NGO

FAMILY PLANNING CONVENTION

DHAKA 2-3 APRIL 1986

Contents

বাণী

তৃতীয় পঞ্চবার্ষিকী পরিকল্পনায় সরকার জনসংখ্যা বৃদ্ধির হার ক্রমান্বয়ে দুই দশমিক চার শতাংশ থেকে এক দশমিক আট শতাংশে নামিয়ে আনার লক্ষ্যমাত্রা গ্রহণ করেছেন। এজন্য ব্যাপক জনমত গঠন এবং পরিবার পরিকল্পনা ব্যবস্থা ও সামগ্রীর প্রাপ্তি ও সুষ্ঠু সরবরাহের ব্যবস্থা নিশ্চিত করতে হবে। সরকারের পাশাপাশি বেসরকারী সংস্থাসমূহের বৃহত্তর ভূমিকা ও অবদান নির্দ্ধারিত লক্ষ্যমাত্রা অর্জনে বিশেষ ফলপ্রসূ হবে।

জনসংখ্যা বিস্ফোরণের হাত থেকে দেশকে বাঁচাতে হলে সংশ্লিষ্ট লোকদের মধ্যে সচেতনতা সঞ্চার করতে হবে। বৃহত্তর জাতীয় স্বার্থে এই কাজে সমাজ সচেতন প্রতিটি ব্যক্তি ও সংগঠনকে বিশেষ ভূমিকা পালন করতে হবে। এই সম্মেলন পরিবার পরিকল্পনা কর্মসূচীর সংগে সংশ্লিষ্ট বেসরকারী উদ্যোক্তা ও কর্মীদের কাজের সমন্বয় সাধন ও সম্মিলিত প্রচেষ্টা গ্রহণের পথ সুগম করবে এবং পরিবার পরিকল্পনা ব্যবস্থা অবলম্বনের প্রয়োজনীয়তা সম্বন্ধে জনমনে ব্যাপক চেতনা সঞ্চারে বিশেষ অবদান রাখবে বলে আমি বিশ্বাস করি।

জনসাধারণের জীবন-যাত্রার মানোন্নয়ন এবং জনগণের আর্থ-সামাজিক অবস্থা উন্নয়নের লক্ষ্যে আমরা আজ সকলে যে আন্তরিক প্রচেষ্টা চালিয়ে যাচ্ছি পরিবার পরিকল্পনা নীতি বাস্তবায়নের সংগে এর সাফল্য জড়িত। এই লক্ষ্য অর্জনে বেসরকারী সংস্থাসমূহের আরো প্রশংসনীয় ভূমিকা আশা করে আমি এই সম্মেলনের সর্বাংগীন সাফল্য কামনা করছি।

(লেঃ জেনারেল হুসেইন মুহম্মদ এরশাদ)
রাষ্ট্রপতি
গণপ্রজাতন্ত্রী বাংলাদেশ

Message

A Word of Encouragement

The number one problem of Bangladesh is the "population over growth." A check has to be brought to the alarming increase of population growth. Govt. has drawn plans to curb this. We should always remember Bangladesh Family Planning program is a totally voluntary program. No pressure, allurement or element of coercion is there in the program. Method mix, with a wide range of voluntary option has taken the programs nearer to the people. For this the NGOs have contributed substantially. Their share is highly appreciating and in the wake of the fastly changing situation of the country NGOs can do much more better than before. Their innovative ideas can open up new venues and directions for the future. Organising this Convention is very appropriate and timely. I like to encourage not by mere words but by paying rich tributes for their achievements. I wish a very Productive Convention.

M Manzoor ul Karim
Secretary
Ministry of Health & Population Control

Message

Best wishes for the success of The NGO Family Planning Convention and for the Bangladesh Programme.

H Hoogenboom
Association for Voluntary
Surgical Contraception
New York.

Message

The people of Bangladesh have embarked on an historic family planning mission over the last ten years that will benefit Bangladesh's future generations for years to come. Leaders of the family planning movement, have spearheaded the effort to bring down the population growth in order to build a strong and vibrant Bangladesh society.

We at Family Planning International Assistance (FPIA), have been privileged to work with you and support you in making family planning services available throughout the country.

I have praised the work of the last 10 years. And I am sure you know full well that in the next ten years we must build dramatically on your previous efforts.

There are many good signs that the next 10 years will be even more successful than the last ten years. Most importantly, there is a strong and effective cooperation between the NGOs and the Government of Bangladesh to expand the availability of all contraceptive methods to people living in urban as well rural areas. This partnership is a victory.

There is also a commitment to voluntarism. And finally, there is a commitment to Bangladesh. FPIA shares these commitments with all of you.

Dr. Daniel R. Weintraub
Chief Operating Officer
Family Planning International Assistance

Message

Dear Friends :
I am happy to note that the agencies involved in implementing the national family planning programme in Bangladesh are to organise a Family Planning Convention.

Voluntary family planning is a programme of top priority not only in Bangladesh but in all countries of the Indian Ocean Region of the International Planned Parenthood Federation.

The theme chosen for the Convention, namely "Community Participation - A Key To The Success of Family Planning", is a crucial one, for community participation is essential in making family planning a people's movement.

I fully support this theme and wish every success in the innovative enterprise in organising such Convention to demonstrate support for this vital programme.

Yours sincerely

Avabai B Wadia
President, IPPF

Message

Congratulations on the First NGO Family Planning Converntion of Family Planning movement by NGOs in Bangladesh. I feel very honoured for having an opportunity in sending a Message to the people in Bangladesh. The integrated Family Planning Parasite Control and Nutrition Project which JOICFP is promoting in the sixteen countries in the world was initiated in Bangladesh in 1980. We utilize the parasite control as a means for eliciting community participation which is one of key factors in successful implementation. It is observed among the countries that the NGOs participating in the project have shown the unique and important role in implementing the project, especially in urban areas.

I wish the First Convention very successful and to become a spring board for the NGOs to the further development.

Thank you.

Mr. Chojiro Kunii
Executive Director
JOICFP.

Message

The Pathfinder Fund extends its most sincere good wishes and hopes for success to its organizing the forthcoming NGO Family Planning Convention. We are particularly proud to be able to support and actively participate in an event which is significant to the expanded support of Family Planning in Bangladesh. We are looking forward especially to the outcome of the workshop on community involvement, since it is only through this establishment of true commitment and involvement at the community level, that national family planning goals will ultimately be achieved. Congratulations on conceiving such a landmark event.

Daniel Peelegrom
Pathfinder Fund
Boston

Few Words of the Organizing Committee

The Organising Committee of the NGO Family Planning Convention warmly welcomes all the participants. The Organising Committee has contacted each and every Organisations engaged in Family Planning, to participate in this Convention. All of you either a dedicated Volunteer or a staff has put a commendable effort in achieving Family Planning objectives and most important is that you have been able to earn respect from the community and its people .

But Family Planning movement of Bangladesh has to go a long way before we could achieve substantial improvement in the quality of life. So we have hard and difficult task ahead. The CPR of the country as a whole is around 25% and there is great different between the urban and rural prevalence.

To achieve the desired demographic objectives a clean out breakthrough has to be made particularly in out rural areas, where 80% of the people live. Key to the success of Family Planning Program depends largely upon the involvement and participation of the each and every communities.

This is the main theme of the convention for which we have assembled here. During this two days, we will discuss the ways and means how to convert the movement of Family planning in to a Social movement for circularing Family Planning acceptance and small Family norms.

The Organising Committee will try to make your stay at Dhaka comfortable however if there is any in-convenience we are sure you will show your generosity.

Again the Organising Committee extends a warm greetings.

Organizing Committee

Patron: Mr. Aminul Islam
Additional Secretary
Family Planning.

Convenor: Dr. Azizur Rahman, BAVS.

Members:
1. Col. Latif Mallik, D.G., F.P.
2. Mr. Alamgir M.A. Kabir, FPAB.
3. Dr. M. Alauddin, P.F.
4. Mr. Abdur Rouf, FPSTC.
5. Dr. Mina Malakar, CHCP.
6. Mrs. Mufaweza Khan, CWFP.
7. Mr. S. Adhikari, CCDB.
8. Mr. Peter Amacher, IUCW.
9. Lt. Col. (Retd.) M. Shahabuddin, IPCN & FP.
10. Mrs. Sandra Kabir, BWHC
11. Moulana M. Nuruzzaman, ISBB.

Finance Sub-Committee
Coordinator : Mr. Habibur Rahman

Members Mr. Alamgir M.A. Kabir
Dr. Azizur Rahman

Publication & Technical Sub-Committee :
Coordinator Dr. M. Alauddin
Members Dr. Manowah Hossain
Dr. Barket-E-Khuda
Mr. M.H. Hazari
Mr. Nazmul Hoque
Mr. S.R. Chowdhury
Dr. Paul S. Baidya
Mrs. Maleka Rahman
Dr. Morshed Chowdhury

Public Relation Sub-Committee

Coordinator : Mr. A.M.A. Kabir
Members
° Mr. Mozammel Huq
° Mr. M. Nuruzzaman Khan
° Mr. Motaharul Islam
° Mrs. Sandra Kabir
° Mr. Nazmul Huda Khan

Reception Sub-Committee

Coordinator : Mr. O.Z. Mazumder
Members
° Mr. M.A. Hassan
° Dr. Salahuddin Ahmed
° Mrs. Mufaweza Khan
° Mr. M. Shahjahan

Program Sub-Committee

Coordinator : Lt. Col. (Retd.) Dr. M. Shahabuddin

Members
° Mr. M.A. Rouf
° Mr. S. Walliullah
° Mr.H. Rahman
° Dr. Sultana Begum
° Dr. A.J. Faisel

Convntion Secretariat

Co–ordinator : Dr. A.J. Faisel, BAVS
Members
1. Mr. Nazmul Huda Khan, BAVS
2. Dr. A.B. Chowdhury, BAVS
3. Mr. Md. Shahjahan, ISBB
4. Mrs. Maleka Rahman, IUCW
5. Dr. Morshed Chowdhury, HFA
6. Mr. Kawsar Ahmed, IEM
7. Mr. Syed Mahbubur Rahman, IEM

Logistics
1. Mr. M.A. Jalil, BAVS
2. Syed Shahabuddin, BAVS
3. Mr. Anisur Rahman, BAVS.

NGO Family Planning Convention

"Community Participation-A Key to the Success of Family Planning"

Program in short

Place : Shilpakala Academy

Date : April 2 - 3, 1986
1st Day 2nd April, 1986
9 a.m. - Inaugural Session
10 a.m. - Refreshment
11 a.m. - Working Session I
1 p.m. - Lunch by invitation
2.30 p.m. - Working Session II

2nd day 3rd April, 1986
9 a.m. - Working Session III
10.30 a.m - References
11 a.m. - Concluding Session
1.30 p.m. Lunch by invitation

More than 180 NGOs involved in Family Planning activities and the Government of Bangladesh conjointly sponsores this Convention.

