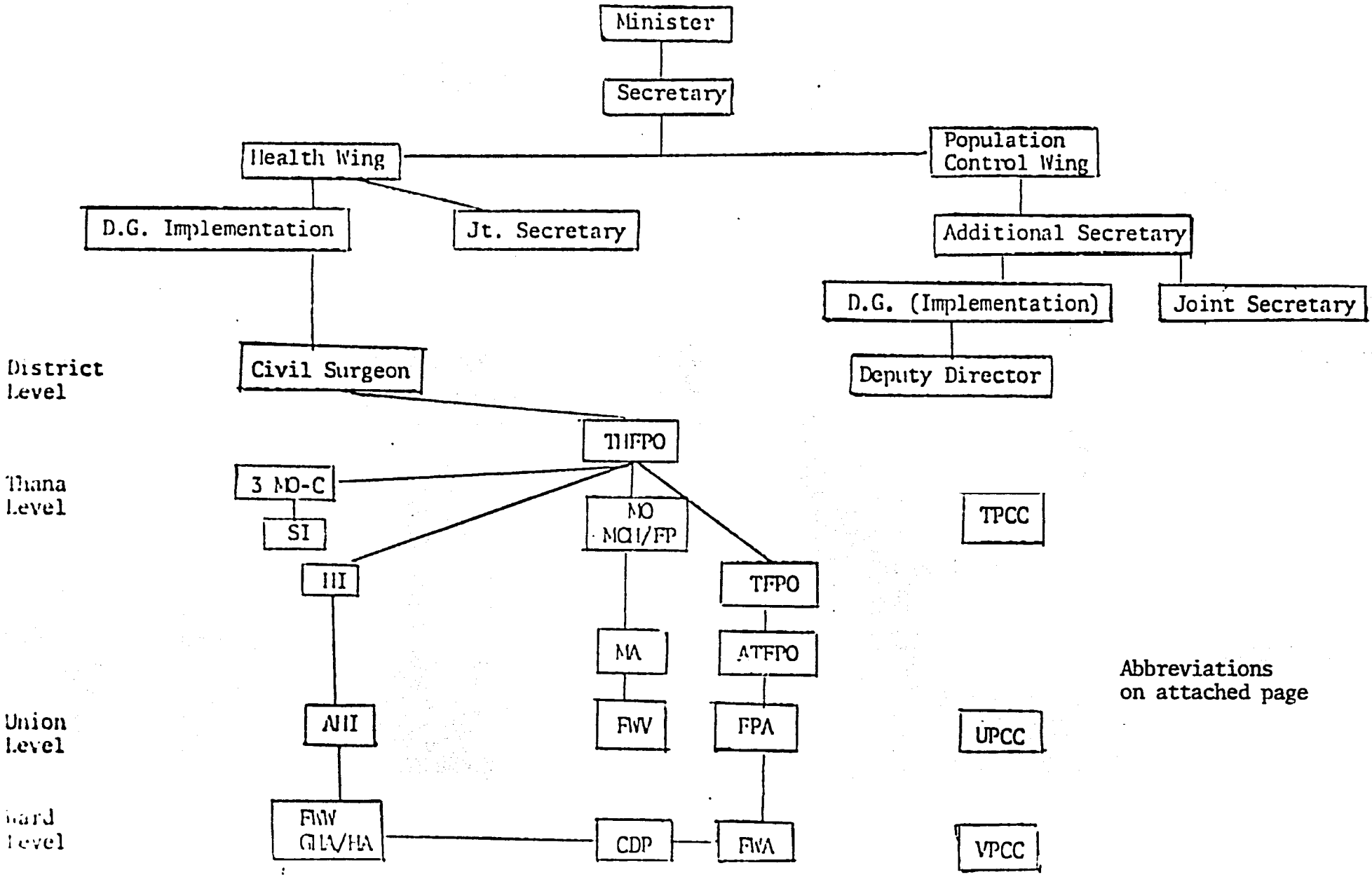
FIGURE 4

Latest MOHPC Organizational Chart From Ministerial to Fieldworker Level
(October 1983)



Abbreviations on attached page

ABBREVIATIONS FROM FIGURE 4

THFPO = Thana Health and Family Planning Officer

MO-C = Medical Officer - Clinical

MO-MCH/FP = Medical Officer - Maternal Child Health/Family Planning

HI = Health Inspector

TFPO = Thana Family Planning Officer

MA = Medical Assistant

ATFPO = Assistant Thana Family Planning Officer

AHI = Assistant Health Inspector

FWV = Family Welfare Visitor

FPA = Family Planning Assistant

FWW = Family Welfare Worker

GHA = General Health Assistant

HA = Health Assistant

FWA = Family Welfare Assistant

CDP = Contraceptive Distribution Point (home of FWA/FWW/GHA/HA)

TFPC = Thana Family Planning Committee

UFPC = Union Family Planning Committee

VFPC = Village Family Planning Committee

FIGURE 5

STERILIZATIONS PERFORMED BY BAVS
AND BDG & OTHER PROGRAMS

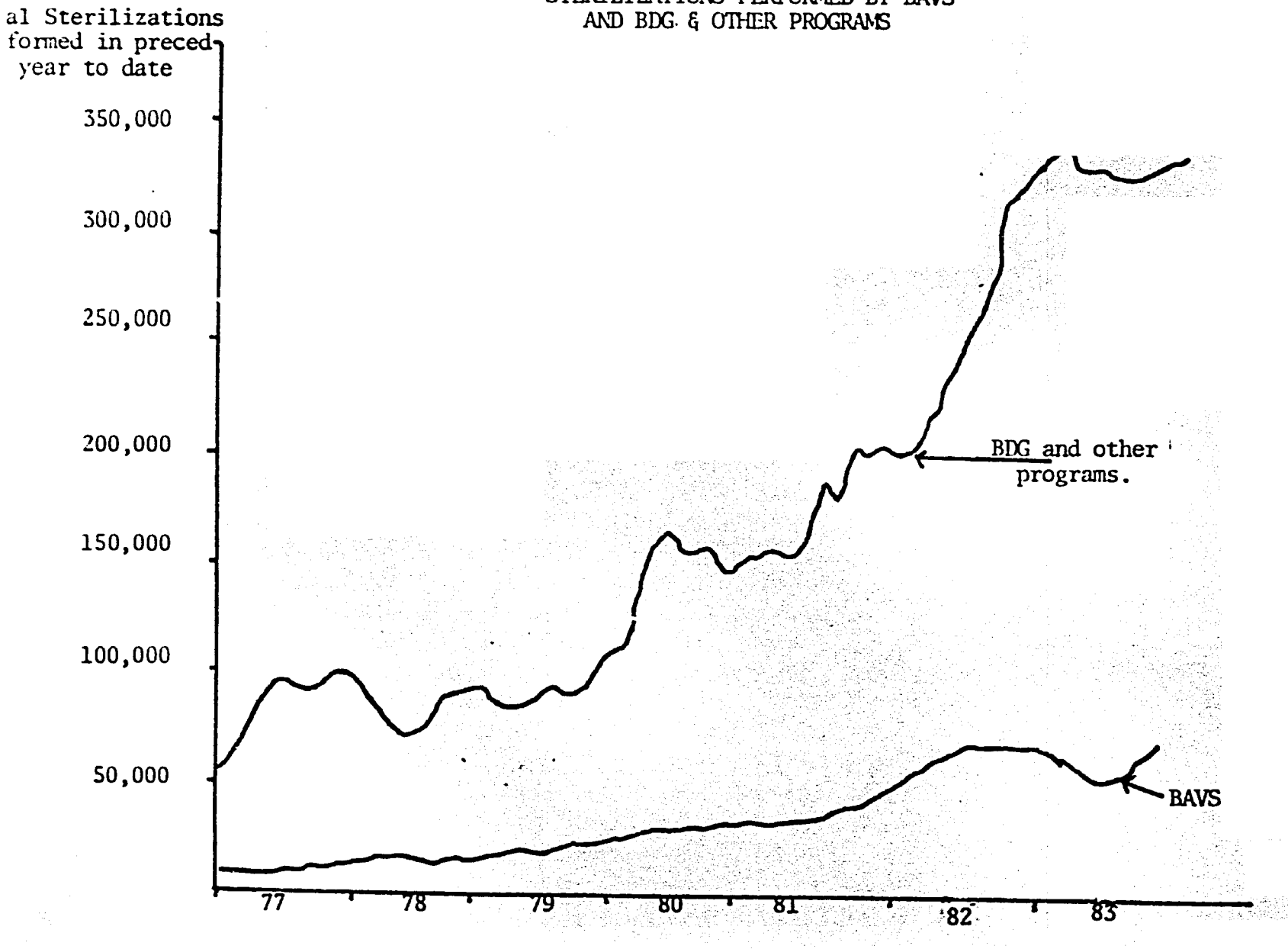


FIGURE 6

TOTAL NUMBER ELIGIBLE COUPLES STERILIZED
1977-1983

(With additional sterilization added in quarterly and totals decremented 5% annually)

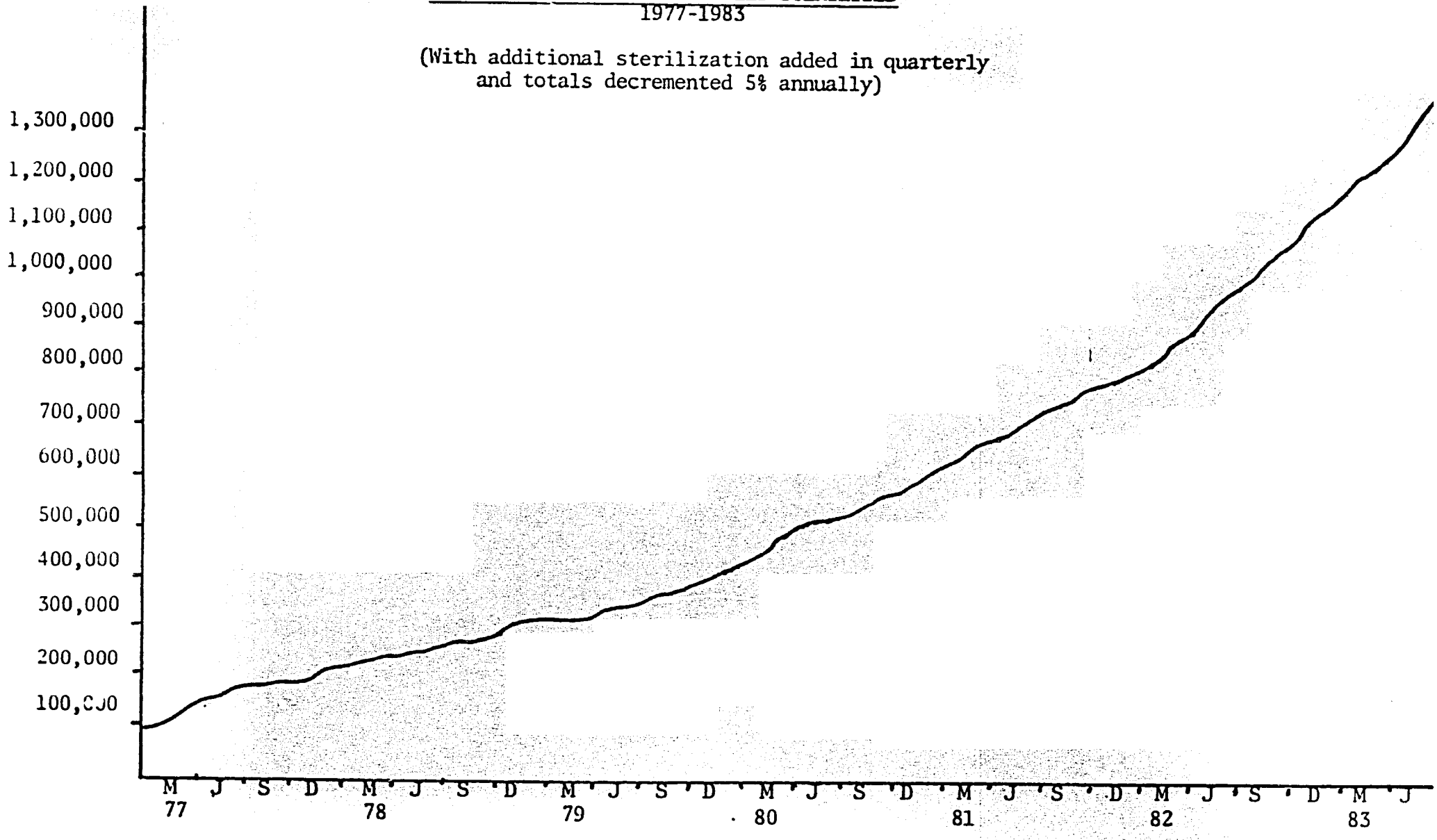


FIGURE 7

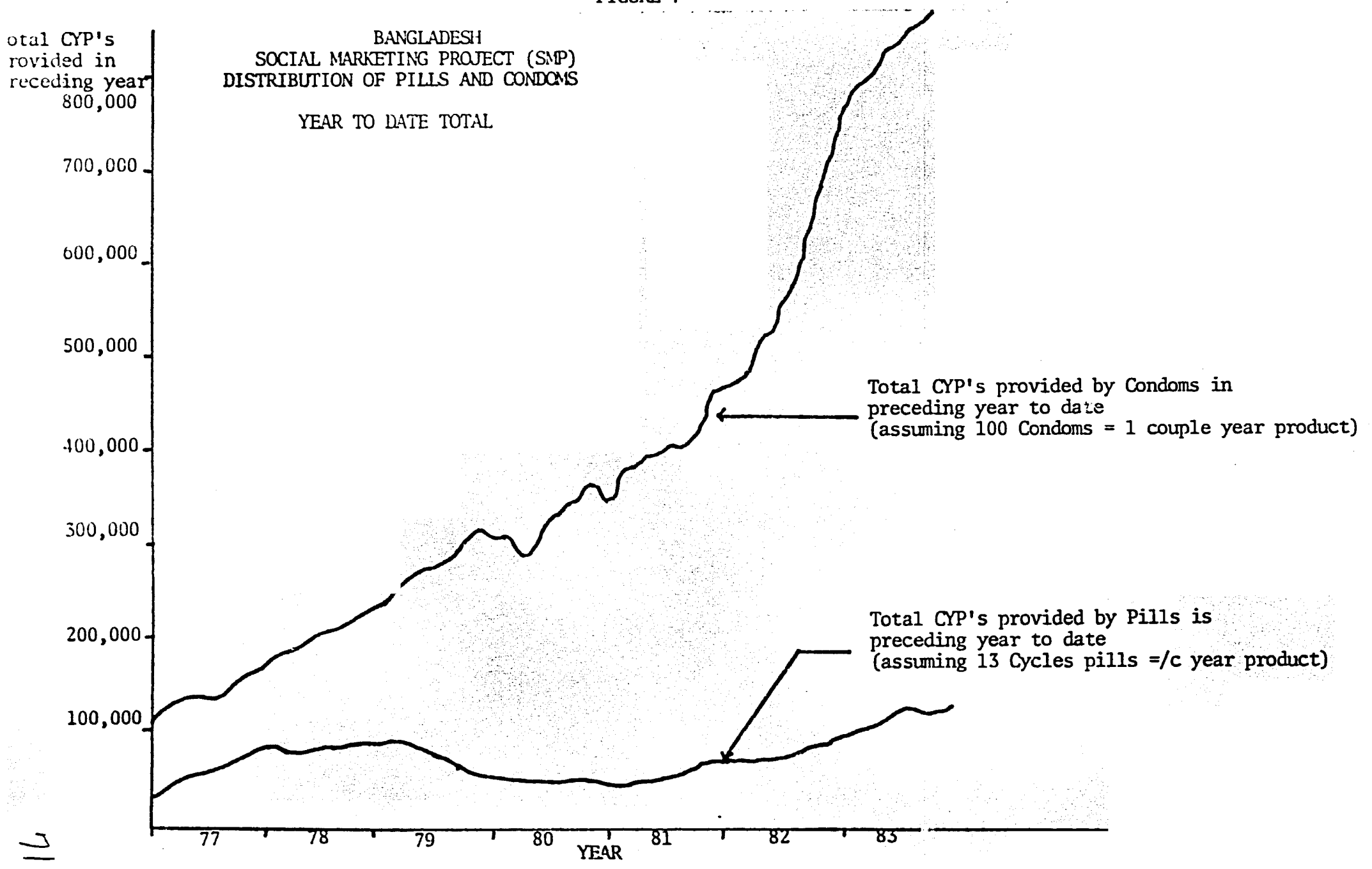
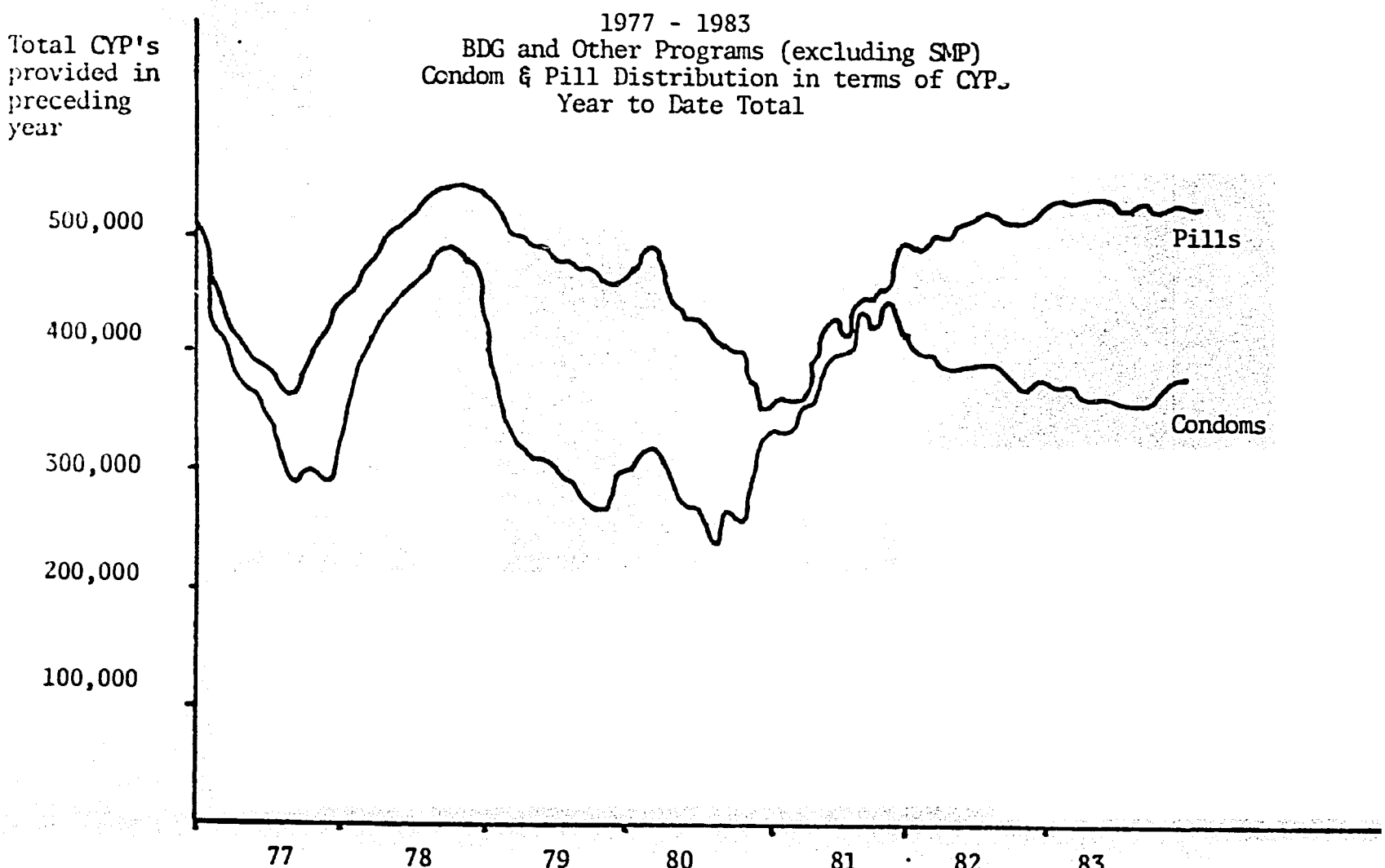

BANGLADESH
SOCIAL MARKETING PROJECT (SMP)
DISTRIBUTION OF PILLS AND CONDOMS
YEAR TO DATE TOTAL
otal CYP's
rovided in
receding year
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
77
78
79
80
81
82
83
YEAR
Total CYP's provided by Condoms in
preceding year to date
(assuming 100 Condoms = 1 couple year product)
Total CYP's provided by Pills is
preceding year to date
(assuming 13 Cycles pills =/c year product)

Figure 8


1977 - 1983
BDG and Other Programs (excluding SMP)
Condom & Pill Distribution in terms of CYP.
Year to Date Total
Total CYP's provided in preceding year
500,000
400,000
300,000
200,000
100,000
Pills
Condoms
77
78
79
80
81
82
83

Donor Support to the National Population Control Program (NPCP)

The IBRD is the largest multilateral donor, representing IDA and a consortium of seven participating governments (Canada, Australia, F.R.G., Netherlands, Norway, Sweden, U.K.). The Bank has financed two population projects since 1975. The first Population and Family Health Project (1975-82) focussed on increasing the supply of family planning and MCH (maternal and child health care) services. Forty-five million dollars were provided primarily for the construction of a number of clinics, family welfare centers and training facilities; fieldworker salaries; information dissemination activities in the Ministry of Agriculture, Labor and Education; and the inevitable equipment necessary to support the project. The Second Population and Family Planning Project (1979-85) provides an additional $10 million to continue and expand these activities. The four-part project includes efforts to strengthen rural health care and family planning service delivery; increase and improve the capacity for training health care and family planning workers; strengthen evaluation and research capacity; and generally improve the government's project implementation capability.

The UNFPA has been providing family planning assistance to Bangladesh since 1974. The First Country Program (1974-79) provided $10 million for the analysis of 1974 census data; population dynamics research; some commodities-including injectables, MCH drugs, and medical kits; and population education programs in schools, cooperatives and various Ministries. This program was considerably expanded with the $30 million Second Country Program which, like the Bank Projects, is jointly financed by UNFPA from its own resources and four participating governments (Canada, Netherlands, Sweden and Denmark). The UNFPA portion has provided for the analysis of 1981 census data; research; and improvement in health care and family planning service delivery. The so-called multi-bi portion is provided for improving the training capacity of the Family Welfare Visitor Training Institute (Netherlands funding); fieldworker salary support (Danish funding); MCH activities (Swedish funding) and general manpower development (Canadian funding).