1000 plus delegates representing the NGO, Government & Donor agencies will be attending the Convention.

History of Family Planning Movement in Bangladesh

Alamgir M.A.Kabir

The movement for responsible parenthood started in an organised way in Bangladesh in 1953, when a voluntary social service organization under the name 'East Pakistan Family Planning Association was formed with a band of talented social workers, who saw the vision of a better life for the people.

The Association in the then East Pakistan was a component of the Family planning Association Of Pakisdtan. The late Dr.(Mrs.) Humaira Sayeed, who was a wadrm hearted person and Professor of Gynaecology of Dhaka Medical College was the Founder President. On her unfortunate sudden death, Dr.(Mrs.) Hamida Malik who was her co-worker was elected as the President. Mr. Alamgir M.A. Kabir was then elected for 10 consecutive terms as the President from the end of 1957 till 1967, when he was elected as President of the Family Planning Association of Pakistan.

During the first few years, the Association had to move slowly and cautiously because it had to work against a general atmosphere of prejudice and ignorance.

Even then the Association in East Pakistan had helped in running 3 clinics viz.(i) one in a tin shed in the Dhaka Medical Hospital where Dr. Sayeed worked and was always available for advice and guidance, (ii) a clinic run for sometime in Johnson Road, which was supervised by Dr. (Mrs.) Hamida Malik and (iii)a clinic managed by the Red Cross Maternity Hospital.

The scope of the activities of these clinics was limited because of paucity of funds and supplies and also as the society was not then prepared to accept the movement.

The Association was greatly helped with a grant of Rs. 10,000/- from the National Council of Social Welfare of the Government of Pakistan in 1958 and the generous contribution later given by late Dr. Clarence J. Gamble, M.& his Pathfinder Fund, who also lent the service of his representative Mrs. Margaret F. Roots.

The Association had its first independent office and clinic in a hired small flat at no. 33, Topkhana Road, Dhaka in October 1957. With the expansion of work, these were shifted to other addresses. In 1970 the Association moved into its own premises at No. 2, Naya Paltan, Dhaka- 2.

The Family Planning Association started work in right earnest and did a good deal to motivate the people and even obtained a favourable response from the Government of Pakistan. When it is realised that in those days the subject of family planning was taboo and no one mentioned it in public, this is indeed a great achievement.

The then Government of Pakistan for the first time in history made a token provision of Rs.5,00,000.00 in the budget of 1957-58 and this was voted by the Parliament.

The Government of Pakistan formed a National Board of Family Planning of which Begum Sayeeda Wahid and Mr. Alamgir M.A. Kabir were the first members from the then West and East Pakistan respectively representing the Family Planning Association of Pakistan.

In the first year, however, the money passed in the budget could not be drawn for a technical flaw. This was taken up in the Board and an equivalent amount which was appreved in the budget for the subsequent year was fully drawn.

The Government, however decided that instead of working directly in the field, it would help with grants-in-aid to organisations and voluntary social service agencies working on this movement. The Family Planning Association was the principal and only non-official agency in this respect.

About this time, the Family Planning Association of East pakistan, which was getting recognition both at home and even abroad, realised that the activities had to spread far out of Dhaka if it meant even to come near the fringe of the problem. Dhaka, of course, has been the nerve centre and set the pacs.

The real problem was with the rural population, who are all over the world extremely conservative and never keen in accepting changes in traditional patterns of social behaviour. As the consequences of working directly among the village people were not known, particularly of the apprehended determined opposition from a school of orthodox opinion, it was felt that to start with clinics should be set up in all outlying district and subdivisional headquarters. The Assocition was thus able to open 30 such centres and carried the movement to

the country. District Family Planning Associations were also set up as affiliates.
The plan of work was to approach the literate lower income people but who came from and had roots in the villages, where the fathers and brothers or near relatives still worked in the field. The targets of attention then were the clerical staff and the like. It was felt that they must be finding it hard to maintain a certain minimum standard of life with their limited income and being literate they would also more easily understand when the advantages of a small family norm are explained to them. If they have fewer children who enjoyed relatively better health and whose mothers did not have constant trouble from repeated child bearing, their own kith and kin in the villages were likely to be influenced by their example. This was likely to be more efficacious than our preaching the theme to them. The Association also employed a staff of Motivation Officers in amost all the Sub-Divisions to visit the populous areas and to make the community aware of the need of family planning.
In the meantime, soon after Field Marshall Mohammad Ayub Khan became the President of Pakistan, he unequivocally gave out as the policy of the Government that just like preventive and curative measures of health it would be a direct responsibility of the Government that the knowledge and materials for Family Planning will be brought within easy reach of the citizens.
The Government initially decided that the hospitals should be the principal centre of family planning work and directed that there should be no other clinics as were being run by the Association. Except the clinic in Dhaka because of its historic origin, all other clinics of the Association had to be closed down and the Motivation Officers withdrawn. But it was soon discovered that the Government Hospital staff who were over worked had hardly any time to take up motivational work or to render service to the users.
It was then decided that there should be a separate organisation to take up the work. Since then the Government through the Pakistan Third Five Year Plan for 1965-70 took up a nation-wide programme and this process has continued in Bangladesh.

The International Planned Parenthood Federation [IPPF] has also been generous in making grants for implementation of various schemes. The Association through the help of the Federation ran a clinical river boat for family planning work to serve people living in inaccessible riverine areas of the country. This was regarded as the first such clinic in the world.
As already stated during 1960-65 the Government introduced experimental programme through hospitals and experimental rural project through Bangladesh Academy of Rural Development [BARD] of Comilla. In the next phase during 1965-75 Government action programme was initiated throughout the country with part time male and female workers and Dais at grass-root level and clines in urban areas. The programme was taken out of the Department of Health to increase its input.Since then a multi-structural community based distribution and MCH programme under Ministry of Health and Family Planning is being executed all over the country as a national programme.

In Bangladesh some six National level and 160 local level non-Government Organisations are working, supplementing and complementing the national programme and have been working hard with the goal of achieving a better life for our people in future.

NGO in FP Programme in Bangladesh. Scope and opportunity

Introduction

Non-Government and Voluntary Organisations have a glorious past in pioneering the population control program in Bangladesh. The family planning activities in this country started in early 1953 with the voluntary efforts of the private organisations. During the last 30 years, Non-Government/Voluntary Organisations have been supplimenting/complementing the government efforts with significant contribution in the program performance. It was therefore, a widely felt need since long to provide an authentic source of information on the nature and extent of participation of Non-Govt./Voluntary Organisations in the population control activities. The Ministry of Health and Population Control decided in December, 1983 to publish a comprehensive documentation of the population control program activities in the non-government sector.

Objectives of the document:

The major objectives of this document may be summarised as follows:—

i) To provide information on the nature and extent of participation of Non-Govt./Voluntary Organisations in the population control program.
ii) To provide a source of reference to the policy makers, planners, program managers, researchers, academicians on private sector activities in population control program.
iii) To provide information on the terms and reference on formation and procedure of registration of Non-Govt./Voluntary Organisations working in the population control program.
iv) To assist in the appraisal and evaluation of population control activities by Non-Govt./Voluntary Organisations.
v) To provide a bench mark statistics for determining the future need and scope of voluntary efforts in family planning.

Background of voluntary program:

Family planning activities started in Dhaka in 1953 with the formation of Family Planning Association by a concerned group of individuals. Initial activities of the Association were mostly confined to remove existing social prejudice and taboos against family planning and approaching the Government to adopt family planning as official program. Persons renowned for such voluntary movement were late Dr. (Mrs.) Humaira Sayeed, Late Dr. Alauddin Ahmed, Late Dr. Mozharul Haque, Mrs. Raisunnessa Haque, Dr. Md. Ibrahim, Mr. Alamgir M.A. Kabir, Mrs. Saida Waheed and Dr. Zarina Fazalbay.

At the initial stage, a clinic was set-up for providing information on prevailing contraceptive technology and motivational literature for popularizing family planning. There was practically no official support till 1958 except a minimum grant of Rs.10,000/-from the Pathfinder Fund, Boston, USA, to the Family Planning Association. After 1958, when a new Government assumed the power and recognised population as a problem, a financial support of Rs. 50 lacs was provided to promote family planning through voluntary efforts. But the clinic based program of 1960-65 could not make a dent to popularise the program, generate awareness and involve the community with the program activities.

During the period 1965-70, Government emphasised on the population control program and formed the Family Planning Board. The establishment and construction of clinic and field-based infrastructure under the Ministry of Health, Labour and Social Welfare were undertaken as priority program. Besides, financial compensation for wage loss,

transportation etc. to acceptors and referrers, trainining of paramedics, TBA/Dais were intensified. Non-Govt./Voluntary Organisations were limited during this decade and were mostly confined their activities in the motivational efforts. No substantial support was given to promote the family planning activities in the Non-Government sector. Besides FPAB, organizations like Bangladesh Mahila Samity, Jatiya Tarun Sangha, Bangladesh Mahila Samaj, APWA were formed and started functioning during this period.

During the post liberation reconstruction phase under first five year plan of 1973-78, although the Government was mostly concerned with the economic, social, administrative reorganisational activities on priority basis, the population control program was also continued as planned program of the Government. International agencies, who had provided assistance to Bangladesh during the war of liberation and post liberation period had shown their interest and concern on the population problem. HEED Bangladesh, Oxfam, Save the Children Fund, CARE (Bangladesh) Radda Barnen, New Life Centre, RDRD, MCC etc. took up programs on health and population control and started to provide assistance to the local voluntary organisations. The national population policy of the Governmnet declared in 1976 emphasised on the participation of Non-Govt. Organisations as quoted below:

> "The policy with regard to youth, women, may be to support them financially and otherwise more extensively, so that their involvement in MCH and FP activities is expanded and intensified. These organisations will be actively involved at all levels of family planning".

In fact, during the period of 1973-78, quite a good number of Non-Govt./Voluntary Organisations came forward to complement the population control program, with their innovative approaches and community based distribution services programs. Organisations like BAVS (1974). CHCP (1974), CWFP (1975) etc. started functioning during this period. The Ministry of Health and Population Control has also taken a project namely "Use of Voluntary Organiations in MCH-FP" with the assistance of World Bank to promote and support the Non-Govt. Organisations haveing innovative ideas and approaches.

In order to ensure effective operation of voluntary organisation, the Government established a council namely "Family Planning Council of Voluntary Organisation" in early 1978. The FPCVO felt the need of creation of a service cell to provide promotional, technical and other support to the voluntary agencies and sought approval of establishing the cell from the National Population Council, the highest policy making body. Family Planning Services and Training Centre (FPSTC) was then established in late 1978 to function as an organisation outside the Government set-up.

During the priod from 1978 to 1983, a good number of local level voluntary organisations were promoted with the active support of international agencies like USAID, Family Planning International Assistance, The Asia Foundation, The Pathfinder Fund, Population Crisis Committee, Oxfam. The Government also continued to provide seed money to certain organisations working in the population control program. During the period, Population Control and FP Division has issued notification regarding the rules and procedures of registration of voluntary organisation-involved in the population control and also issued a circular indicating the guidelines for the purpose of formation, operation and co-ordination of the program by voluntary organisations.

Nature and Scope of the Non-Govt./Voluntary Organisation

2.1 Definition: As per Foreign Donation (V.A.) Regulation Ordinance, "Organisation means a church or a body of persons, called by whatever name, whether incorporated or not, established by persons for the purpose of undertaking or carrying on any voluntary activity in Bangladesh"

"Voluntary activity" has been defined as an activity undertaken or carried on partially or entirely with external assistance by any person or organisation of his or its own free will to render agricultural, relief, missionary, educational, cultural, vocational, social welfare and development services and shall include any such activity as the Government may, from time to time specify to be a voluntary activity".

The term "Non-Govt. Organisation" is being widely used around the world to indicate the

activities undertaken in the private sector. In fact, all Non-Govt. Organisations are established with the initiative of a group of persons to undertake voluntary activities. Most of the persons who initiate the organisation are not in the pay roll of the organisation but providing services on voluntary basis with salaried executive staff.These organisations are operated with the approval of the Government and implemented as per guidelines given by the Government with the objectives to complement and supplement the program undertaken by the Government. Activities of these organisations are also implemented keeping in view the Govt. rules and procedures but having financial and operational flexibility to ensure the implementation of innovative approaches. The source of finance of almost all these organisations is the foreign donation/local contribution obtained with the approval of the Government. Thus, activities undertaken by these organisations are regulated by the Government although their constitution, nature, mode of operation etc depend on the body of persons who established the organisation. Therefore, these organisations are formed on voluntary efforts with the approval of Government for a national cause and managed by volunteers keeping in view the Government's guidelines. Thus these organisations are frequently and interchangeably called Non-Govt. and Voluntary Organisations as have been used in this document also.

Nature of Organisations:

In order to ensure the proper monitoring of the activities of Non-Govt./Voluntary Organisations, the Ministry of Health and Population Control has classified these organisations into three major categories:

i) National level organisations.
ii) Local level organisations.
iii) Foreign voluntary organisations.

A national level organisation is one having at least 10 branches or projects throughout the country e.g. FPAB, BAVS, CWFP, BMPA etc. Organisations established and functioning in a particular area/locality having no branches/projects employing at least 10 workers are regarded as local level organisations e.g. Comilla Atmanivedita Mahila Sangstha, Sobhanbag Mothers Club, Patiya Samaj Kallyan Mohila Samity. Organisations formed outside but working in Bangladesh are termed as Foreign Voluntary Organisations e.g. New Life Centre, Radda Barnen, Save the Children Fund etc.

The Non-Govt. and Voluntary Organisations are mainly involved at present in the following field of activities:

i) Community based distribution program.
ii) Clinical Services
iii) CBD-cum-clinical services
iv) Family planning integrated with income-generating, MCH and Nutritional activities.
v) Research and Evaluation
vi) Social Marketing of Contraceptives

Area of operation:

Non-Govt./Voluntary Organisations are basically urban based organisations. In population sector, these organisations are operating mostly in urban areas due to the fact that operation of a community or clinic based project in urban areas is more easier than in rural areas. Besides, the Directorate of Population Control has its field workers already operating in rural areas. In practice, whenever a NGO is allowed to operate in a particular area, the workers of the Directorate of Population Control are withdrawn and the area of operation is well demarcated for the purpose of effective supervision and monitoring of the NGO performance. But there is no restriction on the NGO to work in the rural areas with their program of innovative nature and income generating activities. In fact, about 15 organisations out of 23 being financed by The Asia Foundation have their program in rural areas. Presently, Govt. has also recruited field workers for a few urban areas.

Target of Performance:

Non-Govt./Voluntary Organisations were allowed earlier to fix up their target of performance on area and worker basis at their own convenience. These procedures of fixation of target, however, could not produce a convenient and uniform format to evaluate the comparative performance of the organisation. Therefore, the Ministry of Health and Population Control has set up a committee to recommend a workable organisation-wise contraceptive target. This was also felt necessary in order to estimate the performance of the organisation to be eligible for reward as announced by the Government. The

Government has accepted the recomendations of the committee and fixed up the method-wise target for different organisations as noted below:

a) There will be two separate sets of contraceptive targets-one for the Community Based Distribution Projects and the other for the Clinic Based Projecs.
b) There will be separate method-wise target for the workers of the old and new projects as stated below:

Method	Old Project	New Project
Sterilization	2	2
I U D	2	2
Condom	2	4
Pill	3	6
Injectables/others	1	1
	10	15

c) The monthly target per clinic for sterilization has been fixed organisation-wise as follows:

i) BAVS	300
ii)FPAB	200
iii)CHCP and others	100

Worker-Population Ratio:

Normaly, at least one full-time worker will be employed for every 5000 population and there will be one supervisor for such 5 workers.

Registration, Coordination and Monitoring

Registration/Affiliation of Non-Govt./Voluntary Organisations

Registration of Voluntary Organisations were administered under the Voluntary Social Welfare Agencies (Registration and Control) Ordinance 1961 (XLVI of 1961). In 1979, the Population Control and Family Planning Division issued a notification vide No. EP 11/354/75/155 dated 25.4.79 exercising powers conferred by clause (e) of Section-2 of the Ordinance and authorised the officers to exercise the powers of Registration Authority under the Ordinance.
The Foreign Donation (Voluntary Activity) Regulation Ordinance (amendment) 82 provided that the Registration is obligatory for both foreign and Bangladeshi agencies or persons undertaking voluntary activities in Bangladesh with foreign donation. For registration, agencies or persons are required to apply to the Director, Department of Social Welfare in form FD-1 under rule of 3 of Foreign Donation (VA) Regulation Ordinance and take action for registration of an organisation and/or issue approval for receipt and operation of foreign donations on the basis of approval of ERD. ERD will also convey the approval on the basis of the recommendation of Standing Committee constituted for the purpose in the ERD.

Since the responsibility of Registration of Voluntary Organisations as per Foreign Donation (VA) Regulation Ordinance (amendment)'82 has been given to the Deptt. of Social Welfare, notification issued from the PCFP Division in 1979 has no effect. In order to monitor the activities and performance of the Non-Govt./Voluntary Organisation, the Ministry of Health and Population Control has devised the procedure of affiliation of organisation, primarily involved in the population control program. In accordance with the same, all organisations have the primary and main objective of FP will require the affiliation of the Directorate of Population Control.For this purpose, Dte. of Population Control will accord affiliation to organisations having more than 10 branches throughout the country. For other local organisations, concerned Deputy Director, FP may accord affiliation.

Coordination of Non- Govt./Voluntary Organisations

The coordination of activities of the Non-Govt./Voluntary organisations working in the population control program is an important responsibility, in view of the fact that a large number of Non-Govt./Voluntary organisations are actively involved in population control

program with diversified project activities. Government in the Ministry of Health and Population Control has developed a mechanism to coordinate the activities of Non-Govt. Organisations.

Theprocedure of coordination comprises the following:

i) Family Planning Council of Voluntary Organisations headed by the Secretary, Ministry of Health and Population Control meets quarterly to review the performance of all Non-Govt. Organisations, discuss their problems, if any relating to the funding, supply of logistics etc. FPSTC serves as the Secretariat to this Council.

ii) Deputy Directors, Family Planning of every district are supposed to hold a meeting of NGO in every month to resolve the issues relating to area of operation, achievement of the target, supply of contracceptives, MSR etc. and identify the field of activities requiring extensive cooperation and coordination between Non-Govt. Organisations and the Government functionaries at the field level.

Monitoring and Reporting:

A multi-channel working system has been developed for monitoring and reporting of the activities of the Non-Govt./Voluntary Organisations.

The system comprises the following:

i) Management information System Unit of Population Control Wing collects the information of contraceptive performance of all NGOs through its normal channel and exhibit the same separately in every month in the monthly contraceptive performance report.

ii) Non-Govt./Voluntary Organisations send their report of activities and performance to main organisations they belong who further examine the same in relation to given target and contraceptive prevalence rate. Say, all FPSTC sub-projects submit their report to FPSTC and equally the branches of FPAB, BAVS, CWFP etc.

iii) DD (FP) of the concerned Zila monitor the NGO activities in every month in a meeting.

iv) FPCVO in its quarterly meeting discuss in details the performance of Non-Govt. sector along with their constraints and future program strategies.

The reporting system has also been modified to reflect the accuracy of performance and avoid duplication. At present, Non-Govt. Organisations having clinical facilities are to report their clinic-wise performance as "performed ' whereas NGOs having no such facilities report their performance of Sterilization, IUD, MR, Injection as "Referred" and follow-up activities are not reported as "performed".

Evaluation:

The evaluation of performance of all Non-Govt./Voluntary Organizations is done as usual and routine matter. The Asia Foundation, The Pathfinder Fund, FPIA and other donor agencies usually make evaluation of the performance of each and individual organisations prior to refunding. The Government also from time to time evaluates the performance of an organization as and when required. FPSTC evaluates the performance of all organizations receiving the support from Subvention Committee. FPSTC evaluates the performance of their sub-projects every year and the Scrutiny Committee takes the same into consideration prior to the refunding of the projects. Besides, the Ministry advises its field functionaries to conduct an evaluation of a project as and when it is felt necessary.

Supply of Contraceptives and other Logistics

In order to ensure the adequate and timely supply of contraceptives and other logistics to Non-Government and Voluntary Organisation the Ministry of Health and Population Control has developed a mechanism of procurement and supply of contraceptive and other logistics.

At present about 8 national level organisations are getting supply of contraceptive directly from Transport Equipment Maintenance Organisation (TEMO) (a central store of M/O. Health and Population Control) Dhaka. All organisations/projects under FPSTC get supply from FPSTC directly who in turn procure the same from TEMO. Family Planning Association of Bangladesh receives the store of contraceptive from TEMO for all organisations financed by FPIA. The Asia Foundation, The Pathfinder Fund, Foreign Voluntary Organisations and Organisations supported by the Subvention Committee get their supply of contraceptive from Deputy Director Family Planning of the concerned district.

In supplying the contraceptive and logistics to a Non-Government/Voluntary Organisation the following principle is followed:-

a) All Non-Govt./Voluntary Organisations get the wageloss, transport cost, food charge, surgical apparel, referral fee etc. from the Directorate of Population Control as admissible by the Government for each case of Sterilization.