The Asian Development Bank, a new multilateral contributor to the government program, is now developing a $30 million Health and Population Project (1984-88) at the request of the government. The project is expected to strengthen health care and family planning service delivery in four districts-Dinajpur, Mymensingh, Comilla and Jessore; strengthen the national system for procurement, storage and distribution of medical supplies; and improve the maintenance and repair of medical equipment.

In addition to the major multilateral activities, WHO has also sponsored a small but very important sterilization surveillance program.

The FRG through their bilateral Technical Cooperation Agency, has also provided $3.5 million for both projects and commodities since 1979. For commodities, the Germans financed 600 thousand cycles of oral contraceptives ($100 thousand) and a small amount of injectables during 1979-82. They are presently financing 4.5 million cycles of Combination 5 oral contraceptives ($600 thousand) for delivery during 1982-85. The Government of Bangladesh's recent request for 450 thousand doses of Noristerate and 14.5 million cycles of Combination-5 ($2 million) for delivery during 1985-88 is now being negotiated.

The FRG is also supporting a $2.8 million MCH-based Family Planning Project (1979-82) in Dhaka-Munshigonj. The population control objective of the project is to deliver family planning messages as an adjunct to primary health care activities in the Munshigonj subdivision. This is to be accomplished by generating community interest through a variety of information, education and motivation programs at Mother's Clubs, Family Welfare Centers and Rural Dispensaries. An evaluation of the project is not scheduled until October 1983; however; preliminary evidence indicates that the family planning component of this predominantly MCH activity has not been successful.

The Netherlands has also provided some bilateral assistance for activities related (albeit indirectly) to the family planning program. This includes the $14 million Medical Assistants Training Program (1979-84) which has a family planning training component in the curriculum. The Netherlands also commissioned a study of the feasibility of domestic contraceptive production.

The Norwegian and Swedish Governments also provide small amounts of contraceptive pills and sterilization-related drugs.

ACTION MEMORANDUM FOR THE ADMINISTRATOR

Vehicle Manufacture and Source /Origin Waiver

Waiver Control No. ASIA/84/G/ /388-0050

FROM : USAID/DHAKA, James Norris

PROBLEM: Request for Two Waivers to Permit Contractor and NGO Grantees to Purchase Code 935 Vehicles during Extension of Project No. 388-0050:

1. Waiver of Section 636(i) of the Foreign Assistance Act of 1961, as amended (U.S. manufacture requirement for vehicles);

2. Source/Origin Waiver to Code 935 (Free World including Cooperating Country).

(A) Cooperating Country : Bangladesh

(B) Authorizing Document: Project No. 388 - 0050 Authorization Amendment

(C) Project : Family Planning Services

(D) Nature of Funding : Development Assistance Grant.

(E) Description of Goods : 96 Motor Vehicles: 85 Jeeps; 11 Small Trucks/Microbuses

(F) Approximate Value : $1,110,000

(G) Source/Origin : Code 935

Discussion and Justification:

In authorizing the extension of Project No. 388-0050 (Family Planning Services - Bangladesh), you are requested to waive the requirement that vehicles be of U.S. manufacture, and waive source and origin requirements to permit Population Services International (PSI), an A.I.D. contractor, to purchase 89 vehicles of Code 935 source and origin. In addition, NGO grantees will need 7 vehicles. PSI has managed the Bangladesh Family Planning Social Marketing Project (SMP) under A.I.D.-direct Contract No. 388-0050-C-00-1009, and predecessor contracts, for 8.5 years. The SMP, which markets pills, condoms and vaginal spermicide through approximately 105,000 shopkeepers, is the most successful nation-wide family planning program in

Bangladesh, contributing about 50% of all non-clinical contraceptive protection at the annual rate of 931,000 couple-years of protection. For a full description of the SMP, see the USAID/Bangladesh Evaluation submitted in October, 1983.

To increase the mobility and effectiveness of field personnel, SMP proposes to replace worn-out vehicles and purchase additional vehicles through the PSI contract or grant during the 0050 project extension period. These 89 new vehicles (jeeps, trucks or minibuses) will be used by SMP local staff for distribution, marketing, field inspection and mobile film shows in all districts in Bangladesh.

In the past PSI/SMP procured a number of U.S. manufactured motor vehicles for deployment in the field for the distribution of contraceptives. These vehicles have been very difficult to maintain due to the lack of spare parts and maintenance facilities. As a result, the work of the SMP sales force has been hampered greatly, causing disruption in the distribution of contraceptives. The cost to operate and mantain these vehicles is high. Driving vehicles with left-hand drive is too dangerous to be permitted in Bangladesh, as demonstrated by the death of an A.I.D. contractor (NRECA/CAI) employee during 1983, who was sitting in the front passenger seat of a left-hand drive vehicle. The addition of new vehicles can contribute substantially to improved distribution of contraceptives. SMP needs to replace and upgrade the vehicles in its fleet, as these are now very old, in order to distribute contraceptives in rural areas.

SMP experience over the past few years with American vehicles has not been optimum. Despite initially smooth operation, U.S.-made vehicles have caused serious maintenance and repair problems for the following reasons:

a. Spares of American vehicles are not available on the local market, unlike the universally available parts for Japanese or other non-American vehicles (e.g., Bedford trucks), even in district towns.

b. Imports are necessary, but the cumbersome process involved in importing American vehicles has been so time-consuming that SMP has been subjected to dislocation of its distribution schedule.

c. It is difficult to maintain stocks of spare parts for American vehicles because they are not often interchangeable between models. Model changes which render spares in stock obsolete also increase costs.

d. As against spares of American vehicles, those of Japanese vehicles can generally be stored for use in successive years without difficulty, despite model changes.

e. There are assembly plants for Toyota and Mitsubishi Jeeps and trucks in Bangladesh, from which SMP could procure vehicles quickly.

f. Because of the dominance of Japanese vehicles over non-Japanese, maintenance and repair workshops all over Bangladesh are oriented toward Japanese vehicles, and mechanics are familiar with them.

g. Trained mechanics and well-equipped workshops for American vehicles are not available in district towns, where SMP has sub-offices for distribution of contraceptives. As a consequence of non-availability of qualified mechanics and spares, American vehicles are dead-lined for extensive periods or are brought to Dhaka for repair, where additional weeks of service are lost in quest of spares. Distribution therefore suffers.

h. American vehicles with left-hand steering are difficult and dangerous to drive in Bangladesh, where vehicles must keep left.

i. Japanese vehicles generally are more suitable for Bangladeshi by-lanes and narrow rural roads, which are inaccessible to wider wheel-base American vehicles.

j. SMP's four Toyota Jeeps have run about 150,000 miles and are in better shape than any one of the twelve AMC Jeeps, which have logged about 60,000 miles each.

k. SMP experience suggests that over the life of the vehicle the Toyota Jeep gets about 20 miles per gallon, and the AMC about 14. Thus, the savings in fuel alone over 100,000 miles for 80 Jeeps would be over $425,000.

The SMP plans a significant expansion, and by 1986 may have as many as twelve sub-offices as against eight now. The number of field staff will also increase and will require larger transport support. At the time, the deteriorating condition of some existing vehicles requires their replacement. The projected SMP total requirement for replacement and additional vehicles is estimated as follows:

	Approximate Value	
	American made	Japanese made
1984 - 22 (both replacement and additional)	$ 374,000	$ 275,000
1985 - 33 (,,)	$ 614,000	$ 350,000
1986 - 34 (,,)	$ 697,000	$ 460,000
SMP Total: 89 vehicles	$1,685,000	$1,025,000

Approximate savings if Japanese vehicles are purchased: $660,000

Therefore, for reasons of economy, productivity, and safety, Japanese vehicles for personnel transport and contraceptive delivery offer substantial advantages over American vehicles in Bangladesh. For large-scale delivery to sub-offices and wholesalers, Bedford lorries offer a similar range of advantages.

For NGOs, vehicles are required for transportation of field workers to rural district areas under conditions similar or identical to those faced by SMP field workers. The waivers requested herein are justified under the following authorities:

1. FAA Sec. 636(i): Handbook 1B, Section 4C2d(1)(a), "...inability of U.S. manufacturers to provide a particular type of needed vehicle, e.g.,...right-hand drive vehicles" and (1)(b), "...present or projected lack of adequate service facilities and supply of spare parts for U.S. manufactured vehicles."

2. Code 935 Source and Origin: Handbook 1B, Section 5B4a(2),..."the commodity is not available from countries or areas included in the authorized geographic code" and (7), "such other circumstances as are determined to be critical to the success of project objectives."

Delegated Authority:

You have authority to grant these waivers under the above cited authorities and under IDCA Delegation of Authority No.1, dated October 1, 1979 (44 FR 57521).

Recommendation:

That you waive the requirement of Section 636(i) of the Foreign Assistance Act of 1961, as amended, and waive the source/origin requirements of Handbook 1B, Chapter 5 to permit Code 935 source/origin procurement of a total of 96 vehicles, 89 vehicles by Population Services International for the Family Planning Social Marketing Project, and 7 vehicles by other NGOs financed under Project No. 388-0050 in Bangladesh.

ANNEX C

LOG FRAME

GOAL	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
To reduce the rate of population growth through fertility reduction as a critical factor in overall economic development.	1990 / 2005 NRR 2.0 / 1.0	Demographic Surveys	Family Planning and Beyond Family Planning efforts are succesful.
PURPOSE To increase the contraceptive prevalence rate of modern methods from 15% at the end of CY 1983 to 28% at the end of CY 1987.	Contraceptive Prevalence Rates (Survey)	National Contraceptive Prevalence Surveys conducted by independent Bangladeshi Research Firms	1. BDG remains committed to supporting the family planning program. 2. Other donors continue to support BDG family planning program. 3. Political stability 4. MOHPC program improves in effectiveness. 5. MOHPC organizational issues are resolved.

Modern Method	Year 1983	1984	1985	1986	1987
Pill	3.5	3.6	3.9	4.3	4.7
Condom	1.9	2.3	2.7	3.2	3.6
IUD	0.9	1.0	1.8	2.6	3.3
VS	8.2	9.9	11.7	13.6	15.6
Other	0.6	0.7	0.8	0.9	1.0
Total	15.1	17.5	20.0	24.6	28.2

OUTPUTS	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
Increase in modern contraceptive method use by each of the project implementing agencies.	Contributions by Implementing Agency: Contraceptive Prevalence Rates (Derived)	BDG: MIS Service Statistics SMP: MIS Service Statistics and SMP reports NGO: MIS Service Statistics and reports for USAID-funded NGOs	1. Complementary Other Donor support for BDG activities and commodities continues. 2. BDG improves logistics system. 3. BDG does not restrict activities of SMP and NGOs. 4. Demand for VS remains high. 5. No shortages of supplies.

Year/modern method	BDG	SMP	USAID-funded NGO	Total
Dec. 1986				
Pill	2.3	0.9	1.6	4.8
Condom	1.4	8.7	0.6	10.7
IUD	2.3	-	0.3	2.6
VS	11.2	-	2.4	13.6
Other	0.4	0.4	0.1	0.9
Total	17.6	10.0	5.0	32.6
Dec. 1987				
Pill	2.3	1.0	1.9	5.2
Condom	1.4	10.0	0.7	12.1
IUD	2.8	-	0.5	3.3
VS	12.7	0.5	2.9	15.6
Other	0.4	-	0.1	1.0
Total	19.6	11.5	6.1	37.2

Outputs in term of performance and distribution are given in Annex N, Technical Analysis, and in the Input/Output Tables (Annex H)

INPUTS	INDICATORS	FY 84	FY 85 (Million $)	FY 86	MEANS OF VERIFICATION	ASSUMPTIONS
1. Centrally-procured Commodities (MOHPC, SMP, NGO)	1. Commodities:				1. USAID project records	1. BDG maintains informed consent procedures and the VS surveillence system.
	Condoms	8.1	9.8	11.9	2. BDG Reports	
	Pills	0.3	0.4	0.4	3. SMP Reports	
	Total	8.4	10.2	12.3	4. USAID-funded NGO Reports	
2. MOHPC	2. MOHPC:					2. BDG institutes an acceptable Awards Program.
a. Reimbursements	VS	2.5	5.1	3.0		
b. Awards program	IUD/Inj.	0.7	1.1	1.3		
c. FPSTC	Awards	1.0	1.2	1.3		
d. Contraceptive Prevalence Surveys	FPSTC	0.2	0.4	0.4		3. SMP can expand in terms of outlets and products offered.
	CPS	0.05	0.0	0.2		
	Total	4.45	7.8	6.2		
3. SMP	3. SMP:					
a. Service Delivery b. Demand Creation		6.7	3.6	3.1		4. NGOs can continue to absorb USAID resources and expand family planning activities.
4. NGOs	4. NGOs					
a. Service Delivery b. Demand Creation c. Training		6.4	5.3	6.3		

5C(1) - COUNTRY CHECKLIST

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

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FAA Sec. 481; FY 1984 Continuing Resolution. Has it been determined or certified to the Congress by the President that the government of the recipient country has failed to take adequate measures or steps to prevent narcotic and psychotropic drugs or other controlled substances (as listed in the schedules in section 202 of the Comprehensive Drug Abuse and Prevention Control Act of 1971) which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States Government personnel or their dependents or from entering the United States unlawfully? — No

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

3. 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

4. FAA Sec. 532(c), 620(a), 620 (f), 620D; FY 1982 Appropriation Act Secs. 512 and 513. Is recipient country a Communist country? Will assistance be provided to Angola, Cambodia, Cuba, Laos, Vietnam, Syria, Libya, Iraq, or South Yemen? Will assistance be provided to Afganistan or Mozambique without a waiver? — No

5. ISDCA of 1981 Secs. 724, 727 and 730. For specific restrictions on assistance to Nicaragua, see Sec. 724 of the ISDCA of 1981. For specific restrictions on assistance to El Salvador, see Secs. 727 and 730 of the ISDCA of 1981.	N/A
6. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction by mob action of U.S. property?	No
7. FAA Sec. 620(l). Has the country failed to enter into an agreement with OPIC?	No, OPIC agreement signed January 15, 1975
8. FAA Sec. 620(o); Fishermen's Protective Act of 1967, as amended, Sec. 5. (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made?	a) No b) N/A
9. FAA Sec. 620(g); FY 1982 Appropriation Act Sec. 517. (a) Has the government of the recipient country been in default for more than six months on interest or principal of any AID loan to the country? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the appropriation bill appropriates funds?	a) No b) No
10. FAA Sec. 620(s). If contemplated assistance is development loan or from Economic Support Fund, has the Administrator taken into account the amount of foreign exchange or other resources which the country has spent on military equipment? (Reference may be made to the annual "Taking into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)	N/A
11. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have they been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?	No

12.	FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the AID Administrator in determining the current AID Operational Year Budget? (Reference may be made to the Taking into Consideration memo.)	Not in arrears
13.	FAA Sec.620A;FY 1982 Appropriation Act Sec. 520. Has the country aided or abetted, by granting sanctuary from prosecution to, any individual or group which has committed an act of international terrorism? Has the country aided or abetted, by granting sanctuary from prosecution to, any individual or group which has committed a war crime?	No
14.	FAA Sec. 666. Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA?	No
15.	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 transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device, after August 3, 1977? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.)	No No
16.	ISDCA of 1981 Sec. 720. Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Session of the General Assembly of the U.N. of Sept. 25 and 28, 1981, and failed to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the Taking into Consideration memo.)	No
17.	ISDCA of 1981 Sec.721. See special requirements for assistance to Haiti.	N/A

18. FY 1984 Continuing Resolution. Has the recipient country been determined by the President to have engaged in a consistent pattern of opposition to the foreign policy of the United States? — No

B. FUNDING SOURCE CRITERIA FOR COUNTRY ELIGIBILITY

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

2. Economic Support Fund Country Criteria. — N/A, as Project is DA funded.

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

b. ISDCA of 1981, Sec. 725(b). If ESF is to be furnished to Argentina, has the President certified that (1) the Govt. of Argentina has made significant progress on human rights; and (2) that the provision of such assistance is in the national interests of the U.S.? — N/A

c. ISDCA of 1981, Sec. 726(b). If ESF assistance is to be furnished to Chile, has the President certified that (1) the Govt. of Chile has made significant progress in human rights; (2) it is in the national interest of the U.S.; and (3) the Govt. of Chile is not aiding international terrorism and has taken steps to bring to justice those indicated in connection with the murder of Orlando Letelier? — N/A

Project No.

5C(2) PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A. includes criteria applicable to all projects. Part B. applies to projects funded from specific sources only: B.1. applies to all projects funded with Development Assistance Funds, B.2. applies to projects funded with Development Assistance loans, and B.3. applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

A. GENERAL CRITERIA FOR PROJECT

1. FY 1982 Appropriation Act Sec. 523, FAA Sec. 634A; Sec. 653(b).

(a) Describe how authorizing and appropriations committees 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 amount)?

a) CN will be sent to Congress before obligation.

b) Yes, FY84 OYB is $25,895,000 (STATE 010388) and FY84 CP, Annex II reported a proposed $25 million FY 84 obligation.

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

a) Yes

b) Yes

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

Not required.

4. FAA Sec. 611(b); FY 1982 Appropriation Act Sec. 501. If for water or water-related land resource construction, has project met the standards and criteria as set forth in the Principles and Standards for Planning Water

N/A

	and Related Land Resources, dated October 25, 1973?(See AID Handbook 3 for new guidelines.)	
5.	FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?	N/A
6.	FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so,why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.	No
7.	FAA Sec. 601(a). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; and (c) encourage development and use of cooperatives, and credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.	a) No b) Yes c) No d) N/A e) N/A f) N/A
8.	FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).	N/A
9.	FAA Sec. 612(b), 636(h); FY 1982 Appropriation Act Sec.507. Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.	The Government uses its own resources to support the Ministry of Health and Population Control.
10.	FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?	No

11. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?	Yes
12. FY 1982 Appropriation Act Sec. 521. 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?	a) N/A b) No
13. FAA Sec. 118(c) and (d). Does the project comply with the environmental procedures set forth in AID Regulation 16? Does the project or program take into consideration the problem of the destruction of tropical forests?	a) Yes b) N/A
14. FAA Sec. 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated therefrom)?	N/A

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria.

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

b. FAA Sec. 103, 103A,104,105,106. Does the project fit the criteria for the type of funds (functional account) being used?	Yes, Sec.104(b)
c. FAA Sec. 107. Is emphasis on use of appropriate technology (relatively smaller, cost-saving,labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?	N/A
d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?	Yes
e. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"? (M.O. 1232.1 defined a capital project as "the construction, expansion, equipping or alteration of a physical facility or facilities financed by AID dollar assistance of not less than $100,000, including related advisory, managerial and training services, and not undertaken as part of a project of a predominantly technical assistance character."	No
f. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustained economic growth?	Yes
g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.	a) Family Planning services are a critical need of Bangladesh desired both by the Government and by the rural poor. b) The Project will help develop several population-related institutions in Bangladesh including the Ministry of Health and Population Control. c) N/A

2. Development Assistance Project Criteria (Loans Only)

a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan, at a reasonable rate of interest. N/A

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

c. ISDCA of 1981, Sec.724(c) and (d). If for Nicaragua, does the loan agreement require that the funds be used to the maximum extent possible for the private sector? Does the project provide for monitoring under FAA Sec. 624(g)? N/A

3. Economic Support Fund Project Criteria

a. FAA Sec. 531(a). Will this assistance promote economic or political stability? To the extent possible, does it reflect the policy directions of FAA Sec. 102? N/A

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

c. FAA Sec. 534. Will ESF funds be used to finance the construction of the operation or maintenance of, or the supplying of fuel for, a nuclear facility? If so, has the President certified that such use of funds is indispensable to nonproliferation objectives? N/A

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

5C(C) - STANDARD ITEM CHECKLIST

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

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

A. Procurement

1.	FAA Sec. 602. Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed?	Yes
2.	FAA Sec.604(a) Will all procurement be from the U.S. except as otherwise determined by the President or under delegation from him?	Yes
3.	FAA Sec. 604(d). If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States agaist marine risk with such a company?	Yes
4.	FAA Sec.604(e); ISDCA OF 1980 Sec. 705(a). If offshore procurement of agricultural commodity or product is to be financed, is there provisions against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)	N/A
5.	FAA Sec. 604(g). Will construction or engineering services be procured from firms of countries otherwise eligible under Code 941, but which have attained a competitive capability in international markets in one or these areas?	No
6.	FAA Sec. 603. Is the shipping excluded from compliance with requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent that such vessels are available at fair and reasonable rates?	No

7.	FAA Sec. 621. If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? If the facilities of other Federal agencies will be utilized, are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?	a) Yes b) N/A
8.	International Air Transport. Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?	Yes
9.	FY 1982 Appropriation Act Sec. 504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States?	Yes, such clauses are routinely inserted in all A.I.D.-direct contracts.

B. Construction

1.	FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services be used?	N/A
2.	FAA Sec. 611(c). If contracts for construction are to be financed, will they will let on a competitive basis to maximum extent practicable?	N/A
3.	FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed $100 million (except for productive enterprises in Egypt that were described in the CP)?	N/A

C. Other Restrictions

1.	FAA Sec. 122(b). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter?	N/A
2.	FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?	N/A

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

4. Will arrangements preclude use of financing:

a. FAA Sec. 104(f); FY 1982 Appropriation Act Sec. 525: (1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization? (3) to pay for any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; (4) to lobby for abortion?

1) Yes
2) Yes
3) Yes
4) Yes

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

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

d. FAA Sec. 662. For CIA activities? — Yes

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

f. FY 1982 Appropriation Act, Sec. 503. To pay pensions, annuities, retirement pay, or adjusted service compensation for military personnel? — Yes

g. FY 1982 Appropriation Act, Sec. 505. To pay U.N. assessments, arrearages or dues? — Yes

h. FY 1982 Appropriation Act, Sec. 506. To carry out provisions of FAA section 209(d) (Transfer of FAA funds to multilateral organizations for lending)? — Yes

i. FY 1982 Appropriation Act, Sec. 510. To finance the export of nuclear equipment, fuel, or technology or to train foreign national in nuclear fields?	Yes
j. FY 1982 Appropriation Act, Sec. 511. Will assistance be provided for the purpose of aiding the efforts of the government of such country to repress the legitiomate rights of the population of such country contrary to the Universal Declaration of Human Rights?	No
k. FY 1982 Appropriation Act, Sec. 515. To be used for publicity or propaganda purposes within U.S. not authorized by Congress?	No.