Similarly, Referrel fee, Follow up fee, Insertion fee etc. are also paid by the Directorate of Population Control for each case of IUD as admissible by the Government.

b) Non-Govt./Voluntary Organisations get these supplies on the basis of their performance. Usually, the supply is ensured on the principle of one month running and one month stock in advance to each organisation which is again estimated on the basis of the average of the previous 3 months performance and requirement.

c) All methods of Contraceptive, Condom, Pill, IUD Injectable, Foam, etc. are given to all affiliated NGOs free of cost on the basis of their performance.

d) MCH-drugs and DDS kits are also supplied to Non-Govt./Voluntary Organisations on the basis of certain principle.

In fact, at present NGOs do not find problem of contraceptive supply for their effective program performance.

Performance of Non-Govt./Voluntary Organisations

The performance of Non-Government /Voluntary Organisations in the contraceptive performance of population control program has been found to be satisfactory. United Nations Fund for Population Activities (UNFPA) in their country review report of early 1984 observed that the Non-Government and Voluntary Organisations are contributing to the extend of 40% of the total national performance. The contribution of NGOs is around 29% in Sterilization, 62% in IUD, 12% in Pill, 51% in Injectables.

In method-wise performance, some of the Non-Govt./Voluntary Organisations have the remarkable contribution as observed from the analysis of the contraceptive performance. The contribution of Family Planning Social Marketing Projects (FPSMP) in Condom distribution is around 65% and 85% in Foam Tablet and Community Health Care Projects contributes 56% in Injectables. The performance of BAVS in Sterilization is around 25% to 30% in a given year.

Source:Pop. Control Programm in the Non-Govt. Sector.
IEM Unit.
Ministry of Health & F.P (1985)

Health Benefit of Family Planning

Dr.Sultana Begum, M.R.C.O.G.

Gynaecologist and Gynaecological Endoscopist.

I am glad that Government of Bangladesh has changed the name of Ministry of Health, Population Control and Family Planning to Ministry of Health and Family Planning. I would have been more happy if the change was Health and Family Welfare, however this change is also much improvement from that of "Population Control". As if the Government wishes to control only the population by family planning and it does not care the other side of the Family Planning that is "Health Benefit".

On the occasion of the NGO Family Planning Convention I would like to emphasis the "Health Benefit" of Family Planning which to me as a Gynaecologist is most significant. I am sure many of you know the "Health Benefit" of the family planning, still I will venture to put a few facts before you so that those of you, already know, can refresh their memories and those of you do not know, can strengthen your commitments to family planning.

In our country, maternal mortality and infant mortality are shamelessly high. **Maternal mortality means any death of women in connection with pregnancy.** It is usually expressed death of pregnant women in thousand life birth. Our present maternal mortality is 5,5, deaths per thousand. So if we consider one years maternal mortality of Bangladesh—we find that out of the total of 40 lacs life births—in a year—22000 women die during child birth. This figure does not include death due to complication of illegal abortion. We do not have correct figure, but it is conservablity estimated that around 12,000 to 15,000 women die due to complications of illegal abortion lin a year.Those deaths are preventable. In developed countries the maternal mortality rate is below one per thousands life birth.

Infant mortality means all death during first year after live birth. Infant mortality rate is 121 per thousand in Bangladesh. Again if 40 lacs children are born each year then about 5 lacs are dying within 1st year of their life.

These figures are the grim reality of Bangladesh Health.....Here we have not accounted the morbidity of mothers and children—which is again a story of untold misery—the misery of under nutrition, malnutrition, misery of frequent episodes of infectious disease diarrhoea, slow growth and development, high incidence of congenital anomalies and lastly—generation of children with low intelligence. For mothers, the tale is also a tale of inhuman suffering.

The problems of mother and child health are enormous. The sheer magnitude and size of the problems—so overwhelming that it encourages in-action.

If we ask ourself what are the causes and whats are the remedies of this problems ? I am sure all of us wants to do something—something very quickly to stop this collosal wastage of human life and human misery. We can say very easily that to improve the state of affairs we must have nationwide maternal and child welfare services to provide good care—to mother and children.

No one believes that the vast magnitude of MCH service could be done to-day or tomorrow. But do we think—the nation has the political will and necessary resources to do this in near future, to cover all those group ? In the 3rd Five Year Plan project—we have programme to:-

i) provide ante-natal care to 26% of the pregnant women.

ii) provide safe delivery to 10% of the pregnant mother.

iii) provide immunization cover to 60% of the children under 2.

I am sure if we can do what we say or plan, some improvement will take place, but this is not enough.

From our past experience—it can be easily said that our progress in providing maternal and child care services are very poor. If we even accelerate our effort which is indicated in 3rd Five Year Project document we will cover only the portion of pregnant woman with minimum ante-natal and post-natal care. Similarly EPI Programme will cover in 5 years only 1 million of children. Even we are able to provide those services—vast majority of mother and child will remain uncared for. Should we be satisfied with this ?

What are the other option ?

Evidence around the world shows that highest maternal and infant mortality rates are found in four specific types of pregnancies:-
They are:

- 0 Pregnancy before the age of 18.
- 0 Pregnancy after the age of 35.
- 0 Pregnancy after four birth.
- 0 Pregnancy less than 2 years apart.

This facts could no more be true in case of our country. All the 4 elements are the most important causes of high maternal and infant mortality—is known to all of us. Particularly those of us working in Health and Family Planning sector. These four specific cases of High risk of pregnancy are more important when considered together than one of them separately—simple examples will make this statement clear. Older women usually have many children so her pregnancy fall into two High risk categories. Similarly women who marry too young may have several closely spaced birth before they reach age of 20. So her pregnancy fall also into two High risk categories.

-pregnancy before 20.
-pregnancy to-close.

Now what can be done to safeguard the women from High risk pregnancies.

In Bangladesh women are married way around 15 years of age though some people claim the figure is 17 & rising. This sextually active girl get pregnant quickly within 12-18 months of marriage.

Options for
one - delay her first pregnancy
two - National movement for delayed marriage.

I support the movement of delayed marriage but we all know best the situation so I do not wish to comment.

Regarding dealy the 1st pregnancy—here we come—the **Family Planning people.**
This unfortunate girl might die in her 1st child birth—and can be only saved by you. We must catch this couple and motivate them to dealy their first child birth at least 3 years so that—she overcomes the 1st- **Higth risk pregnancy.** So only Family Planning can help her. This is the Health benefit of Family Planning—this will reduce the unaceeptable high maternal mortality as well as infant mortality. Similarly—once this couple can be motivated to—delay the first child—you have produced a true Family Planning practitioner who will also dealy the 2nd and subsequent pregnancey. Thereby you have also taken care of other cases of High risk pregnancy. On the other side the older woman should be educated and motivated not to have pregnancy. Again this can only be done by perform 1 contraception. This actions has not only influence the maternal mortality also reduces the infant mortality. It has been proved that without health care improvement and other socio-economic development, the only Family Planning practice can bring the maternal and infant mortality down to about 30%.
So, I would advocate that along with economic social and primary health care improvement emphasis must be given to Family Planning if not for anything but for reduction of maternal and infant mortality and thereby morbidity.

No person better than we, who are involved in Family Planning movement can help these **unfortunate groups** mother and child—who incidentally comprises more than 60% of us.

Each NGO both national and local level, particularly those are working with CBD Programme must undertake a special programme to bring these vulnerable groups of our population under the umbrella of Family Planning to prevent High-risk pregnancy

Thus Family Planning has great impact on the health of **mother & children.** On the other way—it can be said that Family Planning is the greatest maternal and child health service.

Islamic Sociology and Ourselves

Moulana M. Nuruzzaman Khan

We have inherited a planned and controlled process of social construction from 'The first pair of man and woman-Hazrat Adam and Hazrat Hawa'-the first parents and the first tier of human society. Their creed and the objectives of their life on this earth through continuous stages of evolution came down to us; and it will continue till eternity. Under that process and supreme creed and concept of humanity we all belong to one ummah or brotherhood of mankind.

كَانَ النَّاسُ أُمَّةً وَاحِزَةً

(Al-Quran)

Man expanded the size of his society and moved to all directions on earth and adopted varied changes under different climates. They differ in culture, colour, shape and size, languages, mode and behaviours of life. But the objective remains, and shall remain, the one and the same:-

اَنَّ الارض يرثُها عِبَازى الصا لِحُون

(The earth-verily Miraath over this (belong to) my "Saleh" servants.)

And in this is the proclamation for the "Aabed" People"

اِنَّ فى هٰزالبَلَغاً لقومٍ عَابِزينَ

"And we sent thee (0 Muhammad (P) !) as the (symbol of my) blessings to universes"

وَمَاارسَلنٰك الَّا رحمةً لِلعٰلَمِينَ

The mankind & the world o" today and the world to come form first beneficiary traget of the verses quoted above.

As a matter of fiction we are the best of creation. We are the rightful vicegerents of Rabbul 'Aalameen and his prophet (P) on earth, we are supposed to enjoy the blessings, benefits and fruits of the legacy from the prophet (P) :i.e. the Holy Quraan and the Sunnah of the Prophet; we must claim to be the right-ful Ummat of the Prophet (P). But what is it in fact has to be examined dispassionately.

Coming to present society of ourselves we are to verify if the aforesaid proclamations of Rabbul'-Aalameen do apply to us. If it does, well and good. If it does not, should we keep mum and dumb or look to the causes debarring us from the above mentioned status and position.

If we are to accept that illiteracy, beggary, submersion in the filth and squalor of ignorance about the self do constitute the "Salaahiyyat" or "capability of Man", I, most reluctantly do accept that we are the earmarked ummat to lead the world civilization to right direction. I frightfully feel it is otherwise and we have forfeited that highest honour.

The Holy Quraan is our code and guide book. This revealed book tells us about our responsibilities and the priorities of life-individual and collective.

The first 2 verses of the second chapter -Sura-Baqarah declares :-

آلم زالك الكِتَاب لاريبَ فيه هُزى لِلمُتَّقِين

"This is the Scripture hereof there is no doubt, a guidance unto those ward off (evil)". This is the basic principle of total planning, total control and total guidance.

The words "Hudan" and "Muttaqeen" lead man to vast ocean of responsibilities, regulations, controls and planning of action for man to follow. These actions embrace :-
a) "Iqra" Read; (b) Allama Bil Qalam-Allamal Insaana Maa Lam Ya' Lam "Teacheth by the pen"; teacheth man that he knew not; Turning to our present popular problems, we are suffering from superstitions and confusions about teachings of Islam on :

1. Population Control;
2. Population Planning;
3. Family Planning; Family Control; and
4. Planned and responsible parenthood.

I woefully believe that we have yet to read, research and understand that the Holy Quraan is not a book of idle philosophy. It is a revealed plan of operation of the objectives of life for which man has been sent down to earth.