REPORT TO THE GOVERNMENT OF BANGLADESH ON THE 1982 MID-TERM EVALUATION OF USAID PROJECT NO. 388-0050, FAMILY PLANNING SERVICES

March 1983

I. Purpose of the Report

The purpose of this report is to inform the Government of Bangladesh concerning the findings and recommendations of the mid-term evaluation of the Family Planning Services Project sponsored by USAID in collaboration with the Population Control Division of the Ministry of Health and Population Control; and also to present the results of the USAID Mission's review and assessment of this evaluation. The report also sets forth USAID's position concerning actions to be taken for improved project implementation in the future.

The evaluation was required to be performed, according to the terms and conditions of the Project Agreement.

The scope of work for the team was:

1. to assess the strategy, inputs, processes and outputs of the current USAID Family Planning Services Project;

2. to recommend feasible and cost-effective interventions to assist the Family Planning Program in Bangladesh to reach a contraceptive prevalence rate of effective methods of 30% by 1985. This required assessment of the BDG Family Planning Program; USAID and other donor inputs, policies, and strategies as they affected the BDG program; and assessment of NGO Family Planning activities in relation to the overall family planning effort in Bangladesh.

The intent of the evaluation, therefore, is to provide guidance to USAID and BDG project managers: to note successes, and to recommend corrections in implementation of various aspects of the project which would lead to improvements in performance.

II. Methodology

The evaluation was carried out by a team of internationally reputed population professionals, including private consultants, a USAID official, and two high-ranking BDG staff. The team employed techniques of site visits, un-structured interviews, and review of relevant documents in its analysis. The team spent three weeks in Dhaka; additional analyses were carried out in the USA after the team's field tour. Due to the methodology employed and the time constraint placed upon the evaluation by official duties and other commitments for the consultants, the data for this evaluation are rather more qualitative than quantitative. Given the complexity of the project, however, it seems warranted to place reliance on the judgements of experienced and qualified professionals for the assessment of project performance and for recommended actions to be taken to improve the performance.

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III. Major Findings of the Evaluation Team - Summary

The full evaluation report has been reviewed in draft by the USAID Mission. The final report, incorporating changes and corrections resulting from the Mission review, will be available shortly. Copies will be provided to the BDG at that time. However, since the BDG representatives of the team are prominent officials of the PCD, and since they played an active role throughout the evaluation, the findings are undoubtedly well known to the BDG already. This report, therefore, will summarize these findings only briefly.

While the new Government assigns continued high priority to population control to develop human and material resources of the country and the last two years have seen an encouraging increase in family planning acceptance, the evaluation team found that program implementation is hampered by fiscal rigidity, too frequent changes in direction, and by shortcomings in organization, administration, logistics and supply management, training, and supervision. The details regarding these findings are spelled out in the evaluation report. The team also noted that the integration of Health and Family Planning has added new and very extensive requirements for training and created very serious administrative problems in the merger of the two departments at the thana level. The report also mentioned the support of the MOHPC for non-governmental organizations (NGOs) and recognized the NGO contribution to the total national program.

IV. Recommendations of the Evaluation Team

For ease of presentation, the recommendations of the report are categorized into seven components: Administration/Management/Finance; Training; Logistics/Supply; Service Delivery; Operations Research/Contraceptive Prevalence Surveys; NGOs/Local Family Planning; "Beyond Family Planning".

A. Administrative/Management/Finance

1. A two-year population and family planning plan with more specific guidance on priorities and requirements for 1984-85 should be developed.

2. Outstanding organizational issues should be addressed with speed so that continuity in direction and management can be assured in the future.

3. Immediate attention should be given to problems related to integration of health and FP/MCH at the thana level and below.

4. The Government's efforts to decentralize the administration of health and family planning programs in the context of more general reforms to strengthen local government should be encouraged; the role of the Union Parishad in relation to health/FP field-workers should be strengthened.

5. Institution building through the development of performance based reward system for field workers and supervisors should be initiated.

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6. Financial procedures to ensure the prompt release of funds should be simplified; the D.G. (Imp.) should be able to retain unspent funds at the end of the year in the P.L. account to tide the program over until the next fiscal year's allocation; otherwise a revolving fund with donor assistance should be established.

7. The hiring freeze should be lifted to allow existing staff vacancies to be filled.

8. The construction of the physical infrastructure should be completed.

9. The mechanism of USAID funding of NGO projects should be preserved and utilized to the extent of USAID's capacity to monitor and provide technical assistance to such grantees.

10. AID/W should promote joint programming missions with the UNFPA and the World Bank as appropriate.

B. Training

1. A task force on training should be formed to identify training needs of the program and to recommend how to approach them.

2. Institution building through development of greater management training capability in the training and research institutions should be continued and strengthened.

3. An orderly plan for the conduct of MCH/FP field worker training should be developed; the MCH materials budget of the FPS project can be used to develop instructional materials; the MCH/FP workers should be assisted in utilising entry points in the MCH cycle for introduction of child-spacing methods.

4. Suitable funding should be found to implement the retraining of physicians in voluntary sterilization (VS) techniques; the PCD should collaborate with the Health Division to utilize the model clinics of the teaching hospitals for training of medical students and interns in VS techniques.

5. Suitable advancement opportunities should be offered to personnel who acquire specialized skills through training.

6. The trainees of the Indonesian program should be helped to identify the principles at work; predeparture and re-entry discussions with the trainee groups should be held.

C. Logistics/Supply

1. A resident logistics and supply specialist should be provided to PCD for a minimum of two years.

2. PCD should make it clear to each person in the supply chain that supply management is of central, not peripheral, importance;

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newly posted personnel should be trained in the rationale, procedures, and importance of the supply system and development of skills in recording, reporting, resupplying and storage; NIPORT should include adequate supply system training in the syllabi for initial and refresher training of administrative, clinic and field staff.

3. The Supply Manual should be revised to incorporate the full range of MCH/FP supplies and equipment into supply management system.

4. A permanent solution for adequate regional storage facilities should be planned.

5. Long range options for adequate transport capability must be assessed now.

6. A TFPA should be designated as "storekeeper"; an additional post of Assistant District Storekeeper in each district should be established.

D. Service Delivery

1. The relative proportion of reversible methods should be increased in the national program.

2. The compensation costs incurred in referral and acceptance of IUD should be continued and Copper-T insertion should be made available at all clinical sites as soon as possible.

3. Sustained emphasis should be put on the quality of VS services; the Government should be assisted in meeting the conditions precedent and the local costs reimbursement payments should be reinstated once the conditions are met.

4. Clinics providing only sterilization should expand the range of contraceptive alternatives offered.

5. An alternative to the current AID oral contraceptive formulation should be found.

E. Operations Research/Contraceptive Prevalence Surveys

1. USAID should continue to pursue opportunities for funding useful projects in OR; special emphasis should be given to the analysis of the implementation process of health and family planning programs.

2. A cost-benefit analysis of family planning in Bangladesh should be a high priority OR project.

3. USAID should continue support and technical assistance to the MIS Unit and request priority approval of the proposed 1982 CPS.

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F. NGOs/Local Family Planning

1. USAID and the Government should facilitate the contributions of NGOs to the program and seek creative measures to maximize their performance.

2. USAID should continue assistance to NGOs with demonstrated ability to make a contribution.

3. The Local Family Planning Project is a creative innovation but it requires careful nurturing and protection from cumbersome bureaucratic routine and excessive centralization.

4. The Director of the Local Family Planning Project should be urged to finalize it and to provide it with maximum support.

G. Beyond Family Planning

1. In future and follow-up USAID projects, greater attention must be given to "Beyond Family Planning" measures to create conditions favorable to a more rapid and substantial fertility decline.

2. Support should be given to BDG's efforts to create widespread acceptance of the small family norm through the multi-sector projects and adoption of "beyond family planning" measures.

3. Increased emphasis should be placed on programs to delay marriage, increase birth intervals, and decrease family size through mass media programs, and strengthing all aspects of maternal and child health.

V. Mission Assessment of the Evaluation Report

The Mission feels that the evaluation team worked sincerely and conscientiously to perform the tasks specified in their Scope of Work. The findings of the evaluation are useful guidelines for action by the BDG and the USAID Mission. Because of the limited amount of time available for the evaluation, the report is not as specific in some areas as the Mission had hoped. For example, the key section on Management (pp 47-48) is too brief to be helpful. However, this evaluation, taken with the findings and recommendations of earlier evaluations not only by USAID but also by other donors, points clearly at major issue areas which must be examined and dealt with effectively on a priority basis if the population program in Bangladesh is to begin showing results before it is overtaken by the consequences of a disastorously high growth rate which is not being adequately checked and limited by the BDG's current level and quality of effort.

The findings and recommendations of the Mid-Term Evaluation in many instances reiterate the concerns of a series* of evaluations, by both USAID and other donors, over the last eight years. This is indeed a discouraging disclosure. It means that problems of project implementation which were identified, and seem capable of solution, have not been

* (List attached to this report)

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This has led USAID, UNFPA and the World Bank to develop a discussion paper recommending a change in the locus of the Population Control Program. The paper, which has been shared informally with some Ministry staff, recommends a national Population Control Board to plan and implement the program. It is felt that this would be the most effective administrative arrangement to overcome the long standing constraints and problems identified in the F.P. Program.

However, this recommended structure may not be acceptable to the BDG, or may take a considerable amount of time to bring into effect, therefore the following section identifies recommendations to be considered at this time.

VI. USAID Recommendations for Improvement in Performance of Family Planning Program

Given the findings and recommendations of this evaluation, those of previous evaluations, USAID's own experience with the BDG Family Planning Services for nearly a decade, we would like to initiate discussion on a number of tentative recommendations. We are excluding discussion on those recommendations already addressed by the BDG, or those we disagree with, or give lower priority. The recommendations below, once discussed and finalized, will be used, where feasible, in the preparation of our follow-on project amendment to the current Family Planning Services Project. This amendment is due in our AID Washington office on June 15, 1983.

A. Administrative/Management/Finance

1. An indepth evaluation of the current MCH/FP strategy including all management systems - fiscal, planning, manpower development and deployment, service delivery and logistics - should be under taken as soon as possible.

   Outstanding issues are:

   - Effect that integration strategy is having on the delivery of F.P. Services.
   - Setting of priorities for implementation of F.P. and MCH Services.
   - Design of an effective delivery system strategy including identification of realistic tasks for all levels of service providers. The number of tasks for field workers needs to be reduced .
   - Development of an effective supervisory system from central to the field level.

2. A study to determine how and what performance incentives can be implemented for F.P. workers.

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3. TFPO and other supervisory positions should be filled. Field workers positions should be filled as necessary.

4. A revolving fund or other mechanism to relieve the financial constraints should be implemented.

5. A study to determine the cost of Family Planning Services should be undertaken.

B. Training

1. A task force on training needs should be constituted. An immediate need is to rationalize the number of tasks an FWA and FWW perform.

2. The F.P. Services Project participant training component should be evaluated and steps taken to carry out the present plan, revise it, or drop the component.

C. Logistics

1. A long-term logistics and supply advisor to the Director General (Logistics and Supply) should continue without interruption. Such additional assistance in this regard as might be seen to be necessary should be immediately arranged for.

2. The MOHPC should accept and implement the logistics and supply system consultancy report prepared by the UNFPA and USAID or an alternative to these agencies.

3. Several actions should be taken immediately by the BDG to improve the system:

   - Take a physical inventory of all USAID funded commodities, noting date of manufacture of orals and condoms, by location. This should be completed by June 30, 1983.

   - Outdated commodities should be destroyed on a quarterly basis.

   - Total cubic feet of storage space in the central and regional warehouses and the cubic feet of space available as of April 30 should be calculated, also how much space will be needed for new supplies. The planned move of the Chittagong warehouse should be re-evaluated.

4. All storekeepers should be trained within six months.

5. Undertake projections by thana for contraceptive and other MCH/FP supplies and over stocks corrected by June 30, 1983.

D. Service Delivery

1. It is a covenant of the F.P. Services Project that a voluntary a voluntary sterilization surveillance system in accordance with a plan accepted by USAID and in a manner satisfactory to USAID

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will be maintained. We now have no formal mechanism to input or to judge the plan and system. Therefore the USAID medical advisor should be made an Ex-officio Member of the Voluntary Sterilization Surveillance Team.

2. NORIDAY oral contraceptives should be replaced by other acceptable preparations, and USAID should phase out its participation in the supply of oral contraceptives.

3. The Mission emphatically disagrees with the Evaluation Team's finding that too much emphasis is placed upon voluntary sterilization. The Mission feels that this is a complementary, and vital component in an overall set of Family Planning alternatives, and that the aim should be not to decrease emphasis on VS, but rather to improve delivery of other, equally important methods for contraception.

E. Operations Research/MIS

1. The Government should cull the findings from the Operations Research reports of higher quality and prepare a response to these findings.

2. The Government should strengthen the administration of the Operations Research project by joining in a collaborative relationship with an academic institution specializing in Operations Research.

3. The present performance statistics reporting system of the MIS Unit should be evaluated by an outside consultant to determine its accuracy and usefulness and to recommend necessary changes.

F. Local Family Planning/Non-Government Organizations

1. The BDG should contract with an experienced and qualified NGO or NGOs to assist the TFPOs to design needed projects and to provide technical assistance to implement the projects.

2. The policy that NGOs can operate only in urban areas should be reviewed.

3. It is the flexibility of NGO project design, activities, and management that accounts for their success. The BDG should take care that its rules, regulations, and review process not constrain these factors.

4. MCHPC should review the numerous evaluations of successful NGO programs and incorporate replicable aspects of such programs into its own programs.

G. "Beyond Family Planning" Measure

1. A study to identify and cost community and individual incentives should be commissioned. This would be funded through the F.P.

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Services project. Pilot projects for project funding should be identified.

2. The cost factors associated with the "Beyond Family Planning" ideas advanced by the Evaluation Team should be analyzed.

REFERENCES

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2. Evaluation Report on Population Programs 1975-79 Planning Commission, External Unit, Population Section, Government of the People's Republic of Bangladesh, November, 1980.

3. U.S. Assistance to the Family Planning and Population Program in Bangladesh 1972-1980, U.S. Agency for International Development, Washington, D.C. and Dhaka, Bangladesh, April 1981.

4. Report on Bangladesh First Population Project, Population, Health and Nutrition Department International Bank for Reconstruction and Development, International Development Association, September 30, 1982.

5. Mid-Term Evaluation of USAID Family Planning Services Project in Bangladesh (388-0050), submitted to Office of International Health Programs, American Public Health Association, November, 1982.

6. Briefing Note for the Honorable Minister of Health and Population Control, World Bank Mission Paper, December, 1982.

7. Report on UNFPA Annual Country Review (ACR), December, 1982, Dhaka, Bangladesh by UNFPA, Dhaka, January 10, 1983.

8. Office Memorandum on Local Consultations Group Meeting on Population held on Tuesday, December 7, 1982. International Bank for Reconstruction and Development, January 11, 1983.

Summary of Findings of the Evaluation of the Social Marketing Project

The Social Marketing Project (SMP) is a part of the National Population Program. It exists through an agreement between the Government of Bangladesh (BDG) and Population Services International (PSI) and has been funded totally by USAID through a contract with PSI since 1974. It has developed its own system for distributing two brands of condoms, two brands of oral contraceptives (OCs) and one brand of vaginal spermicide tablets.

Impact

By June, 1983 the SMP was providing contraception at an annual rate of 931,000 couple-years of protection (CYP), contributing 67% of the national program's condom protection, 21% of OC protection and 70% of spermicide protection. The SMP accounted for 50% of all non-clinical protection provided by the national program. The entire increase in non-clinical protection provided by the national program since 1975 has been the result of the SMP's sales. Based upon BDG information, the prevalence of use of modern contraceptives in Bangladesh was approximately 18% including an SMP contribution of slightly less than 5%: thus, more than one out of every four users is protected by SMP products. The SMP trend is sharply up over 1982. Condoms are now selling at an annualized rate of 82 million: OCs at 1.75 million cycles; and spermicide tablets at 5.5 million. While condoms continue to contribute the lion's share of the SMP's output, the growth rate for OCs in higher than the growth rate for condoms. Current vigor in the OC sales resulted from a new strategy which emphasized the role of doctors and a large, new category of providers; rural medical practitioners or village "doctors" who have face-to-face contact with OC users. This new strategy, plus the second brand of OCs with a better image, is largely responsible for the surge in OC sales. Since its inception, the SMP has used available mass media, but recently added mobile film units which provide about 80 outdoor showings each month to crowds of 3000-5000 in semi-urban and rural areas. The combination of village doctors and rural film shows should succeed in expanding SMP successes in rural Bangladesh. Added to this are the selling and educating activities of about 85,000 shopkeepers who handle SMP products. An estimated 57-60,000,000 of the 67,000,000 condoms sold by the SMP in 1982 were probably used for family planning in Bangladesh. The remainder were smuggled to India and Burma. Recent research indicates that women have probably under-reported condom use in the past and that the true level may be more than 5% in Bangladesh, thus making the condom about equal in popularity to tubal ligation. The average condom purchaser is a man, aged 25-34, married seven years or less, with three children or less. He probably works as a laborer for about $25.00 per month and is either illiterate or has primary school education. Less is known about usage patterns of OCs and spermicides. New outreach into rural areas through village "doctors" will probably result in greatly increased sales of OCs but usage patterns should be evaluated. The impact of SMP's advertising has made "Raja" and "Maya" generic words for condoms and OCs, respectively. Quantified estimates of brand-name awareness should

result from the 1983 Contraceptive Prevalence Survey which will sample women, men, and couples. The BDG program, NGOs and commercial marketers have benefited from the SMP, particularly from the advertising and education activities.

The SMP has demonstrated that a large impact can be made in a low-income, largely rural, developing country by harnessing a large existing marketing sector at very low cost per unit of output. While providing credibility to the social marketing model, it has broadened awareness and legitimized discussion of family planning in this large, conservative Muslim nation.

Cost-effectiveness

Unit costs of output are low. The SMP's cost of protecting one couple for one year is lower than most other family planning activities in Bangladesh: about $1.66, excluding the cost of the donated contraceptives.

Management, and Marketing

The SMP employs almost 300 people. A management development system should be instituted for middle and senior level management. Market planning and development require greater emphasis. Two Zonal Sales Managers are needed to manage expected intensification of sales development. A computerized management information system is needed to integrate the flow of information at several levels. A systematic classification of sales outlets is needed to assist sales area development planning.

SMP should continue to do what it does best: market branded products aimed at increasing contraceptive use. Management should consider adding several more brands of condoms and OCs over a broad range of prices aimed at increasing total prevalence. Other contraceptive methods, particularly injectables, could be test-marketed to graduate doctors. The SMP should also enlarge its "family" of products to include oral rehydration salts, nutritionals for pregnant and lactating women and useful household medicines. These additional projects will probably enhance the sales of contraceptives and are, themselves, beneficial and necessary. Marketing more products should not require large increases in staff or advertising budgets but will require additional packaging budgets, much of which should be offset by increased sales revenues. Project sales revenue, which is close to $500,000 per year will probably increase rapidly. While revenues can continue to be used to offset operating cost, USAID should clarify its postion regarding other uses, including local capital expenditures and the purchase of non-USAID contraceptives.

Institutional Relationships

Technically, the SMP does not exist as an independent legal entity. It exists as a result of an agreement between the BDG and PSI. All of its funding comes from USAID via relatively short-term contracts with PSI. The short-term, time bound, project-oriented atmosphere was acceptable in the earlier years but is becoming detrimental, particularly when top-level

managers are being recruited: it is difficult to attract and hire top-quality commercial sector people when the future of the organization is unclear. The BDG perceives the SMP as an important part of its national family planning program and USAID should take the lead in institutionalizing it and providing it with long-term funding. By 1986 the SMP may need $10,000,000 annually, mostly in the form of contraceptives and family health products.

Additional Activities

The USAID Mission to Bangladesh is considering expanding its private sector activities to further the goals of the national family planning program. It is considering activities such as social advertising aimed at creating more awareness and practice of family planning in general; delivering contraceptive supplies to BDG outlets; and additional clinical activities such as voluntary sterilization. The BDG also acknowledges the possibility of a broader application of social marketing in its agreement with PSI. All of the above activities are worthwhile but should probably not be undertaken by the SMP, itself. The SMP should intensify its brand-name product marketing and strive to double present outputs within three years. The other activities could be undertaken through a broader structure formulated by the BDG, USAID and PSI. Thus, the SMP would be seen as one "Division" of the new venture while the other activities could be undertaken by other Divisions.

Summary of Activities of FY-83 Project Components Which Will Not Be Refunded Under the Amendment Period

1. Local Family Planning — FY 81-83: $0.2 million

To date, there has been little progress in this activity to develop small family planning projects on the thana level and below. The Local Family Planning activity did not receive the necessary attention from the project director, a senior MOHPC official, and accordingly, projects were not approved and implemented. In early 1984, we plan to reprogram these funds into the new category, "Technical Resources, Research and Training."

2. MCH Materials — FY 81-83: $0.4 million

MCH has been identified as an important need by the government and is closely related to family planning service expansion efforts. We have financed the printing of an illustrated child care booklet developed and distributed by NIPORT for use by family welfare visitors and for training of family welfare assistants. In addition, we are sponsoring in conjunction with UNICEF and the Bangladesh National Nutrition Council a standard child growth chart for use by family welfare workers. A sample card is now being field tested for large-scale distribution.

3. Population Sector Assessment — FY 81-83: $56 thousand

In conjunction with the Population Section of the Planning Commission, we commissioned a Population Sector Assessment designed to examine factors outside the family planning delivery system which affect fertility or, specifically, which affect the demand for family planning services. The Population Council of New York agreed to provide consultants to work in collaboration with Bangladesh consultants and an Advisory Committee. Their report was expected to identify those policy changes or program actions which AID might assist the government to implement. Unfortunately, the final report offered only one recommendation for a costly employment guarantee scheme (EGS). An EGS, it was argued, would reduce the social and economic risk of having few children which was believed to be the principal cause of high fertility. We found this scheme to be poorly justified in the report as well as impractical given obvious high financial cost and overwhelmingly cumbersome implementation implications. The Population and Development Unit of the Planning Commission, however, is examining further the "risk hypothesis" and the feasibility of an EGS in Bangladesh.