الرحمن عَلَّمَ القُرآنَ خَلَقَ الانسَانَ عَلَّمَهُ البَيَانَ

This Holy Book tells us about :-

i. Formation of the First Tier of Society through procedures of marriage; (Sura-e-Nissa.)
ii. Rights and obligations of husband and wife : (Nissa.)
iii. Responsibilities of parents towards children : (Sura-e-Baqarah:)
iv. Responsibilities of Mothers to breastfeed the children:verse :233 Sura Baqarah.
v. Responsibilities of parents to maintain the mothers of children vide Sura Baqarah verse 233.
vi. Responsibilities of parents to educate and properly bring up the selves and the members of their family; Verse: 74, Sura-Forqan. All these are the lessons of plannings.

The question of control and planning also involve the principles of "Azl" and scientific methods of contraceptive precautions on reasons of health; and with willing consent of wives. See page 682 of M'ariful Quraan by Mufti Muhammad Shafi.

Rasoolullah (P) did not specifically declare the parctice of Azl as Haraam nor did he make it Farz. That is to prove that he left the matter for judgement according to valid necessity and with willing consent of the wives.

Now we have to look to the General principles of Islam: The Holy Quraan lays down the principle of dealy or postponment of obligations and financial position.

Vide Sura Noor, veres 33.

"And let those who do not/cannot find a match keep chaste till Allah give independance by his grace.

وليستعفف الزين لايجزُونَ نِكاحاً حَتّى يُغنيهُمُ اللّهُمِن فضله

The Holy Quraan has not given open general licence to increase wealth and children. There is also restriction :-

لاتُلهِكُم اَموَ الُكُم وَلااولازكُم عَن زِكرِالله

"(Accumulation of wealth and children must not divert you from the remembrance (Path of Allah)".

Let us look to present society and take our own judgement. I do not claim to be master of Theology and Tafseer. But most humbly I beg of you in the name of Allah tell us whether :-

i. The present population boom has increased the Ummat of one prophet or have multiplied by leaps and bounds the problems and casuses of anti-Islamic curses of lawlessness, chaos, fitna and fassad ;
ii. Has there been any directive in the Holy Quran and Sunnah that "Increase of Population, beggary, illiteracy and thereby chaos and social imbalance is the aim of Islam; and
iii. Is there any verse to show that a Muslim should encourage Fasaad, lawlessaness and causes of all the crimes due to mushroom growth of population must be encouraged. No, definitely not.

I would appeal to the Religious Leaders, to the Ulama, to the Govt. to please devise ways and means to educate mass minds on the provisions of Applied Islam & the Socioligy of Islam and let the problems of the day be solved with willing consent of the properly informed masses who are now governed by superstitions and misconception about Islam on the issues of development-Health and Population.

I would request the policy makers of the country to take suitable steps to develop syllabus and text books on Islamic Sociology and take it as a subject for education in schools, colleges and madrassahs of the country.
We need organized effort of the Ulamas; the academicians, the Theologians, ,the scientists, the Economists and the policy makers to put all heads together to conduct thorough researches on Applied Islam. Because 99 per cent of our total population have not taken the Holy Quran in practical life because 99% of the people have not yet been induced to read and understand the Holy Quran as "The revealed action programme nd the book of Control and Planning of every sphere of man's life-individual and collective."

One word more to remind all of us that :- Islam means total planning, total development and total

enhancement of quality and frontiers human knowledge. Mere reduction of the rate of is not development. Population Programme and population education must therefore be given top war-time priority to all other projects. For after all, developments without developing the quality of life of man shall, as it is now, be an exercise in futility.

Islamic Sociology is an integrated and comprehensive subject which cannot be departmentalised or compartmentalised into Economics, Social, cultural, educational, political so on. That is Islam and Allah says :-

"Get into the fold of Islam, in totality."

اُدْخُلُوافى السلم كَافَّةً

Blue-Print for Tomorrow - Family Planning

Col. Abdul Latif Mallik

Bangladesh with its 100 million population ranks as the world's eighth and Asia's fifth most populous country squeezed in an area of 55,600 square miles, its density has already exceeded 1700 persons per square miles. Bangladesh had a population of only 10 million in 1660 which grew up to 30 million in 1901, followed by further increase up to 40.7 million in 1941, 12 million in 1974. The 1981 census put the population estimate at 89.9 million, showing that population increase was more than double in thirty years, where as the previous doubling time was nearby ninety years and doubling before that about centuries.

Based on several recent studies, the current population growth is estimated to be 2.4 percent with crude birth rate of 39 and crude death of 15 per thousand live births. The very high growth rate of population has many serious consequences includng a high dependency ratio, resuling from exceptionally high population of young population below 15 years (46 percent) and acute shortage of food to the tune of 1½—2 million tons anually, education, health and other related problems.

The urgency for reducing the present rate of growth is well recognized. Infact, every government that came into power in Bangladesh declared population explosion as number one problem and resolved to tackle it on emergency basis. Inspite of all these efforts the success remained marginal until recently. Although there was some increase in contraceptive use during the early half of second five year plan that began in 1980, the performance still fell short of the targets.

On assumption of office the present administration under took a mid-term review in 1982 of the population control programme of the country. The constraints that were impending the progress of work were identified and the government recognized that conventional population control programme could not yield the desired result. In order to accelerate the pace of work government took a number of programatic & administrative steps. The highlight of the recent measures are as under:

-Implementations of Two years Intensive Programme
-Introduction of a system of Functional Integration of health & FP services
-Decutratization & formation of Family Planning Committee at different...
-Expansion of physical infrastructure
-Provision & enhencement of compensation for Clients, Workers & providers
-Emphasis on maternal & child care services,
-Allocation of rational targets
-Strengthening of supervision system
-Declartion of national Award.

The measures outlined above have defenitely improved the programme performance & strenghtened the organization. The last three years progress of work has exceeded that of the previous decade. For example, during the ten year period is 1972-82 a total of 1.1 million sterlization operations were performed the same in the last three years were 1.4 million similarly in IUD, during the previous decade the achivement was four hundred and fifty thousand cases as the same in the last three years were eight hundred and fifty thousand like wise in other contraceptive methods also a vast improvements have been witnessed during the last three years. During the 2nd five years plan that ended in June last year it was possible through a concerted effort to accomplish about 2 million sterilization operations, one million IUD materials half a million injectable administration and distribution of about 600 million units of conventional contraceptive. The total number of births aberted was estimated to be about five million.

The meternal and child health services have also been improved during the recent years. That Govt. considers MCH care as an strategy to promote small family norm. During 1984-85

antenatal cares were provided to over half a million mothers about one hundred thousands save deliveries were conducted five and fifty thousand mother's received post-natal care and over 2.7 million children were provic ed with health care and immunization services. The Govt. has set up three priorities for MCH(1) TT immunization for mother's (2) ORs for control of diarrhoeal diseases and (3) T.B.A. training for save delivery.

It may be mentioned here that the government has not only increased quantity or volume of work but has also pursued a vigorous policy for upgrading the quality of work. Sterilization related deaths have been drastically cut-down to the minimum. The sterilization mortality of 5.76 per 100,000 cases in 1982 has been brought down to 2.01 in 1984. It is tremendous achievement even by international standard.

Third Five Year Plan: Programme Outline & Financial Out lay

a) Within the broad frame-work of the Third Five Year Plan, the Government has continued its efforts for effective implementation of the national population programme with greater emphasis on the following areas.
i. Increased utilization of existing service delivery system,
ii. Expanded coverage of priority MCH services(EPI, ORS, safe delivery practice),
iii. Expansion of physical infrastructue to service rural areas,
iv. Strengthening of manpower development and training,
v. Extended coverage of multisectoral activities particularly women's programme,
vi. Extensive need-responsive IEC activities,
vii. Greater involvement of NGOs
viii. Close and sustained supportive supervision, systematic record-keeping, reporting/monitoring of programme performance,
ix. Testing innovative measures for their wider application by 1990.

For implementation of the population projects during the Third Five Year Plan period, an amount of Tk.870 crore (at 1984-85 price) has been allocated in the public sector and an amount Tk. 70 crore in the private sector. It is also estimated that nearly Tk. 250 core will be spent from non-development budget for the population control sector activities.

Future plan

The Government has setup a target to reduce the present population growth of 2.4 to 1.8 by 1990. In order to reach this target the contraceptive prevalent rate will have to be raised from the present level of 26 percent to 40 percent by 1990 and number of continued users from the persent level of 5 million to 8.2 million.

In view of the current evidences and as a result of new and proposed measures it now appears that the country has achieved the pre-requisite of a favourable setting for a vigorous family planning programme characterized by strong political commitment to family planning, strong programme leadership to translate commitment into action. In the context of the present situation introduction and full operationalization of programme measures the country can genuinely expect to achieve the cherished goal of reaching the not reproduction rate one by the year 2000 AD.

Bangladesh's Population 2000 A.D.

Dr. M.A. Mabud

Bangladesh is the World's eighth and Asia's fifth most populous country. Its population growth took an upward trend from the middle of this century and has grown more than double since then. Whereas, previous doubling took nearly ninety years; and doubling before that, about two centuries. Present population of Bangladesh is estimated to be 100.5 million and growing at the rate of 2.4 percent per annum. If this rate continues, this population will again double itself in less than thirty years.

What is disturbing for Bangladesh, apart from the large size of population, is the tremendous growth potential built into the age - structure, as a consequence of past high fertility. Nearly forty six percent population is under the age of fifteen years. Added to this, another growth potential lies in the large base of female population of reproductive age who represent forty four percent of the total female population.

The most serious problem which Bangladesh is facing today is the large size of population unmatched with its resources. Not to speak of the planners and policy makers of the country, even the casual observer asks himself what would hapen by 2000 A.D., when its present population would exceed 130 million mark even if the current rate of growth is substantially reduced through programmatic measures and antinatal policies.

An analysis undertaken by this author of two population estimates projected below for 2000 A.D. will show how grave are the consequences of today's population growth.

Two population projections on two variants—Substantial and moderate reduction in fertility from 1981 under the assumption of achieving a NRR of I 2000 AD and beyond yield population estimates of 131 m and 134 m respectively. To understand the implications of these two population estimates by the readers, several indicators are considered here. These are density, income per capita, employment, education and politics.

Population Density

The population size, infact, determines density which in simpler sense means the population size per square kilometer or mile. In a constant land space, population density changes in different time in population to the change in population size. A century ago, population density of the area now comprising Bangladesh was only a quarter of the present density of 1850 persons per square mile. The population was then only 24 million (1881). During 1901—1981, population become triple with a corresponding increase in density as evident from the table below :

Table I : Population size (in million) and Density per square miles

	1901	1921	1941	1961	1981
Size	29.92	33.25	42.00	51.00	89.9
Density	526	604	763	927	1730

The total area of Bangladesh is estimated to be 55126 sq. mile or 14,4000 square kilo metres of which nearly twenty per cent are forest, river, canals and roads. The actual pressure on population is on the remaining eighty per cent of the land space which is also gradually attenuated as a result of the growth of new cities and towns, households, industries, market places and so on.