4. Female Education Assessment — FY 81-83: $24 thousand

In conjunction with the Ministry of Education, we financed a compilation and review of relevant studies of the value of female education and the status of women in Bangladesh. The investigation provided information on current female educational opportunities to be used for further assessment of potential projects for AID support. The Foundation for Research on Education and Planning conducted the study.

The study report produced considerable information on female education at all levels of the education system, including vocational, and non-formal (both literacy and skills training) education. The data indicate that female participation at all levels has increased rapidly during the past ten years but that females continue to be relatively disadvantaged compared to male participation. At the primary level, about 5.15 million girls are not in school representing about 60 percent of the primary school age group. The male-female ratios of enrollment are 63:67 at the primary level, 75:25 at the secondary level, and 81:19 at the university level. Literacy is about 14 percent for women and 30 percent for men. Some interesting findings on women's education, employment and fertility were also presented. Fertility was inversely related to women's and husband's educational level. Working women were found to have fewer children. However, only 3.5 percent of the total agricultural labour force and 2 percent of the industrial labour force are women. The analysis of the findings was weak and further analysis is planned.

5. Participant Training FY 1981-83: $0.4 million

a. Thana Family Planning Officer

Since March 1982 there have been severe government restrictions on the training of government officials outside of Bangladesh. The Thana Family Planning Officer training program in Indonesia was cancelled by the Bangladesh Government and a successor program has not been developed. Therefore, under the current project no officers were trained.

b. Academic and Professional

Due to the restrictions on training of Government officers, only a limited number of officers received either long or short term training. There have been no new candidates nominated for long term training.

While no FY 84 or 85 funds will be allocated for training, FY 81-83 pipeline funds for this component and some reprogrammed funds from other components will be used to:

(i) Provide long and short term training for BDG and other trainees in the U.S. or third countries.

(ii) Design a new record keeping system for the logistics system and conduct training and follow-up training for the central, regional, district and thana storekeepers and their supervisors.

(iii) Continue management training for the TFPO, either in Indonesia or in Bangladesh may be considered in the amendment period. If a program is conducted in Bangladesh, it is planned to use Indonesian and expatriate training staff working with an appropriate Bangladesh management training institute. The details of the TFPO training will be based on the recommendations of the IBRD Needs Assessment and the outcome of Donors discussions with the MOHPC.

6. Printing FY 81-83: $15 thousand

Printing funds are used primarily for training materials. Funds were programmed for printing 5000 copies of a revised version of the IUD Manual for FWVs, for reprinting portions of the Manual for Sterilization Operations and for printing 2000 copies of a USAID-revised booklet "Population Growth in Bangladesh". It is expected that an IUD manual and a revised VS manual will also be printed in 1984.

7. Operations Research FY 81-83: $0.3 million

Operations Research studies to identify areas of improvement in the MOHPC program were intended to be developed and monitored by NIPORT. NIPORT only recently established appropriate research priorities and out of an anticipated twenty studies, four have been funded. The reports submitted to NIPORT by the principal investigators have not always approached a professional standard which would make them useful to decision makers. Further, those that have been of sufficient quality have not been used by MOHPC program implementers and policy makers. During the amendment period, Operations Research pipeline funds will be reprogrammed into the new "Technical Resources, Research and Training" category and will be used to fund important research studies identified by the Government and USAID.

Table H-1

Planned Inputs and Outputs of Family Planning Services Project (based on Table III of Project Paper) for Expansion of Family Planning Services: MCHPC Component, FY81-83

Project Component Input	Financial Input: FY81-83 Obligation	Financial Input: Expenditure as of 30 June 1983	Planned Outputs (June 1981 - September 1984)	Actual Outputs (June 1981 - June 1983) (60 percent of Project Time Period)
1. Contraceptive equipment and supplies bilateral	6,400,895	2,028,620	Contraceptive supplies are made available to all categories of fieldworkers; medical kits to physicians and paramedics	MCHPC and SMP's needs met for oral pills and condoms, OUT's and foam. Instead of medical kits, at the requestly of BDG an emergency supply of drugs and supplies for VS program purchased.
centrally procured	22,585,975	17,700,000[a]		
2. Voluntary Sterilization Reimbursements	11,492,343	4,740,512[b]	At least 400 BDG sterilization centers operating year around; a total of 1,625,000 sterilization performed by end of project	At least 400 BDG centers are operating year round. Between April 1981, when reimbursement began and June 1983, 725,510 sterilizations performed, Informed Consent forms printed, Sterilization surveillance team operating as of 17 Nov. 1982. Chartered accountant auditing as of April 1983.
3. Local Family Planning Project	250.000	0	Swanivar villages receive small grants to incorporate family planning into village activities. TFPOs receive small grants to sponsor local level improvements in service	Due to in appropriate locus of authority, project bureaucratically unable to proceed. TFPO training cancelled in Indonesia, thereby obviating one of the goals of the project to provide funds for TFPO plans of action

[a] Estimate obtained by assuming all FY 81-82 funds disbursed, and half FY83 pill and condom funds disbursed.

[b] Including accrued VS reimbursements through May 1983 (June 1983 will not be reimbursed).

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Table H-2

Planned Inputs and Outputs of Family Planning Services Project (based on Table III of Project Paper) for Demand Creation (all Components), FY81-83

Project Component Input	Financial Input: FYSI-83 Obligation	Financial Input: Expenditure as of 30 June 1983	Planned Outputs (June 1981 - September 1984)	Actual Outputs (June 1981 - June 1983) (60 percent of Project Time Period)
1. IUD Reimbursements, Individual, Community and Organizational Awards	576,000	119,733[a]	Activities to create demand within the family planning sector	The IUD reimbursement scheme has been funded retroactive to 1 July 1982. USAID agreed in principle to individual awards for outstanding performance as well as community and organizational awards.
2. Mass Media Campaign	Included in PSI/SKP obligation (Table H-6)		To increase frequency and quality of radio programs designed to motivate married couples to reduce their fertility	PSI contracted with Manoff International to develop mass media campaign. Based on sophisticated market research, messages have been developed, pretested and are now on the radio. Newspaper ads, TV spots and short films are now being developed and tested.
3. Feasibility studies	80,000	77,160	At least 5 feasibility studies and/or small scale experiments undertaken relating to increasing demand for fertility control	A Population Sector Assessment for beyond family planning initiatives funded through grant to the Population Council. A Female Secondary Education Assessment completed by a Bangladeshi research firm.
4. Small Scale Experiments/Projects	1,422,507	319,377	At least 5 feasibility studies and/or small scale experiments undertaken relating to increasing demand for fertility control (See 3 above)	Three projects/experiments funded through NGOs in addition to the two through the BDG (See 3 above). Through a grant with the ICDDR,B an experiment is funded to try to transfer innovations of a successful FP project in Matlab to two BDG thanas and also to test in Matlab whether MCH enhances FP services. Through a grant with Helen Keller International, a blindness prevalence survey was funded as a prelude to more demand creating MCH activities. Through a grant to the Bangladesh Association from Community Education a small scale experiment is being conducted to test whether scholarships for secondary education of girls will improve their school attendance.

[a] Including accrued IUD reimbursements through June 1983

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Table H-3

Planned Inputs and Outputs of Family Planning Services Project (based on Table III of Project Paper) for Training: MCHPC Component, FY81-83

Project Component Input	Financial Input: FY81-83 Obligation	Financial Input: Expenditure as of 30 June 1983	Planned Outputs (June 1981 - September 1984)	Actual Outputs (June 1981 - June 1983) (60 percent of Project Time Period)
1. Thana Family Planning Officer; academic and professional training	444,000	109,960	360 TFPOs trained in supervisory and community organizational skills; three mid-level BDG managers receive masters degree academic training; @ 10 senior and mid-level managers from BDG and private sector receive short term professional training in US or Asian Countries	TFPO training program in Indonesia cancelled. No batch of TFPOs trained under these funds. Three BDG officers currently receiving masters level training and one completed. Four persons received short term training, including two BDG logistics officers who were trained at USAID and in US (observational tour).
2. MCH and FP materials	415,000	29,054	MCH and FP training and fieldwork materials and manuals available for use by FWVs, FWAs, TBAs, and other fieldworkers.	55,000 copies of Better Child Care Manual for FWVs and FWAs printed. Compromise version of Growth Chart being field tested. Motivational kits found to be unacceptable, NTPORT/IEM Unit currently reviewing.
3. Printing	15,000	3,905	Not mentioned in project paper	2,000 copies of Population Growth in Bangladesh printed; IUD Manual submitted and in process of being revised.

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Table H-4

Planned Inputs and Outputs of Family Planning Services Project (based on Table III of Project Paper) for Management Information: MOHPC Component, FY81-83

Project Component Input	Financial Input: FY81-83 Obligation	Financial Input: Expenditure as of 30 June 1983	Planned Outputs (June 1981 - September 1984)	Actual Outputs (June 1981 - June 1983 (60 percent of Project Time Period)
1. Contraceptive Prevalence Survey bilateral NGO	150,000 101,787	21,900 10,000	National level prevalence of contraceptive use data available yearly	Secondary analysis project of 1981 CPS funded, but report not submitted. 1982 CPS cancelled due to unsatisfactory proposal by MOHPC for administrative arrangements; 1983 CPS contracted to a private firm; fieldwork began in October 1983.
2. Operations Research	300,000	21,000	At least 20 evaluation studies on different components of the program are completed	New RFP procedures introduced into grant; one RFP topic cancelled due to change in Government. Unwarranted delays in the research topic approval process, One Bibliography funded and completed; Three studies are on-going and three pending concurrence with USAID.
3. Sterilization Surveillance System	Not funded by USAID, but a covenant to the grant		Surveillance system monitors all aspects of the sterilization program	Serious delay in implementing system. Four Bangladeshi doctors in place as of 17 November 1982. Three expatriate doctors in place as of early 1983. In September 1983, USAID finally received copies of the monthly reports of the team.
4. Evaluation	50,000	0[a]	At least six months before the end of project an in-depth external evaluation will be conducted	An in-depth mid-term evaluation conducted in August 1982. Final report received March 1983 and results incorporated into design of follow-on project.

[a]Bill has not been received from NIH

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Table H-5

Planned Inputs and Outputs of Family Planning Services Project during Amendment Period: MCHPC Component, FY 84-86

Project/ Component Input	Financial Input: Expenditures				Program Objectives	Planned Quantifiable Indicators			
	July-Dec 1983	1984	1985	1986		July-Dec 1983	1984	1985	1986
Voluntary Sterilization (VS)	$1,250,020[a]	5,330,200[b]	5,255,220[c]	5,009,585[d]	Perform VS services - Tubectomy	155,000	362,000	416,000	458,000
					- Vasectomy	77,000	134,000	154,000	169,000
					Perform Audit	2	4	4	4
IUD	$ 153,550	381,000	537,500	640,000	Insert IUDs	78,250	240,000	325,000	360,000
					Perform Audit	1	1	1	1
Injectables	-	201,000	420,000	511,500	Provide injectables (Reimbursements for BDG only)		144,000	300,000	310,000
					Perform Audit			1	1
Awards		1,033,000	1,178,600	1,296,900	Provide F.P. performance awards to:				
					Upazillas	21	21	21	21
					Unions	401	401	401	401
					NGOs	10	10	10	10
					Field Workers	2,000	2,000	2,000	2,000
					Award Consultant		1		
					Perform Audits and Evaluation		1	2	2

[a] No payments for MCHPC VS in June-October
[b] Only 80% of V.S. costs for July-December 1984
[c] Only 80% of V.S. costs January-June 1985 and 60% for July-December 1985
[d] Only 60% of V.S. costs January-June 1986 and 50% for July-December 1986.

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Table H5(Continued)

Project/ Component Input	Financial Input: Expenditures				Program Objectives	Planned Quantifiable Indicators			
	July-Dec 1983	1984	1985	1986		July-Dec 1983	1984	1985	1986
Technical Resources, Research and Training	$54,704	505,095	552,000	488,000					
Research and Evaluation					Complete OR projects from original project	2c	2c		
					Begin and complete additional OR projects	2N	1N 2C	1C	
					New research projects		1	3	2
					Evaluation of MAIPC program			1	
Technical Resources					Consultants				
					short term		2	2	2
					long term		1	1	1
					Print growth charts		1,000,000		
					Print MCH/FP motivational kits			50,000	
					Print IUD and V.S. Manual			5,000 5,000	

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Project/ Component Input	Finaicial Input: Expenditures July-Dec 1983	1984	1985	1986	Program Objectives	Planned Quantifiable Indicators July-Dec 1983	1984	1985	1986
Training					Complete ongoing academic training	3c	3c	1c	1c
					New academic training for BDG staff		1N	1N	1N
					Provide shortterm training for both BDG and NGO personnel	1	3	3	3
					Provide training to Thana level store keepers and officers each year		900	900	900
					Provide training to District level store keepers and officers each year		50	50	50
					Design a new logistics reporting and monitoring system		1	1	1
Commodities (Bi-lateral)	$315,835	782,145	954,387	1,098,813	Provide to the NFCP				
					Enko Foam	38,000	75,000	78,000	80,000
					Copper T	70,000	240,000	325,000	360,000
					Catgut	232,000	496,000	570,000	627,000
					Foaming Tablets	2,205,000	5,175,000	5,950,000	6,850,000
Commodities (Central)	$950,000	2,000,000	2,000,000	2,000,000	Provide condoms to the NMPC and NGOs	19,000,000	40,000,000	40,000,000	40,000,000

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Table H-6

Planned Inputs and Outputs of Family Planning Services Project (based on Table III of Project Paper for Expansion of Family Planning Services: PSL-Component, FY81-83

Project Component Input	Financial Input		Planned Outputs (June 1981 - September 1984)	Actual Outputs (June 1981 - June 1983) (60 percent of Project Time Period)
	FY81-83 Obligation	Expenditure as of 30 June 1983		
The Social Marketing Project	7,310,915[a]	3,235,263[a]	Contraceptive products available universally in all urban and rural commercial outlets. CYP increased from 400,000 to 869,000.	Retail outlets increased to over 85,000; major expansion into rural areas achieved. From Jan-June 1983, SMP provided 967,000 CYP, far exceeding its target, due particularly to condom sales.

[a]These funds also include funds for the mass media campaign included under Demand Generating activities, Table H-2.

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Table H-7

Planned Inputs and Outputs of Family Planning Services Project during Amendment Period: PSL Component, FY 84-85

Input	Financial Input: Expenditures July-Dec 1983	1984	1985	1986	Program Objectives		Planned Quantifiable Indicators July-Dec 1983	1984	1985	1986
					SMP					
Social Marketing Project (SMP)	$4,029,000	10,247,000	12,081,000	14,673,000	• Expand number of sales outlets, especially in rural areas	Total outlets	110,000	120,000	130,000	140,000
					• Increase sales of products	Sales of: Condoms (000's)	42,100	110,000	136,400	170,000
						Orals (000's)	735	1,725	2,000	2,300
						Foaming Tablets (000's)	2,205	5,175	5,950	6,850
						Injectable (doses)	-	5	25	100
					• Increase couple years' protection	Total CYP's (000's)	518	1,287	1,595	1,976
					• Increase Film Shows by Mobile Film Units	Total Viewing Audience (000's)	4,000	5,000	6,000	8,000
					• Increase Mass Media Campaign	Radio TV Hours	52	110	120	135

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Table H-8

Planned Inputs and Outputs of Family Planning Services Project (based on Table III of Project Paper) for Expansion of Family Planning Services: NGO Component, FY81-83

Project Component Input	Financial Input: FY81-83 Obligation	Financial Input: Expenditure as of 30 June 1983	Planned Outputs (June 1981 - September 1984)	Actual Outputs (June 1981 - June 1983) (60 percent of Project Time Period)
(i) IPAVS/BAVS	3,767,550	1,563,000	Number of BAVS clinics doubled from 24 to 48; at least 150,000 sterilizations performed	- 28 clinics in place; 6 additional clinics in process of establishment; 133,072 sterilizations performed
(ii) Family Planning Services and Training Center (FPSTC)	650,000	128,000	At least 20 indigenous Bangladeshi PVOs delivering family planning services; increased use of contraceptives, and community support for family planning.	- 18 indigenous PVOs delivering family planning services with community involvement: 3,200 CYP provided in CY 1982, 12,000 CYP provided January-June 1983[1]
(iii) Bangladesh Family Planning Association (BFPA)	675,000	197,000	Clinical services, IGE programs, youth and women's programs and community-based family planning services made available; increased use of contraceptives and knowledge of family planning; increased community involvement in family planning	- 500 traditional healers and 100 local level clubs and PVOs provide community-based services: 19,000 CYP in 1982 and 25,000 CYP in first half of 1983[1]. - Production of one 20 minute, color, family planning motivational film - 20 seminars on family planning held for 2000 local level opinion leaders
(iv) Pathfinder Fund	1,393,000	384,000	Family Planning Services made available in factories, jute mills; District and Sub-Divisional towns; increased use of contraceptives	- 18 subprojects providing family planning services to urban and industrial populations: 8,500 CYP provided in CY 1982; 18,000 CYP provided January-June 1983[1]
(v) The Asia Foundation	1,192,432	75,000[a]	Community-based family planning services integrated into other development efforts of indigenous PVOs; increased contraceptive distribution and use	- 18 local and national PVOs providing community based family planning services; 18,000 CYP provided in 1982; 34,000 CYP provided January - June 1983[1,a]

[1] Data are not available for clinical referrals for January to June 1983; these are an important output of these CBD programs.

[a] As noted in the narrative, inputs and outputs reported for TAF grant reflect the combined inputs and outputs under both the PVO Co-Financing I and the Family Planning Services Projects. $500,000 was expended under the PVO Co-Financing grant, from August 1979 - August 1983.

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Table H-9

Planned Inputs and Outputs of Family Planning Services Project (based on Table III of Project Paper) for Training: NGO Component, FY 81-83

Project Component Input	Financial Input: FYS1-83 Obligation	Financial Input: Expenditure as of 30 June 1983	Planned Outputs (June 1981 - September 1984)	Actual Outputs (June 1981 - June 1983) (60 percent of Project Time Period)
1. Civil: FWV Faculty training	525,000	298,510	Faculty in all 12 FWVTIs (60-80 trainers) trained to train FWVs in clinical family planning and MCH care	Slow start up due to prolonged negotiation with BDG. 16 trainers from first batch completed and posted and 18 trainers are currently completing their training
2. IPAVS/BAVS	Funds included in general grant. See Table H-8	52,000 (for BDG-related training)	Training activities increased; quality of sterilization services improved in BDG and private organizations	- Refresher training program for 600 BDG physicians approved and under implementation - 56 BDG physicians attended BAVS Regional Medical workshops - Consultant completed needs assessment for initial VS training for BDG physicians (In addition, under its central grant funds, BAVS provided VS training to 118 BDG and 103 NGO physicians, as well as 47 NGO paramedics/health auxiliaries involved in VS service delivery)
3. NGO Staff Development	(See Table H-8 for total obligations)	$34,800	None specified	# of participants attending training
				(a) U.S. Short-Term Training/Workshops 5 program managers
		$75,750		(b) Third Country Short-Term Training/Workshops and Observation Tours 26 program managers, 4 trainers and 8 physicians
		Not available		(c) In-country Short-Term Training and Workshops 134 Program managers 176 Field supervisors 1209 Full-time fieldworkers 1000 Part-time fieldworkers 33 Physicians 144 Paramedics 91 Counsellors 51 Administrative staff

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Table H-10

Planned Inputs and Outputs of Family Planning Services Project (based on Table III of Project Paper) for Management Information: NGO Component, FY 81-83

Project Component Input	Financial Input: FY81-83 Obligation	Financial Input: Expenditure as of 30 June 1983	Planned Outputs (June 1981 - September 1984)	Actual Output (June 1981 - June 1983 (60 percent of Project Time Period)
1. NGO - MIS	$35,000	0	Not mentioned in Project Paper	Commencing September 1983, a PSC has been hired to develop a MIS for USAID-funded NGOs (and to provide TA to the 1983 CPS)
2. Evaluations	$46,936	$10,535	Not mentioned in Project Paper	In July 1982, an evaluation of USAID-funded NGOs was conducted by a contractor. In September 1983 an indepth evaluation of the Social Marketing Project was conducted.
3. FHI/BFRP Oral Pill Trial	69,348	0	Not mentioned in Project Paper	USAID added funds to central grant of FHI to conduct through BFRP an important double fund oral contraceptive pill trial comparing AID-supplied pills, NORIDAY, with the Bangladeshi preferred Combination 5. Study will start in December 1984.

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Table H11

Planned Inputs and Outputs of Family Planning Services Project during Amendment Period; NGO Component, Expansion of Family Planning Services, FY 84-86

Project Component/ Input	Financial Input: Expenditures July-Dec 1983	1984	1985	1986	Program Objective	Planned Quantifiable Outputs*	July-Dec 1983	1984	1985	1986
(1) IPAVS	$600,000	1,600,000	1,900,000	2,100,000	BAVS					
					• Expand VS and other clinical family planning services	BAVS clinics	28	34	36	38
						VS performed	33,600	82,000	95,000	110,000
					• Improve medical and counseling quality through physician, paramedic and counsellor training.	IUDs inserted	-	2,000	2,250	2,250
						BAVS Staff Trained				
						Physicians				
					• Increase cost-effectiveness through improved management, IEC programs and outreach	• International	5	6	8	8
						• In-country	45	80	86	93
						Managers				
						• International	6	6	6	8
						• In-country	18	10	12	12
						Paramedics	79	173	130	137
						Counselors	30	31	40	50
						Field Agents	640	720	760	800
					MOHPC & Other NGOs					
					• Improve medical and counseling quality in MOHPC and other NGO programs through training and other activities.	MOHPC Staff Trained				
						• Physicians	315	360	110	110
						• Paramedics	-	-	50	50
						• Counseling Trainers	-	20	20	20
						NGO Staff Trained				
						• Physicians	5	-	30	30
						• Counselors	-	10	15	20
						Workshops/Seminars/ Conferences	4	5	5	5

* Outputs for centrally-funded activities are also included here; outputs for central and bilateral funds cannot be easily isolated. Current levels of central funding are approximately $300,000 per annum and primarily support training and BAVS central office.

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Table II-11 (Continued)

Project Component/ Input	Financial Input: Expenditures				Program Objectives	Planned Quantifiable Outputs				
	July-Dec 1983	1984	1985	1986			July-Dec 1983	1984	1985	1986
1) FPSTC*	$35,000	230,000	320,000	170,000	Expand family planning services through ongoing FPSTC urban sub-projects and through new urban and rural sub-projects	Sub projects	18	22	26	26
						Year-end active users (temporary methods)	21,000	35,000	49,000	60,000
						VS Referral	1,824	3,960	4,524	4,800
						CYPs (temporary methods)	16,000	28,000	42,500	55,000
					- develop institutional capability of FPSTC and its subgrantees through short-term training.	Training:				
						• FPSTC program staff international	2	3	5	6
						in-country	-	-	10	10
						• Project Managers international	3	3	6	8
						in-country:	6	15	15	15
						• Field Supervisor	8	36	40	40
						• Field Workers	40	164	184	184

* All locally-funded activities only; excludes [illegible] subprojects

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Table H-11 (Continued)

		Financial Input: Expenditures				Program Objectives	Planned Quantifiable Indicators				
		July-Dec 1983	1984	1985	1986			July-Dec 1983	1984	1985	1986
(iii)	BFPA	$55,000	300,000	400,000	500,000	- Promote small family norm thru IEC activities; production of films; seminars for village level opinion leaders; establish film lending library.	Films produced	-	1	1	1
							Seminars held	-	20	20	20
							Villages leaders oriented:		2000	2000	2000
						- Expand family planning services thru existing and new innovative CBD service projects	Traditional Healers Project:				
							Thanas	10	20	20	30
							Healers	500	1000	1000	1500
							Voluntary Agencies Project:				
							PVOs/Clubs	100	200	200	300
							Volunteers	500	1000	1000	1500
							New Projects:				
							Service Providers			2500	3500
							Total year-end Active users (Temporary Methods)	40,000	60,000	80,000	100,000
							VS Referrals	4,000	8,000	10,000	15,000
							CYP Temporary Methods	30,000	45,000	60,000	75,000
						Supply other AID-funded NGOs projects with contraceptives	Number of projects supplied	55	75	84	94
						Develop BFPA institutional capability to manage and implement expanded program	Training BFPA Management Staff international	2	6	6	6
							Supervisors trained:	30	40	40	50
							Outreach Workers Trained (Healers, Volunteers, etc.)	-	1000	2000	3000

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Present /	Financial Input: Expenditures				Program Objectives	Planned Quantifiable Indicators				
	July-Dec 1983	1984	1985	1986			July-Dec 1983	1984	1985	1986
Pathfinder	$190,000	400,000	500,000	600,000						
					Continue and expand community-based family planning services in urban areas; introduce interventions to improve acceptance and continuation rates	CBD Subprojects				
						Urban	16	25	25	25
						Rural	-	4	4	8
						Year and Active Users (Temporary Methods)	44,000	93,000	124,000	160,000
					Expand CBD services in rural areas thru collaborative projects with MOHPC and other Multisectoral Ministries	VS Referrals	2,200	9,200	9,200	10,700
						CYP (Temporary Methods)	30,000	69,000	108,000	142,000
					Expand clinical services in industrial and plantation sectors	Clinical projects	-	4	6	8
						VS Performed	-	9,600	14,400	19,200
						IUD Inserted	-	9,600	17,300	26,400
					Develop institutional capacity of Pathfinder and subprojects thru short-term training for staff at all levels	Pathfinder Program Staff				
						International	-	2	3	4
						In-country	-	3	3	6
						Subproject Managers	-			
						International	-	6	6	6
						In-country	-	9	9	9
						Supervisors	-	24	36	48
						Field Workers	-	150	200	250
						Physicians	-	4	8	12
						Paramedics	-	8	16	24
					Hold workshops and seminars to encourage participation of women and local leaders in family planning activities	Seminars held:		1	2	2
						women and local leader participants:		250	500	500

*Bilaterally-funded activities only; excludes Pathfinder centrally-funded projects

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Table H-11 (Continued)

Project Component/ Input	Financial Input: Expenditures				Program Objective	Planned Quantifiable Outputs				
	July-Dec. 1983	1984	1985	1986			July-Dec. 1983	1984	1985	1986
(b) The Asia Foundation	$250,000	700,000	900,000	1,000,000	Continue and expand community-based family planning services thru local PVOs in urban and rural areas	Subprojects	19	24	30	35
						Year-end Active Users (Temporary Methods)	60,000	120,000	180,000	220,000
						CYP (Temporary Methods)	45,000	90,000	60,000	200,000
						VS Referrals	3,028	6,000	8,500	10,000
					Develop institutional capacity of TAF/ Bangladesh and sub-grantees to manage and to provide an expanded family planning program	Training				
						• TAF local staff (international)		3	2	1
						• Project Managers				
						international	3	6	8	6
						incountry	1	24	30	35
						• Supervisors	15	110	140	160
						• Paramedics	3	15	6	20
						• Fieldworkers	60	440	560	700

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[illegible]	Financial Input: Expenditures				Program Objective	Planned Quantifiable Outputs				
	July-Dec. 1983	1984	1985	1986			July-Dec. 1983	1984	1985	1986
(vi) FPIA		$93,000	445,000	680,000	Expand community-based family planning services in rural areas through subprojects with Bangladeshi NGOs	Subprojects:				
						large	-	0	1	2
						small	-	2	4	4
						Year-end Active Users (temporary methods)	-	3,000	30,000	58,000
						VS referrals	-	500	4,500	9,100
						CYP (temporary methods)	-	1,000	16,000	44,000
						Training: Project Managers				
						International:	-	2	4	4
						In-country:	-	2	2	2
						Field Supervisors:	-	11	66	39
						Field workers:	-	57	328	195
					Assist MCHPC to utilize union population control committees (UPCCs) to strengthen grass roots support and supervision for national family planning program, and to increase rural acceptance of family planning	UPCC's involved in FP activities:	-	-	80	150
						Training for UPCC members international	-	2	5	5
						in-country	-	-	2480	1550
						Increase in contraceptive prev. in trained UPCC areas (percentage points):	-	-	10	20

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Table H-12

Planned Inputs and Outputs of Family Planning Services Project during Amendment Period: NGO Component, Demand Creation and Training, FY 84-85

Input	Financial Input: Expenditures July-Dec 1983	1984	1985	1986	Program Objectives		Planned Quantifiable Indicators July-Dec 1983	1984	1985	1986
ICDDR,B	$ 120,000	1,303,000	687,000	600,000	a. Test enhancement of FP by addition of intensive MCH in Matlab		MCH research implementation	Research reports		
					b. Test the transfer of Matlab innovations to two BDG Thanas		Operations research implementation, documentation notes	Research reports	Moniter-ing of BDG Thanas	Long-term follow-up report
					Transfer of Matlab training innovations to additional thanas		-	Start-up, organi-zing, training	Imple-menta-tion, opera-tions research	Evalua-tion reports
					1. Technical Assistance from Population Council		-	1 Scien-tist (10 mos.)	1 Scien-tist (12 mos)	1 Scien-tist (2 mos)
CARE	$100,000	191,000	160,000		Provide 6 months trainingcourse to new PMTI faculty.					
					No. of Trainers		18	24	20 (?)	
					Provide 2 week refresher training to PMTI faculty.					
					No. of workshops		6	5	5	
					No. of trainers		72	60	60	
BACE	40,000	80,000	90,000	100,000	Provide secondary school scholarship to girls in one rural thana to insrease female secondary enrollments and improve con-tinuation rates, thereby delay-their marriages and reducing their eventual fertility.	Number of scho-larships/ girls enrolled	2350	3040	3700	4400

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USAID Strategy for Funding of Non-Governmental Family Planning Projects in Bangladesh

A. Background

In the past, AID has supported non-governmental family planning services in Bangladesh chiefly through AID/W central grants to intermediary agencies such as IPAVS, FPIA, PSI and The Pathfinder Fund. Experience has shown that non-governmental organizations (NGO's) are highly effective channels for delivery of family planning services. Accordingly, in developing the Family Planning Services Project (FPSP), which comprises the bulk of AID family planning assistance to Bangladesh from 1981 to 1983, the Mission has programmed significant support for NGO's in addition to proposed support for the government family planning program. The FPSP provides for several "bilateral" grants to complement (or in some instances to replace) central grants to NGO's. The objective of increased funding for NGO activities is to expand available family planning services. The end goal of the project is a national contraceptive prevalence rate of 25% by October, 1983. NGO's are expected to account for a prevalence rate of 10%, or two-fifths of national prevalence. To achieve this target, NGO's would have to provide services to approximately 1.9 million eligible couples by October 1983.

B. Family Planning Services provided by NGO's

Three major types of services are described in the Project Paper and are currently provided by AID-funded NGO's:

(i) Contraceptive Retail Sales (CRS) through the Social Marketing Project (SMP): The Project Paper target is to increase couple years of protection from 400,000 to 869,000.

(ii) NGO Clinical Services for Voluntary Sterilization (VS): The primary channel for these services is BAVS. The number of BAVS clinics is expected to increase from 25 to 48 and the target for VS procedures to be performed by BAVS over the three years period is 150,000.

(iii) Community-Based Distribution (CBD) Programs: A variety of such projects are funded bilaterally through Pathfinder, The Asia Foundation, BFPA and FPSTC, as well as centrally through FPIA and Pathfinder. There are no numerical goals specified in the Project Paper for these programs. However, as noted above, if the overall goal is to be met, NGO's must serve approximately 1.9 million acceptors in October, 1983 (this includes centrally-funded and non-AID NGO activities). If SMP and BAVS are to account for approximately 1 million acceptors, other NGO's will have to provide services to a total of about 900,000 acceptors, almost three times the estimated number of acceptors served by NGO projects in mid-1981.

In addition to direct provision of services, AID NGO Grantees are providing technical assistance to the BDG program through the CARE FWV Trainers Training Program and BAVS-sponsored training of government medical personnel.

C. AID Strategy for NGO Funding

As AID significantly expands NGO family planning activities in Bangladesh through "bilateral" grants, there is a need for a coherent policy and establishment of priorities for funding of NGO projects. After consultation with the major AID Grantees and Contractors, the Mission has formulated certain priorities. These are discussed below, focusing on certain key issues AID has identified.

1. Innovation versus Replication of Established Approaches: USAID believes that the three major established approaches to FP service delivery in Bangladesh - CRS, VS clinics and CBD - have proved themselves to be highly effective. The Mission will therefore give highest priority to replication and expansion of all three types of services. However, AID Grantees have expressed the need to explore new channels for motivation and service delivery. The Mission will assess innovative proposals chiefly on their anticipated cost-effectiveness relative to the established models. The proposals should establish that there is a reasonable expectation that the innovations will result in more effective and/or cheaper service delivery than existing approaches.

2. Single-Service or Integrated Projects? The relative merits of vertical and integrated FP projects have long been the subject of controversy. Both bilateral and central grants for family planning activities, however, are made with population funds rather than with general development or health funds. Moreover, without a significant expansion of family planning services, the project goal for Bangladesh will not be reached. Therefore, the primary and overriding emphasis of proposals submitted to USAID should be family planning motivation and service provision.

   Several of the Grant Agreements under the FPSP, however, make provision for funding of ancillary activities. This recognizes that such activities may enhance and reinforce family planning acceptance as well as fieldworker credibility. USAID approval for ancillary activities will depend on their linkage with family palnning. We will look for a strong relationship between the type of ancillary activity proposed and FP acceptance; and we will expect such activities to be clearly secondary to the FP program. We also expect that, as far as possible, proposed non-family planning interventions will be low-cost activities reaching large numbers of people.

   In the past AID has funded so-called "income-generating" activities designed to assist subgrantees in generating at least a part of program costs themselves. We would like to establish two guidelines for funding such activities in the future. First, these types of activities should be established on a non-subsidized profit-oriented

basis as soon as possible. Second, before funding such activities across the board, we will require evaluation of a representative sample of such pilot projects indicating that this approach has had success and identifying criteria that have been associated with achievement of any degree of financial self-sufficiency.

3. Cadillac or Volkswagens? The Issue of Costs: USAID will pay greater attention to acceptor costs than in the past This does not mean that we consider quality unimportant. We recognize that in both clinical and CBD projects, the quality of services is an important factor determining project performance. Moreover, in clinical projects, it is imperative to maintain standards that ensure safe medical care. However, we need to expand FP services to the maximum extent possible within limited available resources while maintaining necessary standards. This would rule out support for "model" projects which emphasize quality regardless of cost. The only justification for a high-cost "pilot" project in our opinion is if it is expected that the activity can be replicated in the future at acceptable cost.

   We do not suggest that NGO's should not concern themselves with the quality of services. This would be antithetical to the spirit of voluntary agency family planning activities in Bangladesh. But we do suggest that NGO's should not only concern themselves with being high-quality "models", but also with providing low-cost and replicable services.

   AID also suggests that Grantees give more careful consideration to refunding projects that have performed poorly in successive years. Experience indicates that where performance is so poor that subgrant costs per acceptor exceed $10 in refunded CBD projects and $50 per sterilization procedure in clinical projects, termination of project activities is indicated, assuming of course that such projects have not responded to serious efforts to improve performance and/or lower costs.

   While we will continue to support small, community-based projects, we feel that more advantage could be taken of economies of scale. Larger-scale projects not only reach more beneficiaries, but they may be more cost-effective. Administrative and establishment costs are high for very small CBD programs and clinics. We would like to see successful small projects expanded, wherever feasible within management constraints. Where there is an ongoing project is a given area, we would prefer to see this developed and expanded rather than a new project initiated next-door.

4. Improved Geographical Coverage: In the past, AID has not had a geographical strategy for funding NGO activities. The BDG, however, has encouraged NGO's to work in urban rather than rural areas. In our discussions, a majority of AID Grantees appeared content to focus on urban areas. We therefore propose a strategy for AID NGO Grantees: to provide clinical and CBD services to District and

Sub-Division towns. The SMP, of course, will continue to expand its retail outlets in both urban and rural areas.

In those Districts towns where several NGO's are already working, we would prefer to see existing projects expanded to meet service gaps (as mentioned in Section 4). The exception to this may be the few major cities in Bangladesh where ongoing projects do not have the capability to meet existing service gaps. Sub-Division towns should be a primary target for new CBD and clinical projects; the majority of these towns are lacking adequate services today.

The majority of Bangladeshis live in rural areas, and contraceptive prevalence rates in these areas lag far behind urban rates. Alongside this "urban" strategy for CBD and clinical programs, therefore, we will support proposals for rural projects that do not contravene current BDG guidelines. The BDG guidelines do not restrict NGO's from operating clinics in rural areas or from utilizing volunteers as opposed to fulltime fieldworkers. Innovative and integrated projects are also permitted in rural areas under these guidelines.

5. Independent Projects or Collaboration with BDG Program? The majority of NGO programs owe their success to their relative independence from government "red-tape" and their freedom from the personnel disputes which frequently disrupt the government program. USAID will therefore continue to support NGO clinics and CBD programs that operate independently of the BDG program.

   However, despite the concerted efforts of NGO's, the reality is that overall prevalence goals will not be met unless performance of the BDG/FP program improves. USAID therefore encourages NGO collaboration with the BDG to improve the motivation and productivity of BDG/FP personnel and the effectiveness of the government program at both national and local levels.

6. Commodities and Logistics: It appears that since FPIA contraceptive commodity imports ceased several years ago, NGO's have faced substantial difficulty in obtaining adequate supplies on a regular basis. USAID will give high priority to resolving existing bottlenecks in the supply of commodities by the government to NGO's, and to exploring alternative proposals for establishing an autonomous supply system for NGO's.

D. Conclusion: The broad guidelines above will be used in assessing proposals for utilization of both bilateral as well as central grants. However, establishment of these priorities does not imply that proposals which do not adhere to these guidelines will be rejected out of hand. But Grantees should be aware that proposals that diverge significantly from USAID's stated priorities will come under close scrutiny and require strong justification for their approval.

Project-Funded NGO Family Planning Service Delivery Activities

	Intermediary/Grantee	Subproject	Location	Type of Organization	Subproject Start-date (No/yr)
1.	International Project of the Association for Voluntary Sterilization (IPAVS)	Bangladesh Association for Voluntary Sterilization (BAVS) Satellite Clinics and Expansion Program	- Chittagong, Mymensingh Rangpur, Pabna Sirajganj, Bogra Tangi, Comilla Jamalpur, Sylhet, Chandpur, Rajshahi Noakhali, Rangpur Cox's Bazar, Faridpur Kushtia, Barisal Jessore, Khulna Dinajpur	National - level family planning NGO with branch clinics at District and Sub-Divisional level	ongoing at inception of Project 0050
			- Keyerbazar (Vasectomy)		April 1981
			- Hilper (Vasectomy)		August 1981
			- Dhaka		September 1981
			- Narsingdi, Natore, Brahmanbaria		August 1983
2.	Family Planning Services and Training Center (FPSTC)	- Jhenidah Mitri Mangal Samity	Jhenidah, Jessore	Women's Organization	March 1982
		- Sarbas Khi Parthar Tarikalpana Samity	Dumlatpur, Khulna	"	"
		- Mahila Angon	Kamshiganj, Dhaka	"	"
		- Sadhipara Samaj Kallyan Mahila Samity	Dhaka	"	"
		- Patiya Samaj Kallyan Sangha	Patiya, Chittagong	Social Welfare Organization	"
		- Ipsarita	Chittagong Municipality	Women's Organization	"
		- Bangladesh Mahila Samaj Samity	Dhaka	"	April 1982

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Intermediary/Grantee	Subproject	Location	Type of Organization	Subproject Start-date (mo/yr)
[illegible] (Contd.)	• Nirdeshika Multilateral Voluntary Women's Organization	Naogaon, Rajshahi	Women's Organization	September 1982
	• Golapkuri Mitri Mangal Samity	Lakshmipur, Noakhali	"	"
	• Kirchan Mahila Samity	Dinajpur	"	"
	• Kalikapur Jaba Sangsad	Patuakhali	Youth Organization	December 1982
	• Kallyani Mahila Sangsad	Chapai Nawabganj, Rajshahi	Women's Organization	"
	• Nari Kallyan Samity	Cox's Bazar, Chittagong	"	February 1983
	• Mill an Club	Nilphamari, Rangpur	Social Welfare Organization	"
	• Bangladesh Mahila Sangha	Narayanganj, Dhaka	Women's Organization	May 1983
	• Ekata Mahila Sangstha	Natore, Rajshahi	"	July 1983
	• Netrakona Family Welfare Association	Netrakona, Mymensingh	Social Welfare Organization	September 1983
	• Uttara Sangha	Kushtia	"	November 1983
Bangladesh Family Planning Association (BFPA)	• Traditional Rural Healer's Involvement in Family Planning Activities	Dhaka: Mirkilaya, Dhaka; Bhuapur, Tangail; Sonbagh, Noakhali; Sitakunda, Chittagong; Durgapur, Rajshahi; Santhia, Pabna; Birol, Dinajpur; Nasirnagar, Kushtia; Mirzagonj, Patuakhali; Dumtola, Khulna	Not applicable	September 1981
	• Utilization of Voluntary Agencies in Population Activities: Phase I	BFPA District Branches in: Barisal, Bogra, Comilla, Chittagong, Dhaka, Faridpur, Jessore, Khulna, Mymensingh, Pabna, Noakhali, and Rajshahi	60 local clubs and women's and social welfare organizations	September 1981

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Intermediary/Grantee	Subproject	Location	Type of Organization	Subproject Start-date (mo/yr)
BFPA (Contd)	Utilization of Voluntary Agencies in Population Activities, Phase II.	BFPA District Branches in Kushtia, Patuakhali, Dinajpur, Jaisalpur, Rangpur, Sylhet, Tangail, Chittagong Hill Tracts	40 local clubs and women's and social welfare organizations	June 1982
Pathfinder Fund	• Jatiya Mohila Porivar Porikalpana	Sirajganj, Rangpur	Family Planning Organization	July 1981
	• Community-based Services (CBS) Pabna	Pabna	Municipal Council	October 1981
	• CBS Habiganj	Habiganj, Sylhet	"	"
	• Tillottama Women's Voluntary Organization	Rajshahi	Women's Organization	December 1981
	• Sabha Porikal	Bagerhat, Khulna	Family Planning Organization	September 1982
	• Bangladesh Jatiya Mohila Sangatha	Ishwardi, Pabna	Women's Organization	October 1982
	• CBS Thakurgaon	Thakurgaon, Dinajpur	Municipal Council	January 1983
	• Voluntary Parivar Kallyan Association	Rajbari, Faridpur	Family Planning Organization	February 1983
	• CBS Perojpur	Perojpur, Barisal	Municipal Council	August 1983
	• Bogra Parivar Kallyan Mohila Samity	Bogra	Women's FP Organization	"
	• CBS Kishoreganj	Kishoreganj, Mymensingh	Municipal Council	"
	• Madaripur Family Welfare Association	Madaripur, Faridpur	Social Welfare Organization	"
	• Chitra Mohila Samity	Narail, Jessore	Women's Organization	"
	• Sebai	Mulishpur, Khulna	Family Planning Organization	September 1983
	• Prostutti	Patuakhali	Social Welfare Organization	October 1983
	• CBS Sreemangal	Sreemangal, Sylhet	Municipal Council	"
	• Aasara Mohila Samity	Satkhira, Khulna	Women's Organization	November 1983

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	Intermediary/Grantee	Subproject	Location	Type of Organization	Subproject Start-date (mo/yr)
5.	The Asia Foundation (TAF)	- Concerned Women for Family Planning (CWFP) MCH, Clinics*	Dhaka	Women's Family Planning Organization	July 1980
		CWFP branch Programs (5)	Sylhet, Shajadpur, Meherpur, Barisal, Bogura		July 1983
		- Fatema Rural Education and Health Center*	Mirsarai, Chittagong	Community Development Organization	May 1981
		- Dedicated Women for Family Planning*	Comilla	Women's FP Organization	January 1979
		- Palashipara Samaj Kallyan Samity*	Gangni, Kushtia	Community Development Organization	May 1981
		- Mirpur Family Planning Project*	Mirpur, Dhaka	Family Planning Organization	October 1981
		- Progotishil Samaj Kallyan Samity*	Dhamrai, Dhaka	Community Development Organization	November 1981
		- Udayan Sangstha*	Daudkandi, Comilla	"	August 1982
		- Nirabik Sahajya Sangstha*	Dhaka	"	"
		- Sarsi Udayan Proshikhon Kendra*	Dinajpur	"	August 1982
		- Bangladesh Development Services Center*	Maheshpur Thana, Jessore; Sarailgram, Kotwali and Gaibandhapur Thanas, Bogra; Tarash Thana, Pabna; Parbatipur Thana, Dinajpur; Sadullapur and Mirpur Thanas, Rangpur;	"	December 1982

*Initially supported under PVO Cofinancing (0010), follow-on funding from Family Planning Services (0050)

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5 (Contd)

Intermediary/Grantee	Subproject	Location	Type of Organization	Subproject Start-date (mo/yr)
TAP (Contd)	• Palli Sishu Clinics	Badalgachi and Naogaon, Rajshahi Kotwali and Golapganj Thanas, Sylhet, Sitakunda Thana, Chittagong, Kazipur Thana, Pabna	Community Health Organization	January 1983
	• Samaj Kallyan Parishad	Kushtia	Community development Organization	May 1983
	• Bandhan	Sadharan Thana, Barisal	"	"
	• Southern Gono Unnayan Samity	Gopalganj, Faridpur	"	"
	• Concerned women working for family planning	Chittagong	Women's FP Organization	June 1983
	• Chinnamul Mahila Samity	Gaibandha, Rangpur	Women's Organization	"
	• Barsaful	Chittagong	"	July 1983
	• Association for Family Development	Mirpur, Dhaka	Family Planning Organization	October 1983

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Summary of Findings of 1982 NGO Evaluation

As part of the Mid-Term Evaluation, a consultant, Keekee Minor, was employed to assess the status of AID-funded non-governmental family planning activities under the Mission grants, and to make recommendations to the Evaluation Team regarding continued AID support for NGO family planning activities.