The population pressure on land will, therefore, continue and population density under the substantial and moderate decline in fertility estimates will be respectively 2720 and 2950 persons. By the turn of this century, the entire to-pography of today's rural Bangladesh will look like subverbs - an extention of Dhaka, Chittagong and other cities.

Income per capita

Issues of population size involve analysis of the results of the pressure of a larger population on fixed supplies of land and natural resources. This analysis is much more relevant in Bangladesh where both land and natural resources have quite limits than in countries where more land can be brought under cultivation and natural resources are in the range of 5–10 percent of GDP. In Bangladesh, natural resource is 2 percent of GDP. Agriculture is still a major source of income — almost 48%. As the population size is increasing the pressure on land, particularly the useable land is concomitantly increasing. Total cropped land was about 30.5 million acres during 1976—77. This pattern of cropped land has been more or less continuing since then. There is not much fellow land left to be brought under cultivation now; and whatever is also needs heavy investment which Bangladesh cannot afford to ensure under the current level of economy. Under this circumstance, to raise individual level income of large base of farm population is difficult. It is, therefore, clear that population sizes under the two different assumptions will have varying impact upon individual level of savings and national investment; because much of the national income derived from exports of Jute, tea, newsprints and other conventional items as well as from revenue earnings etc. will be used for a consumption. As a result, net national income will be less. Consequently national saving will not improve. This is evident from the fact that despite increase in production, per capita income has been some where between $ 120—150 during the last six years. One apperent reason that one can descern for such a per capita income is the rapid population growth which might have neutralised much of the fairs obtained through development efforts.

Another possible source of raising income is natural resources which is 2% of GDP. Natural gas is the main component of this 2% GDP. Domestic consumption of gas and its export need to be increased for generating additional income and saving. This, in turn, calls for huge additional investment which the government cannot afford at present. This has dragged the country into a dual tangles of economic problem and rapid population growth — both hinder the process of economic growth and raising income per capita.

Various studies show that the contribution of the low income group is greater than the high income group to the increase in population sizes. As the population size increases, the gross volume of consumption in the low income group also increase the gross volume of consumption in the low income group also increases. As a result, individual level of saving begins to dwindle. Because the low income group in Bangladesh have large family size than the higher income group, the relative proportion of low income families will be greater. The lower income group are nearly 80% of the total population but share only 20% of national income. Therefore, they are the people who face both the problem of population pressure and income reduction. The rapid population growth complicates the process change in income inequality over time of affecting the low income group more seriously than those in the upper income bracket.

In Bangladesh, the rapid population growth and its consequent increase in population size complicate the process of transfering resources from the higher income group to the lower income group, because the population to be benefitted become proportionately larger and larger in absolute number. As a result, inequality will increase further.

Employment

Decreasing infant and child mortality in Bangladesh during the late 1960s has resulted in significant increase in the growth rate of the working age population during the 1970s and in this decade. Since the young people who will enter into the labour force during the 1980s and 1990s are already born, there will be tremendous increase in labour force in the next two decades. If we review the trend in the growth of labour force in 1950 and 1960, we find that the size of the labour force (civilian) increased in absolute number overtime with the increase in population size. For example, there was 17.0 million labour force in 1961 as against 13.0 million in 1951. Of this civilian labour force, 83% in 1951 and 85% in 1961 were in agriculture. The percentage of labour force absorbed in agriculture sector in 1972 was 80%. The percentages of labour population were 30% and 34% of the total population of

1951 and 1961 respectively. The proportion of labour force of the total population was 35% in 1972. This in creasing trend in labour force roughly corresponds to the increase in the size of population. Assuming that future trend of labour population will be about 32% of the population, in that case, Bangladesh is going to have about 44.8 million and 49.6 million civilian moderate reduction in fertility respectively.

The capacity to absorb the increased labour force by agriculture sector is constrained by the factors of low level of investment for irrigation, fertilizer and pesticides. Arable land dimineshes as the population size is becoming larger and larger. It is quite likely that the present problem of employment and under employment will further deteriorate. Unless agriculture is totally revolutionised and other sectors make definite headway, the problem of unemployment will persist and worsen social, economic and political life of the country.

In a country where 65-70 percent of the workers are engaged in agriculture and labour force growth is 2%, non-agricultural employment opportunities would have to grow at a rate of about 6% to absorb the full growth of the labour force. For densely populated countries, the implications of this are serious. Unless non-agricultural employment grows very fast, presure on land is bound to increase.

In Bangladesh, the size of the non-agriculture labour force were 16.8% and 14.7% in 1951 and 1961 respectively. If urban sector is to absorb the rural unemployed and under employed youth, Bangladesh would need capital intensive investment which means that it shall have to increase per worker investment, a condition which Bangladesh economy cannot afford to fulfil at present.

Unemployment is nore among the females than among the males. In 1951 and 1961, only 7.7% and 15.1% were the female civilian labour force. While there may be slight increase in female employment in Bangladesh, the number of unemployed women in gainful work in absolute numbers will be staggering. Thus, in order to have significant decline in fertility and consequently in population size by 2000 A.D. opportunities for female employment need to be increased both in urban and rural sectors.

Education

Education is an important determinant of welfare of a country in the sense that education beefits the individuals and their families as well as creates an alert citizenry which is necessary for development. That is why, there has been a persistent demand for enhancing educational opportunities both in private and public sector all over the world. In Bangladesh, considerable investment has been made in the past. As a result, number of institutions and students have been increased during the last three decades. Inspite of this investment, there has not been any significant increase in the percentage of literacy (from 18% of 1951 to 23% in 1981). What is surprising is that the illiterates in absolute number have been increasing dramatically over the time.

Table—

Number of students by educational Institutions in Bangladesh 1968 to 1970.

	Number of Institutions		Number of students	
	1968	1970	1968	1970
Primary schools	28449	29029	5116188	5,242954
Secondary schools	3460	3765	1143784	1,269549
Colleges (including professional)	158	172	178948	2,22,420

(Source: Bureau of Educational Information and Statistics, Dhaka, 1974).

In 1974, out of 76.2 million population 13.18 million (22.2%) were reported to be literates and therefore, 63.02 million people were illiterates as against nearly 40.0 million illiterates of 1961. Thus, it is clear that as the populaiion size has increased, the illiterates in absolute number also been increased and thereby compounded the problem of creating an alert citizenry, a prerequisite for social change. Two reasons may be attributed for this slow progress namely (I) poor economy of Bangladesh cannot afford to invest more for education, and (II) lack of educational and public interest in 'leucation. If the current trend continues, the number of illiterates will be more. Assuming that percentage of literacy, will be 30% by 2000 A.D. and the number of illiterates under the different assumptions of fertility reduction will be as follows :

Table —

Population size and number of illiterates by 2000 A.D. under various assumptions of fertility reduction A.D.

Assumptions	Population sizes	Illiterates
Moderate reduction of fertility	134 million	90.0 million
Substantial fertility	131 "	85.0 "

The problems during 1985-2000 in the sphere of education shall be mainly two. First, to provide more schools, teachers and equipment for increasing enrolment. This implies that the number of primary schools, secondary schools and colleges shall have to be double the level of 1970's requiring almost double the investment in education sector which is again a matter to be seen whether Bangladesh can afford to do so. Secondly, to tackle the vast mass of illiterate population will be itself a problem. The illiterate community is, to a large extent, dependent on the fraction of the literates for support and guidance. Besides, fairly majority of them might be vulnerable to diseases and various other social prolems. This will create a social invironment which will not be conductive for social and economic development. The cost of illiteracy is to be found not only in the missed opportunities for the affected individuals but also in its effects on fertility. High fertility and illiteracy are also highly correlated, and tend to perpetuate a cycle of economic improvishment. For having such a large proportion of illiterates, overall problem of Bangladesh will be further deepen and the task of social change will be much harder. Needless to say that illiteracy is a curse to a nation. There are two ways to overcome this situation viz. (I) education should be made universal ; and primary education should be made compulsory. This would involve heavy economic and political investment of the Government and (II) reduction of fertility through voluntary measures. Besides, antinatal policies are also necessary to reinforce the above policy. These measures will reduce the total cost of education and minimise the number of illiterates in absolute number in near future. The economic benefit of the second strategy will be enormous in the long run. This proposal also presupposes heavy political investment as much as the other one. In both the cases, a risk is involved from which no responsible government in Bangladesh can get away.

There are two advantages for reduced fertility. First reduced fertility will reduce population size which is itself a great benefit to a high fertility country like Bangladesh. Secondly, in consequence of having a smaller population size, the country is likely to have a relatively small size of school age population for which investment per student can be increased. It is possible to deepen educational investment. This may ensure better quality of education. Thus, reduced fertility ensure quality rather than quantity as is the case with the developed countries. The economic cost of educating the school age population of 5-21 years is very high indeed. Let us take the case of primary education entry into which is meant for second cohort population, 5-9 years. In three different projected population sizes, we have got three different sizes of second cohort population 5-9 years as shown in table below :

Table —

Second Cohort Population by three Assumptions in 1990 and 2000 A.D. (in million)

	1990		2000	
Assumptions	**Pop. size**	**2nd cohort Population**	**Pop. size**	**2nd cohort Population**
Moderate reduction	**113.9**	**16.39**	**134**	**19.12**
Substantial reduction	**112.58**	**16.08**	**131**	**17.10**

The number of students entering educational system of the primary level, ENRPT is assumed proportional to the population ages 5-9 where enrollment ratio, erp, for each year is prespecified.

$$ENRPT = \cdot \; POPz,t.$$

Where POPz,t is the second age cohort. Assuming that erp = 54 percent of the POPz,t on average during five year period (although it varies in successive years), then the ENRPT will be as follows :

Primary school enrolment (in million) by 1990 and 2000 A.D. under three assumptions of fertility.

Assumptions	1990	2000
Moderate reduction	7.8	9.8
Substantial reduction	7.5	8.1

In 1970, there was reportedly 5.4 million primary school enrollment. During 1980-2000 A.D. there will be 28-30% increase in the primary school level. If 50% of these students continue their advance education upto college level and 20% at the graduate level, hypothetically one can arrive at a cost which will be no less than the double of the present level of educational investment.

Politics

Change in Population size has political consequences. A densely populated country like Bangladesh which is already goaning with various social and economic constraints may have different political consequences of Population change from those of the less densely populated countries with better economic base.

According to one analyst, new demands resulting from population increase may affect the size and character of the bureaucracy and the kind of resources needed by the Government to meet those demands. Another type of political effect of population is the internal distribution of social and political power. Increase in population size as a result of natural increase, shall result in larger younder population. Strength embodied in population composition sometimes weilds political power more than their numerical strength which may offset the balance of political power and affect other age-groupings. Political upheavals in Bangladesh, Pakistan and other countries in late 1960s and early 1970s, were fomented by the young population who, by virtue of their numerical strength, constituted political power to be reckoned with. Thus, under two different estimates, Bangladesh is going to have different population of aged 15-29 by 2000 A.D. some of whom are born new and larger fraction are still to be born.