The consultant concluded that the broad objectives of USAID and its non-governmental population intermediaries were fundamentally compatible, and that the intermediaries for the most part have strong institutional structures and credibility in the area of family planning. The report focussed on problems in the BDG program that adversely affect implementation of expanded NGO programs funded under the bilateral grants. Specific problems areas identified by the consultant and recommended to the Evaluation Team for follow-up action include difficulties in obtaining contraceptive supplies and sterilization reimbursements and long delays in obtaining BDG approval for new activities. She also identified the need for a uniform acceptor reporting system by USAID grantees, in order to evaluate performance of USAID-funded NGO programs more effectively.

The consultant recommended that USAID continue to support NGO programs from bilateral funds at current levels. She also recommended that USAID consider direct funding for large, mature projects. However, direct funding should be restricted to large-scale, soundly-designed, low-risk activities, with more experimental and high-risk activities to be funded through intermediaries.

Technical Analysis: Demographic Estimates and Project Targets

I. Project Paper Estimates and Targets

The purpose of the Family Planning Services project was to increase the prevalence of contraceptive use from approximately 13.6 percent of currently married women in 1979[1] to 25 percent by the end of FY 1983. The project goal of 25 percent prevalence included modern methods only. Estimates of fertility in the project paper were derived from results of the 1975 Bangladesh Fertility Survey, the preliminary results of the 1979 Contraceptive Prevalence Survey (CPS), MIS Service Statistics, and estimates prepared by Dr. Hong[2]. From these, USAID estimated that the crude birth rate had declined from 47/1000 in 1975/76 to about 44/1000 in 1979 and that it would be 42 in FY 81 and around 38 in FY 83. The crude growth rate was estimated to be 2.6 percent in FY 81 and was expected to drop to 2.2 percent in FY 83. The following table summarizes the project paper measures of project success:

	FY 81	FY 82	FY 83
CBR	42.0	40.0	37.8
CDR	16.0	16.0	16.0
CGR	26 0	24 0	22 0
CPR	17.4%	21.2%	25.0%

In 1981, after the project had started, three important data sources became available. The March 1981 census revealed a population of 87,052,024 which was lower than expected based on the results of the 1974 census. After adjusting for undercount on the basis of the post-enumerative survey, the population of Bangladesh was estimated to be 89,940.00. As there was some question about the validity of the 1974 census results, the Bureau of Census advised USAID to compare the 1961 and 1981 census to estimate trends. The intercensul growth rate implied is 2.6 percent.

In June 1981, the final results of the 1979 National Contraceptive Prevalence Survey (CPS) were published. Prevalence of modern methods was 8.8 percent and all methods 12.1 percent -- less than the 13.6

[1]The estimate of 13.6 percent was derived from the preliminary results of the 1979 Contraceptive Prevalence Survey. This included modern and traditional methods.

[2]In 1980 Dr. Hong under contract with USAID, compiled and analysed all available demographic data and produced the monograph, Demographic Characteristics of Bangladesh.

percent originally estimated. The field survey of the CPS was conducted in September 1979 - January 1980. Utilising the regression line derived from comparing prevalence rates and crude birth rates one year later[3], USAID estimated, using the prevalence of modern methods only[4], the birth rate at the beginning of 1981 to be approximately 43.

In December 1981 the results of the 1981 CPS, conducted in the summer of 1981, were available. The prevalence was found to be 18.6 percent, 11.0 for modern methods and 7.6 for traditional. Again, utilising the regression line derived from comparing prevalence rates and crude birth rates one year later, USAID estimated, using the prevalence of modern methods only, the birth rate in 1982 to be 42.

Based on these data, USAID has revised somewhat the demographic estimates for 1981-1983 of the project paper. We estimate the crude birth rate (CBR) declined from 44 in 1979 to 43 in 1981 (instead of 42 estimated previously). We estimate the crude death rate to be 17[5] so that the resulting growth rate is 2.6 percent for 1981, as implied by the census results referred to above.

Assuming no decline in mortality in 1982 and a CBR of 42 as indicated by the results of the 1981 CPS, the resulting growth rate would be 2.5 percent. Table M:1 summarizes the revised estimates for 1981-1983 as well as gives our future project targets under the project paper amendment. USAID has contracted for a major 1983 contraceptive prevalence survey. Field work began in October and will continue through January 1984. Based on these results we will have a more accurate estimate of prevalence at the end of the 1983. As for mortality, we are assuming slight decreases in the CDR as a result of the health impacts of family planning in reducing infant and maternal mortality.

II. New Estimates, Projections and Project Targets

The project had planned to use contraceptive prevalence surveys as the major evaluative tool. Due to delays in BDG approval, the 1982 CPS had to be cancelled. Estimates for future use have had to be derived from the very preliminary results of the 1983 CPS and from the baseline survey of the Communication Project of SMP. From the CPS, we have utilised the

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[3]Nortman, D.L. and E. Hofstatter, Population and Family Planning Programs (A Compendium of Data Through 1978). The Population Council, New York. Figure 4, p.94.

[4]As the proportion of traditional method use is high, utilising the total prevalence versus the estimated birth rates (e.g., with 1975 BFS findings) results in points above the regression line. Modern methods provide a better estimate of contraceptive prevalence to be used in this graph, as the regression line is derived from results of many countries which mainly use modern methods.

[5]From the data presented in the Hong monograph, the CDR does not appear to be greater than 19 nor less than 15. Thus, 17 is a good mid-point estimate.

Table M: 1

Demographic Estimates and Estimates of Number of Eligible Couples (EC) at the End of June and End of December, by Year

Year	Crude Birth Rate	Crude Death Rate	Crude Growth Rate	Modern Method CPR	Population End of June[1] (in millions)	EC End of June[2] (in millions)	Population End of December (in millions)	EC End of December (in millions)
1981[a]	43	17	2.6	11.0[b]	90.5	17.2	91.6	17.4
1982[b]	42	17	2.5	13.0[c]	92.8	17.6	93.9	17.8
1983[c]	41	17	2.4	15.0[d]	95.1	18.1	96.2	18.3
1984[d]	41	17	2.4	17.5[e]	97.4	18.5	98.5	18.7
1985[e]	40	16	2.4	20.9[f]	99.7	18.9	100.9	19.2
1986[f]	38	16	2.2	24.6[g]	102.1	19.4	103.2	19.6
1987[g]	37	15	2.2	28.2[h]	104.3	19.8	105.4	20.0

[1] Using 89.9 million in March 1981 (census result, corrected) as the base population

[2] Using Planning Commission assumption of 19 percent of total population = EC.

[a] Based on 1981 census results. Intercensal growth rate between 1961 and 1981 was 2.59%. (These two censuses are considered better estimates than the one in 1974.)

[b] Based on 1981 CPS results, we estimate, using the regression line between crude birth rate and CPR, that fertility is about 43. Assuming mortality is 17, the resulting growth rate is 2.5 percent.

[c] Based on USAID estimate of CPR of modern methods as about 13 percent in 1982, the corresponding CBR would be 41 in 1983. Assuming mortality remains constant at 17, the resulting growth rate is 2.4 percent.

[d] Based on very preliminary results of the 1983 CPS, the estimate of CPR of modern methods is 15.0. The corresponding CBR would be 41 in 1984. Assuming mortality remains constant at 17, the resulting growth rate is 2.4 percent.

[e] Based on USAID estimate of CPR of modern methods as 17.5% in 1984, the corresponding CBR would be 40 in 1985. Assuming a slight decrease in mortality due to the effect of birth control methods and child spacing lowering maternal and infant mortality, the resulting growth rate is 2.4 percent.

[f] Based on USAID estimate of CPR of modern methods as 20.9% in 1985, the corresponding CBR would be 38 in 1986. Assuming mortality remains constant, the resulting growth rate is 2.2 percent.

[g] Based on USAID estimate of CPR of modern methods as 24.6% in 1986, the corresponding CBR would be 37 in 1987. Assuming a slight decrease in mortality due to the effect of birth control methods and child spacing lowering maternal and infant mortality, the resulting growth rate is 2.2 percent.

[h] Measured by independent CPS

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unedited data from 33 rural spots and 17 urban spots which include district and subdivisional towns. For an estimate of Dhaka and Chittagong metropolitan areas, we have used the urban results of the Communication Project. The two sets of urban results have been averaged and then weighted in relation to the rural results to give total prevalence. We have adjusted the condom, tubectomy and vasectomy prevalences slightly upward to reflect the high usage towards the end of the calendar year which the final months of CPS data collection should reflect. When the final results of the 1983 CPS are available in April 1984, our estimates can be examined and adjusted.

Table 8 of the text presents USAID's project prevalence rates based on a series of assumptions as well as our planned project outputs. From these projections, the goal of this project paper amendment is to increase contraceptive prevalence of modern methods to 25 percent by December 1986 and 28% by December 1987, from an estimated 15 percent in December 1983. As the proportion of traditional method use is difficult to estimate, we only tentatively suggest that by December 1987, overall prevalence will be about 32 percent. The assumptions and calculations from planned outputs are given in sections III and IV. The projections are made to 1987, the period of time when project inputs will be utilised.

III. Assumptions for USAID Estimate of Contraceptive Prevalence

A. BDG will pay performance bonuses to service providers and reimbursements to clients for both VS and IUD.

B. No shortage of supplies.

C. More physicians trained in VS.

D. Between the BDG fiscal year 81-82 and 82-83, there was approximately a 20 percent increase in VS (tubectomy, 18 percent; vasectomy, 27 percent). Given this increase, with increased reimbursements and performance bonuses coming into effect in mid-1984, we expect at least a 25 percent increase from CY 83 to CY 84. From CY 84 to CY 85, we expect a slightly decelerating rate of 15 percent as the pool of potential VS acceptors shrinks. From CY 85 to CY 86 and from CY 86 to CY 87 we expect a further decelerating rate of 10 percent as the number of VS acceptors readily motivated to accept VS further declines. These targets are considered to be somewhat optimistic. However, the MOHPC could do substantially more if its family planning services system were fully operational.

E. Expansion of the Social Marketing Project by 1985 both in terms of quantities sold and items marketed (e.g., injectables).

F. Fieldworkers will not be asked to give more emphasis to other health interventions.

G. Steps taken to meet TFPO demands so that they cooperate with the program.

IV. Estimates of Contraceptive Prevalence, by Method, to be Obtained from Independent Contraceptive Prevalence Surveys (CPS)

This section contains the calculations of estimates of contraceptive prevalence we expect to obtain from independent CPS. Table 8 of the Technical Analysis of the text presents a summary of prevalence by method and by year. The CPS is not a good tool to measure prevalence by implementing agency. This will be estimated instead by using service statistics. See Section V for the estimates of prevalence by implementing agency.

A. Tubectomy Estimates

1. CY 1983: January-September performance was 186,000. Based on preliminary reports of October performance plus examining previous year performance, we estimate October-December performance to be 103,000. The total CY 1983 performance is estimated to be 289,000.

2. CY 1984: (289,000) (1.25) = 362,000

3. CY 1985: (362,000) (1.15) = 416,000

4. CY 1986: (416,000) (1.10) = 458,000

5. CY 1987: (458,000) (1.10) = 503,800

6. In December 1983, we estimate tubectomy prevalence to be 6.5% at the end of CY 1983. We estimate there to be 18.3 million eligible couples. From this we estimate that there are 1,189,500 users at the end of CY 1983.

7. In decrement tables, we use the assumption that 5 percent of VS acceptors per year move out from the cohort of eligible couples. As the estimate derived in point 6 above contains VS acceptors from many previous years, we will reduce the number of VS users in this pool by 10 percent per year.

8. <u>In December 1984</u>

1983:	1,189,500 - 118,950	=	1,070,550
1984:		=	362,000
			1,432,550

We estimate 18.7 million eligible couples

$$\frac{1,432,550}{18,700,000} = 7.7\%$$

9. In December 1985

1983:	1,070,550-118,950	= 951,600
1984:	362,000- 18,100	= 343,900
1985:		= 416,000
		1,711,500

We estimate 19.2 million eligible couples

$$\frac{1,711,500}{19,200,000} = 8.9\%$$

10. In December 1986

1983:	951,600-118,950	= 832,650
1984:	343,900- 18,100	= 325,800
1985:	416,000- 20,800	= 395,200
1986:		= 458,000
		2,011,650

We estimate 19.6 million eligible couples

$$\frac{2,011,650}{19,600,000} = 10.3\%$$

11. In December 1987

1983:	832,650-118,950	= 713,700
1984:	325,000- 18,100	= 306,900
1985:	395,200- 20,800	= 374,400
1986:	458,000- 22,900	= 435,100
1987:		= 503,800
		2,333,900

$$\frac{2,333,900}{20,000,000} = 11.7\%$$

B. Vasectomy Estimates

1. CY 1983: January-September performance was 50,000. Based on preliminary MOHPC reports of October performance plus examining previous year performance, we estimate October-December performance to be 57,000. The total CY 1983 performance is estimated to be 107,000.

2. CY 1984: (107,000) (1.25) = 134,000

3. CY 1985: (134,000) (1.15) = 154,000

4. CY 1986: (154,000) (1.10) = 169,000

5. CY 1987: (169,000) (1.10) = 185,900

6. In December 1983, we estimate vasectomy prevalence to be 1.7%. At the end of CY 1983 we estimate there to be 18.3 million eligible couples. From this we estimate that there are 311,100 users at the end of CY 1983.

7. In decrement tables we use the assumption that 5 percent of VS acceptors per year move out from the cohort of eligible couples. As the estimate derived in point 6 above contains VS acceptors from many previous years, we will reduce the number of VS users in this pool by 10 percent per year.

8. <u>In December 1984</u>:

1983:	311,100-31,110	= 279,990
1984:		= 134,000
		413,990

We estimate 18.7 million eligible couples.

$$\frac{413,990}{18,700,000} = 2.2\%$$

9. <u>In December 1985</u>:

1983:	279,990-31,110	= 248,880
1984:	134,000- 6,700	= 127,300
1985:		= 154,000
		530,180

We estimate 19.2 million eligible couples

$$\frac{530,180}{19,200,000} = 2.8\%$$

10. <u>In December 1986</u>:

1983:	248,880-31,110	= 217,770
1984:	127,300- 6,700	= 120,600
1985:	154,000- 7,700	= 146,300
1986:		= 169,000
		653,670

We estimate 19.6 million eligible couples

$$\frac{653,670}{19,600,000} = 3.3\%$$

11. <u>In December 1987</u>

1983:	217,770-31,110	= 186,660
1984:	120,600- 6,700	= 113,900
1985:	146,300- 7,700	= 138,600
1986:	169,000- 8,450	= 160,550
1987:		= 185,900
		785,610

$$\frac{785,610}{20,000,000} = 3.9\%$$

C. Oral Pill Estimates

1. CY 1983: Based on preliminary results of the 1983 CPS we estimate pill prevalence to be 3.5%.

2. From 1985 ABS Tables adjusted on the basis of the physical inventory and recent projections from SMP, we estimate the following usage rates in cycles:

PILL	CY 1984	CY 1985	CY 1986	CY 1987
BDG	8,000,000	9,000,000	10,000,000	11,000,000
SMP: Ovacon	747,500	859,625	988,568	1,150,000
SMP: Maya	977,500	1,124,125	1,292,744	1,500,000

3. We use standard CYP assumption for SMP orals, 13 cycles per year, but we adjust for distribution inefficiency with BDG pills by increasing the CYP to 15.

4. In December 1984

BDG: $\frac{8,000,000}{15}$ = 533,333 CYP

SMP: $\frac{1,725,000}{13}$ = 132,692 CYP

666,025 Total CYP

$\frac{666,025 \text{ CYP}}{18,700,000 \text{ eligible couples}}$ = 3.6%

5. In December 1985

BDG: $\frac{9,000,000}{15}$ = 600,000 CYP

SMP: $\frac{1,983,750}{13}$ = 152,596 CYP

752,596 Total CYP

$\frac{752,596 \text{ CYP}}{19,200,000 \text{ eligible couples}}$ = 3.9%

6. In December 1986

BDG: $\frac{10,000,000}{15}$ = 666,666 CYP

SMP: $\frac{2,281,312}{13}$ = 175,485 CYP

842,152 Total CYP

$\frac{842,152 \text{ CYP}}{19,600,000 \text{ eligible couples}}$ = 4.23%

7. In December 1987

BDG: $\frac{11,000,000}{15}$ = 733,333 CYP

SMP: $\frac{2,650,000}{13}$ = 203,846 CYP
937,179 Total CYP

$\frac{937,179}{20,000,000}$ = 4.7%

D. Condom Estimates

1. CY 1983: Based on preliminary results of the 1983 CPS we estimate condom prevalence to be 1.9 percent. Based on evidence from the condom gap survey, the ICDDR,B extension project, and the male sample of the 1983 CPS we have strong evidence that rural women underreport condom use. We also know that from 1983 distribution data condom prevalence would be 6.8 percent (6.0 percent adjusted for BDG lower efficiency).

2. We will first estimate condom prevalence on the basis of our estimated usage rates (1985 ABS) as adjusted by the physical inventory and recent SMP projections. We will then adjust these figures downwards to estimate what an independent contraceptive prevalence survey, utilising eligible women respondents, would show.

3. The following usage rates are projected (in pieces):

Condom	CY 1984	CY 1985	CY 1986	CY 1987
BDG	40,000,000	40,000,000	40,000,000	42,000,000
SMP:				
Raja	97,500,000	121,875,000	152,344,000	182,000,000
Panther	8,100,000	10,530,000	13,689,000	14,000,000
Majestic	4,400,000	3,995,000	3,967,000	4,000,000
(Subtotal SMP)	(110,000,000)	(136,400,000)	(170,000,000)	(200,000,000)

4. To calculate CYP, we will use the standard CYP assumption for SMP, 100 condom pieces = 1 CYP. To adjust for inefficiency the BDG distribution system, we will increase the CYP estimate to 150 BDG condoms.

5. In December 1984

BDG: $\frac{40,000,000}{150}$ = 266,667 CYP

SMP: $\frac{110,000,000}{100}$ = 1,100,000 CYP

1,366,667 Total CYP

$\frac{1,366,667}{18,700,000}$ = 7.3% eligible couples

(With BDG unadjusted, CYP would be 1,500,000 and prevalence would be 8.0%)

6. In December 1985

BDG: $\frac{40,000,000}{150}$ = 266,667 CYP

SMP: $\frac{136,400,000}{100}$ = 1,364,000 CYP

1,630,667 Total CYP

$\frac{1,630,667}{19,200,000}$ = 8.5% eligible couples

(With BDG unadjusted, CYP would be 1,764,000 and prevalence would be 9.2%)

7. In December 1986

BDG: $\frac{40,000,000}{150}$ = 266,667 CYP

SMP: $\frac{170,000,000}{100}$ = 1,700,000 CYP

1,966,667 Total CYP

$\frac{1,966,667}{19,600,000}$ = 10.0% eligible couples

(With BDG unadjusted, CYP would be 2,100,000 and prevalence would be 10.7%)

8. In December 1987

BDG: $\frac{42,000,000}{150}$ = 280,000 CYP

SMP: $\frac{200,000,000}{100}$ = 2,000,000 CYP

2,280,000 Total CYP

$\frac{2,280,000}{20,000,000}$ = 11.4% eligible couples

(With BDG unadjusted, CYP would be 2,420,000 and prevalence would be 12.1%)

9. As we know there is a large discrepancy between estimates of condom prevalence using distribution data and using CPS data, we are adjusting our distribution data by examining percent increases in prevalence derived from distribution data and applying the same percent increases to CPS estimates.

Year	Prevalence Obtained from Adjusted Distribution Data	Percent Increase	Estimated Prevalence
1983	6.0%		1.9%
		22%	
1984	7.3%		2.3%
		16%	
1985	8.5%		2.7%
		18%	
1986	10.0%		3.2%
		14%	
1987	11.4%		3.6%

E. Injectable Estimate

1. From 1983 CPS, we estimate injectable usage is 0.3%. We expect this to increase when SMP begins marketing. We expect the CPR to be 0.4% in CY 1984, 0.5% in CY 1985, 0.6% in CY 1986 and 0.7% in CY 1987. To achieve this, there would need to be 74,800 users in CY 1984 (approximately 25,000 doses a month), 96,000 users in CY 1985 (approximately 32,000 doses a month), 117,600 users in CY 1986 (approximately 39,200 doses a month), and 140,000 users in CY 1987 (approximately 46,667 doses a month).