As the population size will increase, cost of bureaucratic apparatus to serve will increase, cost of bureaucratic apparatus to serve the population in the country-side will also increase. This realism is well pronounced by the successive governments in Bangladesh from time to time.

The economy of scale that is argued in favour of present centrifugal power will no longer hold good. Localised bureaucratic structure is deemed to be necessary by the Bangladesh Government to look after the welfare of the increasing population. Such expenditure could be avoided, if population growth rate could be slowed down considerably in the last two decades.

Increase in population size means the increase in population under age 15-to the extent of 40-50% during next two decades. Health and environmental facilities proportionate to the demand of this age-group needs large fraction of GDP. The political demand for services needed for this age group depend on humanitarian will of the Government and also on the relative priority to their problem which is often bypassed by the demand of other age-groups, having political power. For example, old age population in the USA who are about 12% of the population can exert political pressure upon the Government for creating health and other welfare services for them, as they have political power by virtue of voting right and numerical strength. The U.S. Government recognises them as a political power and meets their demands. In high fertility country like Bangladesh, less politically active population is likely to be neglected and shall have to live on the mercy of politically active population, as they are now.

Community Participation in Planning: Role of Non-Governmental Organisations

International Planned Parenthood Federation

Rationale

Until fairiy recently, programmes and projects aimed at improving the socio-economic and health conditions of the poor tended to be initiated, designed and implemented from the "top-down" by agencies and institutions without systematic consultation and involvement of the intended beneficiaries. The basic idea was that the introduction of modern technology and science would automatically lead to a decent standard of living for all and that the availability of modern health services would defeat illness and disability.

However, with experience has come the awareness that top-down approaches to development create an increasing dependence of the people on outside resources and also sharpen social divisions. Moreover, the cost of this approach to welfare and development is so high that no government in any low-income country can reasonably expect to meet the needs of all its people in the near future. It also became clear that the intended beneficiaries of development and health care do not necessarily share the preparation outsiders have of their priority needs. As a result services offered to the people were often rejected or under-utilzed because theydid not meet their needs, or did not respect their sensitivities.

Meanwhile grass-root movements were quitely pioneering the community-centred approach to development, based on principles and initiatives coming from the people themselves. In Asia, in particular,there are many examples of the successful merging of self-help traditions with modernization and development. Recognition of the shortcomings of the top-down approach to development and an increasing awareness of the potential of "self-help" are causing governments and agencies world-wide to re-examine their assumptions and priorities.

As a result the approach to development has begun to shift from top-down to bottom-up, from specialized to integrated, from lecturing to dialogue, from modern technology to appropriate technology. Development agencies, and some government agencies, and some governments have adopted new policies to guide their activities based on the principle well expressed in the old Chinese saying:"Start with what the people know, build on what they have".

To implement this community centred development approach presents a challenge. It requires a great deal of new learning and adoption on the part of development planners and institutions. Attitudes and styles have to be adopted, responsibilities decentralized and new modes of accountability developed. The difficult but worthwhile task ahead had just begun.

The concept of community participation

"Community participation" combines two concepts which are in themselves ill-defined."Communities" vary from tightly knit rural villages to urban areas where few people know each other. The term also applies to professional groups, members of a churchetc. It denotes a group of people who share a feeling of belonging and have interests and needs in common.

"Participation" varies from active to passive as well as in its intensity and implies a voluntary decision. Within the development context the term"community participation" generally aenotes a grop of people within a specific geographical

area who have common interests and needs and who take an active part in furthering one or more of those through voluntary collaboration.

Community participation covers a wide spectrum responsibilities which members of community voluntarily take upon themselves to fulfil.
At one end of the spectrum, communities may initiate, design and take total responsibility for action programmes to meet their common needs. Alternatively, members of the community may take part in some of the deliberations and actions initiated,designed and implemented by others from outside the local area.

Community participation in family planning programme

Adapting the programme to local needs

The idea of"family planning" is not itself a new one. All human socities, throughout time have known and utilized at least some practices having an influence on the fertility of the group. These pratices vary from delayed marriage,temporary abstinence and breastfeeding to induced abortion and infanticide.

Most groups also "know" some means of regulating the timing of births. They may relay on prayers, charms, devices and concoctions. Effective means of regulating the timing of births, however, have become available only fairly recently through new technology.

If family planning by modern effective means is to be fully accepted, it needs to adapt to people's life-styles. The new technology must find its place within familiar and respected community institutions and not violate the traditional values and sensitivities of the people.

Family planning programmes designed and implemented by outsiders not aware of the underlying cultural forecast the local level are likely to violate traditional systems of decision making. They night ignore local power structures and traditional relationships within the families. Communities might react with scepticism if not fear and reject the new technology as foreign and alien to their way of life.

Obviously no outside body can be aware of all the different facets of life at the village level. Even if the facts were known, it would not be able to develop the most approriate service model to meet the variety of needs of each different situation. To ensure that the programme and its activities meet the local needs, the communities themselves must be involved from the beginning, in planning the programme and in its implementation. They are the vital partners in any such undertaking.

Participation of the community in all aspects of programme planning ensures that the new technology is adaptd to people's life- styles. During implementation, the programme is more likely to draw on available local resources (traditional healers/ midwives, formal and informal leaders etc.) In that way the new technology finds its place alongside familiar and respected commuity resources and becomes part of the indigenous way of life.

The community's role-in-motivation and support for family planning

All human communities have norms and values shaping the behaviour of its members. These are particularly strong in the areas of sexual relations and reproduction. Members who deviate from the established norm may be subject to rebuke and disapproval depending on the severity of their actions and the cohesion of the community itself. Where contraceptives are offered through channels alien to the community, early acceptors might be confronted with ridicule and misapprehension by their fellow-members. In this climate rumours on the perils of modern contraception tend to thrive and find willing listeners.

Where a family planning programme is based on community participation, however, the community itself recognizes the value of family planning and the benefits to be derived from its practice. As a consequence, practising family planning will be considered responsible behaviour to which its members should adhere. The prestige and influence of the leaders who actively support the programme and perhaps participated in the process of planning and implementation helps to overcome fears and doubts which may be held about the use of contraceptives.

Traditional health practitioners in the community

such as traditional birth attendants (TBAs) are trusted by the people and relied upon during times of crises, be it childbirth, illness or death. They are aware of the living conditions affecting their clients and know when family planning becomes a need and a benefit to a particular client. They are potentially powerful allies in the cause of family planning and should be familiarized with the aims and means of the programme and encouraged to incorporate this knowledge into their work. Community based groups such as women, youth, specific interest groups etc. who have organized themselves to enhance thier social and economic goals are also conducive channels to ensure genuine democratic participation in welfare programmes and to further the inclusion of groups wich are marginal to the decision-making process at the community level.

Community channels for family planning education and service delivery

Traditionally, family planning programmes have delivered services through medical/clinical channels. In many cases, medical doctors were the pioneers of family planning in their countries. They were intimately aware of the problems women faced as a result of excessive childbearing and the health consequences associated with it for mother and child. They also had a prestigious voice at the national level in advocating the benefits of family planning and urging the government to adopt policies and provide services. As a result family planning services became associated with MCH services through clinical channels. This approach contributed enormously towards gaining acceptance for family planning as an important and legitimate service benefitting the health of the people. It also became clear however that integration with clinical health services has serious limitations. Medical establishments and personnel are distant to the majority of the people in the developing word in every sense of the world. Large proportions of the world's population have never consulted a medical doctor either because there are none within a reasonable distance, a consultation is too expensive or the thought simply never occurred. Others only consult a doctor in cases of extreme urgency when all other sources of help have failed. Not surprisingly for many "consulting-a-doctor" is associated with serious disease and death: a frightufl exprience to those involved.

As contraception concerns healthy people who take an interest in the consequences of their actions, the traditional linkage between the medical profession and contraception can be counterproductive and is unacceptable to many. The fact that in many countries a large amount of contraceptives, in particular the pill, are sold over the counter of pharmacies, drug-stores and other retail outlets without prescription, testifies to the fact that many people prefer to get their supplies from familiar neighbourhood sources.

Community based distribution programmes of contraceptives, a non-clinical strategy for the delivery of family planning education and services, have been in operation since the early seventies in many countries: proof of the acceptability of this approach is in the increase in their number, scope and diversity and the significant degree to which they have generated community participation and co-operation in family planning.

Dependency versus self-reliance in family planning programmes

The co-operation of communities in activities for the common good has deep roots in history. People have always had to work together to achieve ends beyond the means of individuals. Evidence of such community venturers are found throughout the world in the form of places of worship, roads, terraces, irrigation systems and wells to name but a few. However modern or specialized high cost technology has worked against community self-help. Formal institutions under state sponsorship replaced community action, officials took over from natural leaders. Experience has shown that specialization breeds fragmentation of services and that a system dominated by officialdom generally functions less well than any broadly based community group.

Family planning services are eminently suited to integration with community self-help activities. The idea of family planning is not new and the administering of modern contraceptives such as the pill and condom requires no complicated technology: natural leaders in the community can be given the necessary technical expertise. Such leaders understand the values and beliefs of their people and can provide services which are socially and culturally appropriate as well as medically correct. Contraceptive methods such as IUDs and

sterilization can be provided through referral from community channels to the nearest family planning clinic. By integrating family planning into local self-help activities, dependence on external aid and other forms of assistance can be minimized and the need for an outside presence in the community is diminished: using this approach local resources and capabilities are used fully and with sess likelihood of duplication of services.

The role of NGOs in community participation in family planning

Background

The full dimensions of the immense task of making family planning knowledge and services available to all can be understood when one considers that :

- — Family planning relates to the intimacy of family life which is not easily discused.
- — The achievement of a desired family size means long-term preventive measures and these often entail daily self-medication or taking precautions when spontaneity is at its peak.
- — The population to be reached with family planning education and services is very large, i.e. all women and men of reproductive age; their number increases daily and fastest where the need is greatest.
- — Family planning services must be available on a continuous basis providing stability and familiarity of service outlets while at the same time be flexible and adaptable to changing mores and technological advances.

Given these facts it is vital that communities be helped to meet their own family planning needs so that their quality of life may be raised in a culturally acceptable way. However, communities need to be enabled to cope with the challenge ahead. Outside agencies may have to play a catalyst role, and assist in the training of local workers.They also need to provide back-up services and the necesary supplies.

Co-operation between communities and agencies in this task must be as genuine partners with the community participating as fully as possible and the outside agency filling in the gaps in resources.