F. IUD's

1. In our Cu T order for 1983, we based our request on the following targets: 1983 (10 months) = 135,000; 1984 = 240,000; 1985 = 325,000. Using these figures, our estimates of IUD usage are as follows:

   CY 1983 = 156,500
   CY 1984 = 240,000
   CY 1985 = 325,000
   CY 1986 = 360,000
   CY 1987 = 400,000

2. Our CPS estimate of IUD prevalence in December 1983 is 0.9% estimate of Active Users: (.009) (18,300,000) = 164,700

3. <u>In December 1984</u>

   We will assume most of the 164,700 active users began in 1983 and only relatively few retain from previous years. We will use a 60 percent decrement for the entire amount: For 1984, we will estimate that about 70 percent retain; but that the insertions were done over the year, resulting in an average amount of 35 percent retention.

1983: (164,700) (.6) = 98,820 CYP
1984: (240,000) (.35) = 84,000 CYP
182,820 Total CYP

$$\frac{182,820}{18,700,000} = 1.0\%$$ eligible couples

4. In December 1985

1983: (164,700) (.5) = 82,350 CYP
1984: (240,000) (.6) =144,000 CYP
1985: (325,000) (.35) =113,750 CYP

340,100 Total CYP

$$\frac{340,100}{19,200,000} = 1.8\%$$ eligible couples

5. In December 1986

1983: (164,700) (.4) = 65,880 CYP
1984: (240,000) (.5) =120,000 CYP
1985: (325,000) (.6) =195,000 CYP
1986: (360,000) (.35) =126,000 CYP
506,880 Total CYP

$$\frac{506,880}{19,600,000} = 2.6\%$$ eligible couples

6. In December 1986

1983: (164,700) (.3) = 49,410 CYP
1984: (240,000) (.4) = 96,000 CYP
1985: (325,000) (.5) = 162,500 CYP
1986: (360,000) (.6) = 216,000 CYP
1987: (400,000) (.35)= 140,000 CYP
663,910 Total CYP

$$\frac{663,910}{20,000,000} = 3.3\%$$

G. Vaginal Methods

Although we expect increases in the absolute number of Emko foam and Neo-Sampoon users, we do not expect increases in prevalence (due to the increasing number of eligible couples). Therefore, our December 1983 estimate of 0.3 percent will stay constant through 1987.

H. Traditional Methods

The preliminary results of the 1983 CPS indicate prevalence of traditional methods to be about 4.2 percent. We will assume that this prevalence remains constant through 1987. It may decrease, however, as more people switch from traditional to modern method.

V. Calculations of Prevalence Estimates by Implementing Agency to be Derived from MIS Service Statistics and USAID-funded NGO Data for End of CY 1986 and CY 1987

A. Estimates of USAID-funded NGO and BDG prevalence for December 1986 and 1987

1. Non permanent methods.

a) In Table 5, USAID-funded NGOs were to supply 516,000 CYP by December 1986 and 642,000 CY by December 1987.

$\frac{516,000}{19,600,000 \text{ EC}}$ = 2.6% prevalence by December 1986

$\frac{642,000}{20,000,000}$ = 3.2% prevalence by December 1987

b) To breakdown the 2.6% and 3.2% by method we will estimate what proportion of the total BDG distribution/performance, USAID-NGOs are likely to do by December 1986 and December 1987. The total prevalence by method as will be estimated by distribution data (unadjusted for efficiency) is given below:

<u>Oral Pill</u>: Dec. 1986, BDG = 10,000,000

$\frac{10,000,000}{13}$ = 769,231 CYP

$\frac{769,231 \text{ CYP}}{19,600,000}$ = <u>3.9% in December 1986</u>

Dec. 1987, BDG = 11,000,000

$\frac{11,000,000}{13}$ = 846,154 CYP

$\frac{846,154}{20,000,000}$ = <u>4.2% in December 1987</u>

<u>Condom</u>: Dec. 1986, BDG = 40,000,000

$\frac{40,000,000}{100}$ = 400,000 CYP

$\frac{400,000}{19,600,000}$ = <u>2.0% in December 1986</u>

Dec. 1987, BDG = 42,000,000

$\frac{42,000,000}{100}$ = 420,000 CYP

$\frac{420,000}{20,000,000}$ = <u>2.1% in December 1987</u>

IUD: Dec. 1986 = 2.6% (See Section IV)
Dec. 1987 = 3.3% (See Section IV)

Injectables: Dec. 1986 = 0.6% (See Section IV)
Dec. 1987 = 0.7% (See Section IV)
This includes SMP-marketed injectables. We will assume in 1986 0.2% is attributable to SMP and 0.4% to BDG/NGO. By 1987 we will assume 0.3% is attributable to SMP and 0.4% to BDG/NGO.

Vaginal: Dec. 1986 and Dec. 1987 = 0.3% (See Section IV). This includes SMP-marketed foaming tablets. We will assume the SMP accounts for 0.2% and the BDG/NGOs, 0.1%.

Estimates of BDG and USAID-funded NGO prevalence are estimated as follows for December 1986 and December 1987.

Non permanent Methods	BDG Total (Exclusive of SMP)	Proportion Attributable to USAID-funded NGOs	Estimate of USAID-funded NGO prevalence	Balance of Prevalence Attributable to BDG and other NGO
December 1986				
Oral Pill	3.9%	40%	1.6%	2.3%
Condom	2.0	30%	0.6	1.4
IUD	2.6	10%	0.3	2.3
Injectable	0.4	25%	0.1	0.3
Vaginal	0.1	Negligible	Negligible	0.1
Subtotal	9.0%		2.6%	6.4%
December 1987				
Oral Pill	4.2%	45%	1.9%	2.3%
Condom	2.1	35%	0.7	1.4
IUD	3.3	15%	0.5	2.8
Injectable	0.4	30%	0.1	0.3
Vaginal	0.1	Negligible	Negligible	0.1
Subtotal	10.1		3.2%	6.9%

2. Estimates of Prevalence of Permanent Methods in December 1986 and 1987

a) From USAID-funded NGO data gathered in 1982 we estimate about 175,000 active users by the end of the year. Estimated performance is:

CY 1983:	67,200
CY 1984:	91,600
CY 1985:	109,400
CY 1986:	129,200
CY 1987:	141,000

b) We will assume 10% decrement per year for the 1982 active users (from all years) and 5% per year for the CY 1983-1986 users.

c) <u>In December 1983:</u>

1982:	175,000-17,500 =	157,000
1983:		67,200
		224,700

$$\frac{224,700}{18,300,000} = 1.2\%$$

d) <u>In December 1984:</u>

1982:	157,500-17,500 =	140,000
1983:	67,200- 3,360 =	63,840
1984:		91,600
		295,440

$$\frac{295,440}{18,700,000} = 1.6\%$$

e) <u>In December 1985:</u>

1982:	140,000-17,500 =	122,500
1983:	63,840- 3,360 =	60,480
1984:	91,600- 4,580 =	87,020
1985:	=	109,400
		379,400

$$\frac{379,400}{19,200,000} = 2.0\%$$

f) <u>In December 1986:</u>

1982:	122,500-17,500 =	105,000
1983:	60,480- 3,360 =	57,120
1984:	87,020- 4,580 =	82,440
1985:	109,400- 5,470 =	103,930
1986:	=	129,200
		477,690

$$\frac{477,690}{19,600,000} = 2.4\%$$

g) In December 1987:

1982:	105,000-17,500 =	87,500
1983:	57,120- 3,360 =	53,760
1984:	82,440- 4,580 =	77,860
1985:	103,930- 5,470 =	98,460
1986:	129,200- 6,460 =	122,740
1987:	=	141,000
		581,320

$$\frac{581,320}{20,000,000} = 2.9\%$$

h) The overall program estimate is 13.6% in December 1986 and 15.6% in December 1987 (see section IV A and B above). In December 1986, we estimate 2.4% to the USAID-funded NGOs and the balance, 11.2% to the BDG (plus other NGOs). In December 1987, we estimate 2.9% to the USAID-funded NGOs and the balance, 12.7% to the BDG (plus other NGOs).

3. Total USAID-funded NGO prevalence:
December 1986: 2.6% + 2.4% = 5.0%
December 1987: 3.2% + 2.9% = 6.1%

B. Estimate of PSI/SMP Prevalences.

1. Total SMP sales of condoms estimated to be 170,000,000 in CY 1986 and 200,000,000 in CY 1987 (see section IV D)

$$\frac{170,000,000}{100} = 1,700,000 \text{ CYP}$$

$$\frac{1,700,000}{19,600,000} = \underline{8.7\% \text{ in December 1986}}$$

$$\frac{200,000,000}{100} = 2,000,000 \text{ CYP}$$

$$\frac{2,000,000}{20,000,000} = \underline{10.0\% \text{ in December 1987}}$$

2. Total SMP sales of oral pills estimated to be 2,281,312 in CY 1986 and 2,650,000 in CY 1987 (see section IV D)

$$\frac{2,281,312}{13} = 175,485 \text{ CYP}$$

$$\frac{175,485}{19,600,000} = \underline{0.9\% \text{ in December 1986}}$$

$$\frac{2,650,000}{13} = 203,846$$

$$\frac{203,846}{20,000,000} = \underline{1.0\% \text{ in December 1987}}$$

3. For injectables, we will estimate 0.2% in December 1986 and 0.3% in December 1987, assuming successful injectable sales program to doctors.

4. Based on current proportion, we estimate that the prevalence of vaginal methods attributable to SMP will be 0.2%

C. Table M: 2 presents a summary of the derived CPR estimates and Table M: 3 presents proportions of prevalence to be attributed to each implementing agency, by method.

Table M: 2

Summary of CPR (derived) Estimates for December 1986 and 1987 to be Derived from MIS Service Statistics and USAID-funded NGO data

Method	BDG (+ Other NGO)	SMP	USAID-funded NGO	Total
December 1986 (EC = 19.6 million)				
Oral Pill	2.3%	0.9%	1.6%	4.8%
Condom	1.4	8.7	0.6	10.7
IUD	2.3	-	0.3	2.6
Injectable	0.3	0.2	0.1	0.6
Vaginal	0.1	0.2	Neg	0.3
Sterilization	11.2	-	2.4	13.6
Total CPR (derived)	17.6%	10.0%	5.0%	32.6%
December 1987 (EC = 20.0 million)				
Oral Pill	2.3%	1.0%	1.9%	5.2%
Condom	1.4	10.0	0.7	12.1
IUD	2.8	-	0.5	3.3
Injectable	0.3	0.3	0.1	0.7
Vaginal	0.1	0.2	Neg	0.3
Sterilization	12.7	-	2.9	15.6
Total CPR (derived)	19.6%	11.5%	6.1%	37.2%

Table M: 3

Proportions of Prevalence to be Attributed to Implementing Agency in December 1986 and December 1987 Utilising MIS Service Statistics and USAID-funded NGO data

Method	BDG (+ Other NGO)	SMP	USAID-funded NGO	Total
December 1986 [Total CPR (derived) 32.6%]				
Oral Pill	7.0	2.8	4.9	14.7
Condom	4.3	26.7	1.8	32.8
IUD	7.1	-	0.9	8.0
Injectable	0.9	0.6	0.3	1.8
Vaginal	0.3	0.6	Neg	0.9
Sterilization	34.4		7.4	41.7
Total	54.0%	30.7%	15.3%	100.0%
December 1987 [Total CPR (derived) 37.2%]				
Oral Pill	6.2	2.7	5.1	14.0
Condom	3.8	26.9	1.9	32.6
IUD	7.5	-	1.3	8.8
Injectable	0.8	0.8	0.3	1.9
Vaginal	0.3	0.5	Neg	0.8
Sterilization	34.1	-	7.8	41.9
Total	52.7%	30.9%	16.4%	100.0%

Economic Analysis: Methodology and Calculations

1. Introduction

Our economic analysis has two distinct, but related, components. The first component is a cost-effectiveness study while the second is a preliminary effort to quantify the benefits of the family planning program as a whole. The cost-effectiveness analysis examines the relative efficiency of various program components. However, the conclusions of the cost-effectiveness analysis should be reviewed recognizing that while ideally every effort should be made to allocate resources efficiently, there is, at the same time, a competing need to increase the overall scope of family planning activities in Bangladesh which may justify continued support for even relatively high cost components. The preliminary cost-benefit approach attempts to bring this point out quantitatively. In this context, we must also note the consensus that rapid population growth is effectively frustrating all development efforts in Bangladesh and that reduced fertility is sine qua non for development in Bangladesh.

The original project paper compared alternative programs using a projected cost per continuous user criterion. The program was divided into (i) Sterilization, (ii) BDG services other than Sterilization, (iii) Social Marketing and (iv) BDG Services. Planned annual budgets were compared with projected contraceptive use to derive a projected annual cost per continuous user by component.

For the amendment, an alternative cost-effectiveness analysis has been undertaken. This analysis uses actual 1982 data to examine the relative position of program components in terms of cost-effectiveness and efficient utilization of program resources. Three broad program components or subsectors have been defined for this analysis:

(i) Social Marketing Project (contraceptive retail sales) (SMP)

(ii) Clinical and CBD programs of AID-funded non-governmental organizations (NGOs)

(iii) A residual category comprising primarily the BDG's MOHPC and government multisectoral family planning program, but also including a small number of non-AID funded NGOs. (The residual category could not be further disaggregated because of informational constraints.)

Actual data of cost and impact are available for SMP and for AID-funded NGOs. Estimates of impact and approximate estimates of costs have also been made for the total national program. However, no separate estimates are available for the BDG sector, and the residual category was therefore obtained by subtracting the SMP and AID-funded NGO data from estimates for the total program. A weakness of the analysis is the quality of aggregate data, particularly, the estimate of total costs of the national program. However, we believe that the analysis yields general conclusions that are valid and of importance to national population policy.

2. Impact Estimates

The analysis uses "Total Couple Years of Protection" (TCYP) as the measure of program impact. The concept of Couple Years of Protection (CYP) is well established in the family planning evaluation literature. It consists of estimating the number of years of protection provided by various contraceptive methods. The measure can be easily applied to family planning service statistics and has the advantage of being a single number which can translate the very different demographic impact of different contraceptive methods into a single unit of measure. We have used measure "TCYP" primarily to distinguish our future oriented impact estimates from the standard usage of the term CYP. In this analysis, we have modified the CYP measure somewhat to include the impact to the future of VS and IUD acceptance. That is, we have projected the future impact of VS and IUD insertions performed in the reference year in order to estimate the total impact of the reference period. To do so, we have decremented sterilizations in the reference year by 5 percentage points annually (rather than the standard 10 percent), based on life table data from the ICDDR,B Matlab project and age distribution data obtained from BAVS. By so doing, we estimate that each VS provides 7.75 TCYP. IUD retention is also decremented using standard assumptions, resulting in an estimate of 2.45 TCYP for each insertion. Standard CYP assumptions are used for the nonclinical modern methods.

Impact data used in this analysis were

(i) CY 1982 retail sales data reported by SMP to the MIS Unit

(ii) CY 1982 contraceptive distribution data and clinical performance data reported directly to USAID* by AID-funded NGOs

(iii) impact estimates for the residual category obtained by subtracting (i) and (ii) from total CY 1982 program performance reported in the MIS monthly reports.

Using this methodology, we have arrived at the impact data by program component summarized in Table N:1 which indicate that of 5.1 million TCYPs provided nationally in 1982, 13.6 percent were provided by AID-funded NGOs, 15.8 percent by SMP and 70.6 percent by the residual category.

An important clarification is that in the above analysis we have excluded all clinical referral activities from impact estimates. In the case of referrals, the work of generating a case is shared between two organizations and the impact should be attributed between them proportionate to the difficulty associated with the respective tasks fo recruiting a case and providing a clinical service. However, owing to the difficulties posed by cross-referrals within the NGO component and between the NGOs and the residual category, we have excluded referrals totally from impact estimates, giving full credit to the organization providing the clinical service. This methodology probably works against the performance estimate for the NGO sector. For completeness sake, referral data is also included in Table N.2

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*Active user data were available for NGOs, but contraceptive distribution data were used for reasons of comparability with SMP and the residual category.

Table N: 1

Estimated Total Couple Years of Protection (TCYP) by Method and by Implementing Agency in CY 1982[1]

Method	AID-Funded NGOs	SMP	Residual (BDG & Other NGOs)	Total Program
Oral Pill	77,379	84,976	460,057	622,412
Condom	52,268[a]	684.763	341,517	1,078,548
Emko	1,987	-	10,911	12,898
Foam Tablet	488[a]	35,087	5,843	41,418
Injectable	2,219	-	13,904	16,123
IUD/Copper-T	9,720	-	251,308	261,028.
Sterilization	548,824	-	2,506,529	3,055,353
MR	-	-	11,919	11,919
Total	692,885	804,826	3,601,988	5,099,699
Percent of Total Program	13.6%	15.8%	70.6%	100.0%

[a]Excluding condoms and foam tablets given to vasectomy acceptors by BAVS.

[1]Source: MIS monthly distribution/performance report and distribution/performance data supplied by AID-funded NGOs to USAID in June 1983.

Cost Analysis of AID-Financed NGOs (Unadjusted for Capital Depreciation)

	FPIA[1]	TAF[2]	IPAVS[3]	BFPA[4]	FPSTC[5]	Pathfinder[6]	Total AID-funded NGO
Total Grantee Disbursements in 1982 (adjusted)	$742,071	$245,560	$1,012,190	$ 86,017	$58,580	$567,003	2,711,451
Total Estimated Value of Contraceptives, VS and IUD Reimbursements	$245,982	$ 62,321	$ 742,763	$ 74,831	$11,440	$132,175	1,269,512
Total Disbursements Plus Contraceptives Costs and VS, IUD Reimbursements	$988,053	$307,881	$1,754,953	$160,878	$70,020	$699,178	3,980,963
TCYP Provided in 1982	73,140	18,410	519,521	18,652	3,201	59,961	692,885
TCYP Unit Cost Without Contraceptives and Reimbursements	$10.15	$13.34	$ 1.95	$ 4.61	$18.30	$ 9.46	$ 3.91
TCYP Unit Cost With Contraceptives and Reimbursements	$13.51	$16.72	$ 3.39	$ 8.62	$21.87	$11.66	$ 5.74
TCYP in 1982 Including TCYPs from VS, Injectable and IUD referal	216,125	28,082	519,521	47,627	14,091	88,731	914,177
(TCYP + TCYP Referal) Unit Cost Without Contraceptives and Reimbursements	$ 3.43	$ 8.74	$ 1.95	$ 1.81	$ 4.16	$ 6.39	$ 2.97
(TCYP + TCYP Referal) Unit Cost With Contraceptives and Reimbursements	$ 4.57	$10.96	$ 3.38	$ 3.38	$ 4.97	$ 7.88	$ 4.36
VS Procedures Performed in 1982	-	-	67,002	-	-	3,814	70,816
Cost per Unit Without MSR and Reimbursements	-	-	$15.11	-	-	NA[8]	NA[8]
Cost per Unit With MSR and Reimbursements	-	-	$26.19	-	-	NA[8]	NA[8]

[1]Family Planning International Assistance (entirely AID/W centrally funded)

[2]The Asia Foundation (family planning activities entirely USAID/Dhaka funded)

[3]International Project, Association of Voluntary Sterilization (Funds from both AID/W and USAID/Dhaka; combined total disbursements given)

[4]Bangladesh Family Planning Association (only family planning activities funded by USAID/Dhaka grant included)

[5]Family Planning Services and Training Center (from USAID/Dhaka funds only; costs inflated by 20 percent to include program management costs covered by IPIA grant)

[6]The Pathfinder Fund (cost estimates: $118,365 from USAID/Dhaka funds and $118,035 from AID/W funds)

[8]Pathfinder funds clinical and CBD programs; costs are not available separately

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and TCYP cost data with and without referrals are presented. (A referral is given the same TCYP value as actual performance.) These comparisons are only valid internally within an NGO because one NGO may be referring to another.

3. Cost Estimates

For SMP and for AID-funded NGOs, cost data were obtained directly from the organizations and adjusted as indicated below. For SMP, all U.S. and local overhead and project costs are included, as well as contraceptive and freight costs. The costs have been adjusted for capital depreciation and, as the SMP operated independently of the BDG program, no overhead from the BDG program has been attributed to SMP (Table N:3).

For AID-funded NGOs, Grantee disbursements for 1982 are used as a proxy for actual expenditures. These include not only direct service delivery costs, but also IEC, training, program management and indirect costs. Cost data have been adjusted to exclude disbursements to new activities initiated in the last quarter of 1982 with no service outputs during the reference year. Estimates of contraceptive and MSR costs as well as VS and IUD reimbursements have also been included (Table N:2). Expenditures (excluding commodities and reimbursements) were increased by $200,000 for estimated costs borne by the government for commodity distribution and storage for NGO programs.

Finally, the cost for the total national program was estimated by utilizing data gathered by the Population and Development Cell of the Planning Commission. These estimates of FY 81-82 and 82-83 expenditures for the national family planning program were averaged to arrive at an estimate of Tk. 116.5 crore ($52,714,932) for CY 1982.

Cost estimates	BDG FY 1981-82	BDG FY 1982-83
1. Within ADP		
(a) Donor supplied project aid	62.4	72.3
(b) GOB Taka project-related		
2. Outside ADP		
(a) GOB Taka in Revenue Budget	11.2	12.3
(b) Direct commodity aid	17.8	17.8
(c) Direct support to NGOs-PVOs	19.6	19.6
	111.0	122.0

Table N: 3

1982 PSI/SMP Cost Statement

1.	Local Expenses (Depreciating Assets) Taka 29,691,653 at Tk. 22.1/$1.00	$1,343,514[a]
2.	Headquarter Expenses	$ 417,228
3.	Value of Contraceptives Distributed (including ocean freight; using retail sales)[b]	$3,805,842
4.	Total Expenses	$5,566,584
5.	Less Sales Revenue[c] (Taka 9,360,585 at Tk. 22.1/$1.00)	$ 23,556[c]
6.	Total Cost (net)	$5,143,028
7.	Total Couple Years of Protection (using Retail Sales)	804,826
8.	Cost per Total Couple Year of Protection (TCYP)	$6.39
9.	Cost per TCYP Excluding Contraceptives	$1.66

[a]Unaudited expenses

[b]Commodity costs are estimated as follows:

Commodity	SMP Distribution from MIS figures	Price: Commodity plus transportation	Value of Commodities
Oral Pill	1,104,710	0.195 per cycle	$ 215,418
Condom	68,476,348	0.049 per piece	$3,355,341
Foam Tablet	3,508,696	0.067 per tablet	$ 235,083
Total			$3,805,842

[c]This monetary amount represents a cost to the public sector of services provided by SMP.

To estimate the cost of the residual program, the total NGO and SMP* costs were subtracted from the total program cost:

(Total cost: $52,714,932)-(NGO: $3,980,963+200,000)-(SMP: $5,143,028*)= $43,390,941. The adjusted cost was divided by 3,601,988 TCYP, resulting in $12.05 per TCYP.

In the cost estimates of the NGO and residual program we have not made adjustments for capital costs. Capital expenditures are clearly program costs, but since capital by definition is designed to provide services to a program activity for several years, it would be inappropriate to charge the full cost of capital improvements against program activities for just one year. Similarly, the program is making use of capital (i.e., buildings) paid for in previous years. Two factors must be taken into consideration when assessing capital cost adjustments: (i) the family planning program is "growing" over the last decade and (ii) the current or marginal capital expenditure is a low percentage (less than a quarter) of the existing value of capital stock. The former factor would lead us to expect that the incremental adjustment for the past is more than offset by the decremental capital cost adjustment for the future, while the latter factor causes the net capital cost adjustment to swing in the opposite direction. On balance, if factor (ii) predominates, the overall cost figures would rise while if factor (i) predominates, the overall cost figures would fall. Now firstly, we have no way of knowing, without a comprehensive research study, which of the two factors is more predominant, and secondly, since the corrections oppose each other, the net correction is likely to be small in comparison to the overall cost figure for both the NGOs and the residual. In view of this, and until better information is available, we did not consider it wise to make a capital cost adjustment. Essentially our argument signifies that the money value of the capital cost adjustment is 0 for the NGO program and the residual. For the SMP program, where better cost data were available, we made a small adjustment for capital depreciation.

4. Cost-Effectiveness Analysis

The final figures for the comparative cost and impact of the three components are given below:

1)	USAID-funded NGOs	
	Estimated adjusted cost**	= $4,180,963***
	Estimated TCYP****	= 692,885
	Cost per TCYP	= $6.04
2)	Social Marketing Program	
	Estimated adjusted cost*	= $5,143,028***
	Estimated TCYP****	= 804,826
	Cost per TCYP	= $6.39
3)	Residual	
	Estimated adjusted cost**	= $43,390,941***
	Estimated TCYP****	= 3,601,988
	Cost per TCYP	= $12.05

*SMP costs adjusted for capital depreciation; commodity costs included.
**Including contraceptive commodities and VS and IUD reimbursements.
***All figures are in current dollars.
****TCYP = Total couple years of protection (see narrative)

The major issue which is not addressed in this analysis, and on which little data are available, is the problem of substitution. This is fundamentally an issue of causality. What was the cause of a given client's decision to use contraception? If the existence of a given program was a necessary condition for acceptance, then we can say that the program's activity "caused" the acceptance to take place. But would a client have accepted contraception from a different source if the given program did not exist? Is there a tendency for NGOs to work in easier areas than the government program and/or to effectively draw off clients who otherwise would have used services provided through the government program? The answer, at this time, is not known.

Moreover, while the average unadjusted NGO cost per TCYP is $5.74, there is a great variation in the costs for individual NGOs (see Table N:2). Some of this variation may be explained by program duration. For example, FPSTC, which has the highest 1982 cost per TCYP for its USAID-funded program only initiated these activities in 1982 and no USAID-funded FPSTC subproject was operational for the entire year. FPIA subprojects, however-including the 20 subprojects funded through FPSTC-are relatively well-established and lower cost. It appears very likely that cost per TCYP decreases with program duration.

Another factor clearly influencing costs is the method-mix; since the methodology in this analysis weights VS heavily because of its future demographic impact, IPAVS, which specializes in clinical VS services appears by far the most cost-effective NGO. In fact, the IPAVS program has a major influence on both the total impact estimates and the low average cost per TCYP for all AID-funded NGOs.

Finally, the impact of referrals on costs of individual NGOs is also of interest. While these were excluded from the overall analysis for reasons explained above, they are included in Table N:2 for purposes of internal comparison. Using the same TCYP assumption for referrals as for actual VS performed, individual NGO costs were very significantly reduced, in most cases by 50 percent or more.

Benefit Analysis

The principal analysis on which the justification of this project rests is the cost-effectiveness analysis presented above. The USAID strongly believes that efforts to reduce population growth rates in Bangladesh are essential to development and that, therefore, a cost-effectiveness analysis is appropriate. The brief analysis that follows is a crude and preliminary attempt to identify an approach to quantifying the benefits of reducing population growth rates.

The benefit analysis is based on the premise that improvements in per capita well being through a specific percentage point marginal reduction in the population growth rate are (in some admittedly gross sense) comparable to the impact on per capita well being of an equal percentage point marginal increase in the income (or GNP) growth rate. From this premise, it can be argued that the benefits (in terms of changes in per capita income) of, let us say, a 0.1% reduction in the population growth rate are equal to the investment expenditures that would otherwise be

required to increase the GNP growth rate by 0.1%. Using a conservative estimate of 2.5 for the incremental capital output ratio, additional annual investments of 0.25% of Bangladesh's GNP ($30 million) would be required to increase the GNP growth rate by 0.1%. Because of the beneficial impact on the death rate of reductions in the birth rate, achieving a 0.1% net reduction in the population growth rate would require approximately a 0.14% reduction in the birth rate. Based on international evidence, a 2.4 (percentage point) increase in the contraceptive prevalence rate is necessary to obtain a 0.1 percentage point reduction in the birth rate. Thus, a 0.1% reduction in the population growth rate implies a $(2.4)x(0.14)/0.1=3.36$ percentage point increase in the contraceptive prevalence rate (CPR).

Since there are approximately 18 million fertile couples at present, a 3.36% increase in the CPR represents an additional 600,000 CYP. As calculated above, the benefits of these additional 600,000 CYP are equivalent to $30 million or $50 per CYP.

Thus, for those family planning interventions that do not have a multiyear impact (e.g., pills and condoms), the benefit of providing services to a couple for a year is $50. For those interventions that also have an impact in the future (e.g., sterilization and IUD insertions), the calculation is more complicated. Using a 15% discount rate to assess the present discounted value of future couple years of protection, yields a calculated benefit of $222 per sterilization and $91 per IUD insertion. These benefits are all very significantly in excess of the costs of even the least cost-effective elements of the family planning program in Bangladesh. To arrive at the present discounted value estimates for the clinical methods, we used decrement tables (based on life tables and age distribution data for acceptors available in Bangladesh) and used a 15% discount rate.

We note here that (i) a higher discount rate would still give Benefit/Cost ratios much in excess of 1 and (ii) a capital output ratio greater than 2.5 would only fortify our results from the benefit side. Although the approach to calculating benefits sketched here is crude and the simplifying assumptions heroic, the numbers generated reinforce our belief that supporting family planning efforts in Bangladesh is a very effective way of using resources. A cost-effectiveness approach to family planning appears to be appropriate.

(Caveat: Quite clearly these benefit calculations are only a crude proxy for the actual benefits of reduced population growth rate. The qualitative impact on society of a 0.1% increase in GNP growth because of an oil discovery (to take an extreme example) is enormously different from that of a 0.1% decrease in the population growth rate due to higher contraceptive prevalence among landless laborers. Also we have abstracted from the time-profile problem of (a) supporting a family planning effort involving a mix of capital and current account expenditures impacting on the population growth rate and (b) capital investments translating into increased output (the so-called gestation lag). However, without seeking to list all of the objections that would be raised against this approach, it is worth

noting two advantages: (1) the qualitative social/economic benefits of reduced population are likely to be greater than the calculated investment proxy presented here; and (2) the actual direct calculation of the benefits of population control are infinitely more difficult and subject to nearly as much uncertainty as the approach taken here.)

6. Conclusion

The findings support the Project Paper Amendment's basic strategy, i.e., expanded support for the NGOs and SMP and continued support for the BDG program. While the success of the NGOs and SMP suggest that they should be given larger roles in the national program, one must recognize the limits, however, to the organizational capacity of the NGOs beyond which their effectiveness may be jeopardized. The NGOs cannot provide universal geographical coverage, and the SMP does not provide clinical services. The Government sector continues to be important, since it has the potential to provide universal, comprehensive services, and for the overwhelming share (70%) of national "TCYP" that it currently contributes. While efforts should be made to improve the efficiency of this sector, this should not be at the expense of program outputs, given the importance of this sector's contribution. While the cost-effectiveness analysis has focussed on issues of relative efficiency, the cost benefit study demonstrates a concern for effectiveness, i.e., the need to increase the overall scope of family planning activities, and leads to the logical conclusion that government sector activities should also be expanded.

ANNEX O
IMPLEMENTATION PLAN

Implementing Agency/Task	Responsible	Planned Date
A. Ministry of Health and Population Control		
1. Grant Agreement Amendments	USAID, MOHPC, ERD	
- Discussions with MOHPC		Nov. 83-Feb. 84, Feb. 85, 86
- Signing		March 84, March 85, 86
2. Awards Program		
- Criteria developed to Implement Program	USAID, MOHPC, NGO	February - April 84
- Review Rates & Procedures and PIL Signed	USAID & MOHPC	May 84, 85, 86
- Review of Program Criteria	USAID, MOHPC, NGO	June 85, 86
- Audit of Program Beneficiaries		
. PIOT	USAID & MOHPC	April 84, 85, 86
. Advertisement	"	April/May 84, 85, 86
. Contract	"	June 84, 85, 86
. Conduct	Private Firm	July 84, 85, 86
- Evaluation of How Awards Used		
. PIOT	USAID & MOHPC	Nov. 84, 85, 86
. Advertisement	"	Nov/Dec. 84, 85, 86
. Contract	"	January 85, 86
. Conduct	Private Firm	April 85, 86
3. VS, IUD and Injectable Reimbursements		
- Revise VS and IUD PILS	USAID & MOHPC	February 84, 85, 86
- Extend Current VS Audit Contract for one quarter	"	March 1984

Implementing Agency/Task	Responsible	Planned Date
- Discuss Injectable Reimbursements, Rates and Procedures	USAID & MOHPC	April 1984
- Injectable Reimbursement PIL Signed	"	May 84, Feb 85, 86
4. "Super" Audit Contract for VS, IUD, Injectable and Commodities Inventory		
- Prepare Scope of Work: Obtain MOHPC approval	"	February - March 1984
. PIO/T	"	March 1984
. Advertisement	"	April - May 1984
. Evaluation of bids	"	May - June 1984
. Contract	"	June 1984
- VS Audit	private firm	quarterly
- IUD, Injectable Evaluation	"	"
- Inventory	"	June 85, 86
5. Commodities		
- PIL to Implement Commodity Procurement and Logistics Training	MOHPC & USAID	April 84
- Procure CDC Assistance in Design of New Logistics & Reporting System	USAID & CDC	Feb. 84 for June 84
- Review and Revise District and Thana Level Storekeeper's Training	MOHPC, USAID UNFPA	March, April 84, 85, 86
- Plan Refresher Training	"	
- Conduct Refresher Training	"	May and June 84, 85, 86

Implementing Agency/Task	Responsible	Planned Date
- FY 84 Physical Inventory		
. PIO/T	MOHPC & USAID	February 84
. Advertisement	"	March 84
. Contract	"	April 84
. Conduct (And pull out-of-date stocks)	Private Firm & MOHPC	May 84
- Order Commodities (See Procurement Plan)		
- Review MOHPC Progress on Logistics System Improvements	"	Quarterly, 84, 85, 86
6. Technical Resources, Research and Training		
a. Overall		
- PIL to reprogram money from Training, Operations Research, MCH Materials, Printing, Local Family Planning Project, and Commodities (partial)	USAID & MOHPC	March - April 1984
b. Training		
- Prepare PIOPs for Long Term & Short Term Participants	USAID, MOHPC	As needed
- Review, Feasibility of TFPO Training and Inputs Needed	USAID, MOHPC Other Donors	May 84
- If Needed Plan Training	USAID, MOHPC	July 84
c. MCH Materials and Printing		
- Growth Chart		
. Review Results of pretest	USAID, MOHPC, Other donors, NNC	February 1984
. Solicitation of Bids	MOHPC	March 1984
. Purchase Order	USAID	April 1984
. Distribution		June 1984

Implementing Agency/Task	Responsible	Planned Date
- IUD Manual		
. Revise	USAID, MOHPC	February 84
. Purchase Order	"	March 84
. Print	"	April 84
. Distribute	"	June 84
- Voluntary Sterilization Manual		
. Revise	USAID, MOHPC	January - June 84
. Purchase Order	USAID	July 84
. Print		July - August 84
. Distribute	MOHPC	September 84
d. Consultants		
- PIO/T	USAID & MOHPC	As needed
e. Research		
- PIO/T	"	"
7. Evaluation of Project		
. PIO/T	USAID, MOHPC	August 85
. Advertisement/Recruitment	USAID	September 85
. Contract	USAID & MOHPC and Consultants	February 86
. Conduct		April/May 86
B. Non Government Organizations		
1. Review latest Monitoring and Evaluation Reports and Negotiate Terms for Grants, Amendment or PILS with	USAID & Grantee	
IPAVS		March 84, Feb. 85, 86
TAF		March 84, 85, 86
Pathfinder		March 84, 85, 86

Implementing Agency/Task	Responsible	Planned Date
BFPA		Mar. 84, 85, 86
BACE		Mar. 84, 85, 86
FPSTC (PIL)		June 84, 85, 86
CARE		Mar. 84, NA, NA
2. BDG Clearance of Grants, etc.	MOHPC & ERD	
IPAVS		NA NA NA
TAF		" " "
Pathfinder		" " "
BFPA		April 84, 85, 86
BACE		April 84, 85, 86.
FPSTC		July 84, 85, 86
CARE		NA NA NA
3. Grant Agreements, Amendments, PILs Signed		
IPAVS	USAID & Grantee	Mar. 84, Feb. 85, 86
TAF	"	Mar. 84, 85, 86
Pathfinder	"	Mar. 84, 85, 86
BFPA	"	May 84, 85, 86
BACE	USAID & Grantee	May 84, 85, 86
FPSTC (PIL)	USAID & MOHPC	Aug. 84, 85, 86
CARE	USAID & Grantee	Mar. 84, NA, NA
4. FPIA		
- Review and Approve Proposal	USAID	Mar. 84, 85, 86
- PIO/T to Add Funds to Central Grant	"	Mar. 84, Apr. 85, 86

Implementing Agency/Task	Responsible	Planned Date
5. ICDDR,B		
- Present Project		
. Grant Agreement Signed	USAID-ICDDR,B	January 84
. PIO/T for Continuation of TA by Population Council	USAID	January 84
Expanded Project		
. Review of Proposal	USAID, ICDDR,B, MOHPC	March - April 84
. Grant Agreement Amendment	USAID, ICDDR,B	May 84, Apr. 85, 86
6. FHI/BFRP (AID/W Grant to FHI)		
- Concur with BFRP Subgrant	USAID	Nov. 83, Nov. 85
- Add remaining funds for oral pill trial	USAID, AID/W	March 84
- Add funds for FHI/BFRP	USAID, AID/W	June 85
7. Training		
Approve International Training Plans		
BFPA	USAID	Dec. 84, 85, 86
FPSTC	"	June 84, 85, 86
Process PIO/P for Participants	"	- as required by - training plans
8. NGO Evaluation		
a. Overall		
. PIO/T	USAID	November 85
. Advertisement/ Recruitment	"	November 86
. Contract	"	March 86
. Conduct	Private firm or individual	April/May 86

Implementing Agency/Task	Responsible	Planned Date
b. Pathfinder Mini CPS		
. Approve Pathfinder Proposal	USAID	January 1984
. Conduct	Private firm or individual	Feb. - March 84
c. BACE Evaluation		
. PIO/T	USAID	January 85
. Recruitment/Advertisement		February 85
. Contract	USAID	March 85
. Conduct	Private firm	May - June 85
d. Evaluation of FHI/BFRP Pill Study		
. Recruitment and Purchase Order	USAID	June 85
. Conduct	Private individual or firm	Nov/Dec. 85

Implementing Agency/Task	Responsible	Planned Date
C. Social Marketing Project		
1. Develop Scope of Work for Cooperative Agreement	USAID	December,83 March, 84
2. Discussion with BDG and SMP Council regarding new initiatives:	SMP	March, 84
a) institutional structure	USAID	
b) building and facilities		
3. Test Market of Orasaline (ORS)	SMP	October, 83 - February, 84
4. Develop proposal for test market of injectables for approval by SMP Council	SMP	November, 83 - January, 84
5. Initiate mass media campaign (Manoff)	SMP	February, 84
6. Develop Protocol for Study of Relationship between MBBS's and Quacks (for injectables)	SMP	January, 84
7. Review non-product specific mass media campaign and media schedule	SMP, USAID	July, 84
8. Develop Proposal for Nationwide Sales of ORS Product	SMP, USAID	March - May, 84
9. Approval of New Scope of Work and PSI Cooperative Agreement	USAID SMP Council	April, 84
10. Increase Number of Mobile Film Units	SMP	April - June, 84
11. Negotiations with PSI on Cooperative Agreement	USAID/PSI	May, 84
12. Cooperative Agreement Signed with PSI	USAID/PSI	June, 84
13. Develop Plan for SMP Reorganization, including Revenue-producing Activities	SMP	June-July, 84
14. Develop Plan for SMP Training Division	SMP	August, 84

Implementing Agency/Task	Responsible	Planned Date
15. Develop Plan for SMP Market Research Division	SMP	September, 84
16. Test Market for Injectables	SMP	July-December, 84
17. Implement National Sales of ORS Product	SMP	December, 84
18. Resurvey for Family Planning Communications Campaign (Manoff)	Contractor	February, 85
19. Develop Marketing Plan for Nationwide Sales of Injectables	SMP/USAID	January, 85
20. Begin in One District Sales of Injectables	SMP	April, 85
21. Complete PIO/T for Evaluation of SMP	USAID	September, 85
a. Recruitment of Evaluation Team	USAID	October, 84-January,85
b. Contract for Evaluation	USAID	March, 85
c. Conduct Evaluation	Contractor	April-May, 85
22. Expand Injectable Sales to One Additional District	SMP	October, 85 January, 86 April, 87
23. Evaluation of Family Planning Communications Campaign		April, 85
24. Develop Plan for Construction of SMP Offices, Warehouse, Training Center and Motor Pool		June-September, 84
a. Acquire Land, Begin Construction		January, 85
b. Complete Construction		January, 86

Implementing Agency/Task	Responsible	Planned Date
D. USAID-Overall Project		
1. Overall Project Evaluation-CPS		
. PIOT	USAID	September 84; 86
. Advertisement	USAID	October-November,84; 86
. Contract	USAID	December, 84; 86
. Conduct	Private Firm	January-June, 85; 86
2. Public Health Physician	USAID	
- PIOT		March, 84
- Advertisement		March-July, 84
- Contract		August, 84
- On the Job		October, 85
3. Research/Evaluation Specialist	USAID	
- PIOT		March, 84
- Advertisement		April-June, 84
- Contract		July, 84
- On the Job		August, 84
4. Logistics Advisor	USAID	
- PIOT		January, 84
- Advertisement		January, 84
- Contract		February, 84
- On the Job		March, 84

Commodities Procurement Plan

Type	Amount	Needed By	ABS	AID/W Confirmation	PIO/C	Contract Signed
I. Centrally Procured Contraceptives						
A. Condoms						
1. BDG	9,834,000	6/30/85	6/83	10/83	10/83	
	40,000,000	6/30/86	6/84	10/84	10/84	
	40,000,000	6/30/87	6/85	10/85	10/85	
2. SMP						
- Raja	150,000,000	6/30/85	6/83	10/83	10/83	
	158,000,000	6/30/86	6/84	10/84	10/84	
	170,000,000	6/30/87	6/85	10/85	10/85	
- Panther	6,204,000	6/30/85	6/83	10/83	10/83	
	5,225,000	6/30/86	6/84	10/84	10/84	
	7,000,000	6/30/87	6/85	10/85	10/85	
- Majestic	12,000,000	6/30/86	6/84	10/84	10/84	
	15,000,000	6/30/87	6/85	10/85	10/85	
B. Orals						
1. SMP						
- Maya	1,134,000	6/30/86	6/83	10/83	1/84	
	1,500,000	6/30/87	6/84	10/84	1/85	
- Ovacon	852,000	11/30/85	6/83	10/83	12/83	
	917,000	11/30/86	6/84	10/84	12/84	
	1,500,000	11/30/87	6/85	10/85	12/85	
II. USAID-Procured Commodities						
A. Foaming Tablets (SMP)[1]	(760,000	9/30/83)	-	-	-	
	2,477,000	6/30/84	-	-	-	
	6,115,000	6/30/85	-	-	-	
	7,000,000	6/30/86	-	-	-	
	8,000,000	6/30/87	-	-	-	
B. Copper-T IUD's[2]	425,000	1/1/85	-	-	3/84	
	420,000	1/1/86	-	-	3/85	
	438,000	1/1/87	-	-	3/86	
	450,000	1/1/88	-	-	3/87	
C. Emko	55,000	6/84	-	-	1/84	
	81,000	6/85	-	-	1/85	
	126,000	6/86	-	-	1/86	
	130,000	6/87	-	-	1/87	

Type	Amount	Needed By	ABS	AID/W Confirmation	PIO/C	Contract Signed
D. Catgut (Pieces)	1,767,000	12/30/83	-	-	4/83	8/83
	781,000	1/1/85	-	-	5/84	8/84
	917,000	1/1/86	-	-	5/85	8/85
	1,150,000	1/1/87	-	-	5/86	8/86
	1,200,000	1/1/88	-	-	5/87	8/87

[1] Assume availability of Eisai product

[2] MOHPC commodity funds will be used for AID/W's central procurement of Cu-T IUDs ; commencing in CY 85, this order may be reduced if Canadian CIDA brings in Multi-load IUDs.