Governments and NGOs have separate parts to play in developing such partnerships with local communities as well as with each other. The work of the communities and governmental and non-governmental organizations should be co-ordinated and complement one another. The goal is: optimal use of resources for 'people-centred' development. The specific contributions each can make will differ in their national contexts.

Frequently NGOs themselves have emerged from indigeneous efforts to find acceptable solutions to local problems. They are generally founded on the principle of self-help and volunteer involvement. Local NGOs organized into a national or international structure provide channels through which grass-roots aspirations and needs flow upwards and outwards, while new information and experience flows back to stimulate and reinforce local actions.

Family Planning Associations (FPAs) provide examples of such grass root organizations, initiated locally, coalescing into national associations and coming together at the international level in a Federation. The International Planned Parenthood Federation takes pride in being the umbrella organization of 108 autonomous national affiliates. The raison d'etre of FPAs is to be pioneers and pathmakers for family planning within their own countries, to serve those people less likely to be served by others and to initiate new approaches to service provision based on local initiatives. In so doing they can assist governments by demonstrating culturally acceptable ways of delivering services.

Flexibility

Since they are grass-roots organizations, decision-making by NGOs is carried out near the action. Often the activities to be developed are initiated by local groups who seek assistance from organizations which can respond speedily and competently to their particular needs. NGOs are frquently in a better position than governments to respond to grass-roots initiatives because of less stringent bureaucratic procedures and an inherent sympathy for innovative action and local enthusiasm.

An example illustrating the co-operation between NGOs and a local community is in Panabai,

Guatemala, a rural neighbourhood of 3,000 people where mothers felt the need to have a local centre for prevention and treatment of malnutrition. They approached ASECSA (Asociacion de Servicios Comunitarios de Salud) in association of NGOs in Guatemala who enlisted the help of Project Concern, an NGO based in the United States of America. The centre was established within a short time, and operated with considerable input from the mothers themselves. They take turns to deal with the tasks in the centre and by doing so not oly contribute to the service but also learn about the importance of food hygience in all its aspects to health. Each mother who learns in the centre returns later and teaches others for a specific period of time, her teaching being enriched by the experience she has gained. In contrast to the 40-50 percent recidivism rate at other nutrition centres the rate at the Panabaj centre is only 5-10 per cent.

Demonstration

Many activities undertaken by NGOs are specifically intended to be experimental: trying out new approaches in different surroundings. Imaginative project ideas are frequently originated and implemented by a specific community.

If the new approach seems to be successful it can be tested further, either by expanding the original project geographically, or by replicating it in several different places. Testing out new ideas is necessarily risky. However the risk is lessened by good local participation, motivation to succeed, flexibility of response and willingness to absorb the lessons of experience.

As voluntary organizations, NGOs are not able to provide their services at a national scale because they do not have the necessary resources-financial or human. Nor, for most NGOs, is this their goal. They are there to use their particular strengths to test and demonstrate, to share lessons learned with governmental and other agencies, and assist in efforts to duplicate successful projects.

The approach of the Japanese Organization for International Co-operation in Family Planning (JOICFP) well demonstrates this function of NGOs. Specific experience in post-war Japan indicated that family planning services are more acceptable if they are provided alongside other measures which have an immediate and visible effect on the health and quality of life of the people involved. Parasite control and nutrition cation were the partners chosen to enhance ily planning acceptance and to generate a it in which people would come together to improve environmental hygiene and community development. First tests of this approach in Asia strongly indicated that it not only enhanced family planning and lowered parasite-infestation rates but also stimulated community action to deal with environmental sanitation: a root cause of high child mortality. These projects were replicated in co-operation with IPPF affiliates throughout Asia and, subsequently Latin America. IPPF affiliates in the Middle East and Africa will shortly initiate similar projects while the activities in Latin America are expanding both within and outside the IPPF structure. National steering committees play a vital role in demonstrating the achievements of the projects and in sharing their experience with governments.

These national committees draw on key personnel in governments and NGOs and always include a parasitologist. Locally there is a steering committee of influential local leaders and staff which oversees the project and ensures co-ordination with the national level.

Co-operative approach

NGOs, like government departments, usually specialize in offering specific services. In the community however, people have many needs which are complex and interrelated. Thus to provide specialized services, each one attending to a fragment of the interrelated needs is not only wasteful of resources but also insensitive to the community's needs. Many NGOs have a long tradition of meeting such needs through co-operation with other groups and institutions with expertise in related and relevant fields.

The Shadab project (Pakistan) illustrates the value of tripartite co-operation (national government/local institution/NGO) which provides the delivery of a totally integrated rural development service with a large measure of community participation.The Shadab project covers an area of 47 villages and seeks to improve agricultural production and general living conditions. Components of the project are community development, agricultural education

and assistance, banking and credit schemes, adult and child education and family planning. What distinguishes Shadab from other rural development projects is that it manages to co-ordinate the services of government agencies and NGOs into one local agency in which the community itself participates to a large degree. The Pakistan EPA provides the family planning component through its training of all project staff i.e. agricultural development assistants, volunteers and provincial government officials. Local leaders, teachers and welfare workers become involved in the family planning activities after orientation sessions. The villages form small representative management committees to ensure that local needs and priorities will be the guiding force in the activities to be developed. The linchpin of the project is organization: co-ordinated under one umbrella are all relevant government agencies as well as quasi-official ones, private organizations and commercial concerns of interest to the project.The villages are linked through Union Councils and ther system is supervised by a project manager who is assisted by the secretaries of the Union Councils. The agencies co-operating in the venture are barely visible at the local level: they make their specialized input only where and when required and leave the project implementation to the local people.

Stability

Unfortunate though it may be, it is a fact that the lives of innocent people are disturbed time and again by unforeseen and unsuspected events. Natural disasters, wars and political strife have caused millions of people to abandon their homes and seek safety elsewhere. Generally there is no national plan to meet the nees of the people affected because of the sheer unpredictability of these events; also the government itself might not be able to function normally.

NGOs, because of the flexible nature and grass-root structure have been responding quickly and effectively to many disasters and their broad local networks enable them to muster forces very quickly. Many a family planning volunteer or field-worker has been converted into a great relief worker in times of need. A basic knowledge of health issues combined with access to a channel for relief supllies place them in an excellent position to temporarily fill gaps in the official structure. Grass-root networks are better able to withstand upheavals than supper-structures.

Examples abound throughout the world. For instance the EPAs of Thailand, Hong Kong and Singapore were the first to offer vitally needed help to those seeking refuge on their shores. The Association brought nationals from those countries on to their staff to reduce language and cultural barriers. Because of their early involvement, they were able to advise their governments on the needs of the refugees.
It is not only violent disasters that bring out the best qualities of voluntary organizations. Services can disappear or be badly affected by changes in government or its policy. Experience has shown that voluntary organizations are sometimes the only ones left to provide services, to demonstrate the benefits of family planning and to represent the peoples needs in such, regretfully not infrequent circumstances.

FPAs in Latin America suffer particularly from the ambiguity their governments maintain towards family planning. Several governments have a history of at times permitting family planning as part of the official health service and at times attacking, prohibiting or preventing services from being given. Waves of approval and disapproval alternate due to political perceptions and the position taken by the national Roman Catholic hierarchies.In most cases FPAs, being relatively independent,are able to defend the cause of family planning and demonstrate that people want and need to have access to family planning services.

Issues arising from community participation in family planning programmes

While the idea of community participation has gained widespread acceptance, its practice has revealed limitations and impediments as well as produced successes. Progress towards implementing the participatory approach can only be made if developers critically assess the "limits" of participation and find out what can realistically be achieved in the different field conditions . So far,experience has indicated number of factors that restrict or complicate its application.While the extent and intensity of these limiting factors is

not yet known, it is clear that developers cannot adopt one single , uniform model i.e. the particiaptory one, and expect it to be the complete answer in all conditions and circumstances.

Family planning may not be a felt need

A crucial and most vital factor in achieving community participation in any development effort is that the people must want the particular service. The use of modern contraceptives is by no means universally accepted as desirable by the client-population.

In many instances, if not in most, family planning is not included when communities express their needs and allocate priorities. They may not recognize te benefits of family planning to mother and child health, and the contribution it makes to the quality of life. If activities are not consciously desired, one cannot expect enthusiasm and eagerness towards participating in them. In such cases family planners look for so farcalled,"entry points", offering family planning in conjunction with other services which are meeting expressed and identified needs e.g. income-generating activities, general health services. In these situations it is anticipated that once people have faith in the programme personnel and their activities, they will become more informed and open to the idea of family planning.

The IPPF Planned Parenthood and Women's Development Programme(PPWD) is one strategy which has been used to give effect to this idea. Projects funded under the programme are small and experimental, designed and implemented in partnership with the women on the basis of needs identified by themselves. Family planning is rarely a strong feature at the initial stages but experience has shown that while women undertake group action to bring about the desired changes, they realize that regulation of births is a relevant component in the process of self-development and determination. At that point family planning information and services are actively pursued and participation in family planning activities is generated.

Communities are not homogeneous entities

Some kind of ranking by class or caste, sex or age group, political affiliation or religion, affects even the smallest and poorest of communities. These internal divisions are not immrediately apparent to visiting programme personnel, but have important consequences for programme implementation.

Local decision-making, in particular in rural areas, conforms to the internal socio-political hierarchy. In some cultures the hierarchy is a traditional one, with the "elders" making the major decisions for the rest of the community. Some groups such as women, young people, and the landless, have no or little influence in this process and thus their interests are not likely to receive much attention. In socialist communities a party cadre may be the decision-making body and, although it may be more representative of the age and sex groups in the community, it is guided primarily by policies and priorities from the centre and these may differ from local perceptions.

Family planning may or not rank highly in the needs as expressed by the community depending on who has a voice in identifying those needs. Concerns of the leadership might well take priority over the concerns of the majority, particularly of women and youth.

Thus, even working within the community's decision-making system and using, as a starting point, needs identified by the community, is in itself no guarantee that the interests of all its people will be served. Careful consideration is required to achieve an effective balance between respect for community structures and ensuring that all community groups receive a fair share of the benefits of programme activites.

Identifying a person to be responsible for the family planning programme locally may be a vital factor in ensuring broad access and participation. Experience indicates that no hard and fast rules apply to the selection of a programme leader. It can be man or a woman, a formal leader or a natural one, an old or quite young person, educated or illiterate. What seems to appear as a common denominator is that the person must be well-known, highly respected and that he or she be motivated beyond an interest in self-improvement. Above all, he/she must be able to relate to people.

Limitations to the ability to participate

Even where people are committed to the idea of family planning they can only participate in

programme activities within their means and abilities. Unrealistically high expectations sometimes put on the ability of people d cate time and effort on programme active p ticipation presupposes that people have spare time and surplus physical energy. However the poorest groups particularly suffer from bad health and live on inadequate diets, they need all their energy to scrape together a living. Mothers of large families who can gain most benefit from family planning also have the least time to spare.

Those who are developing programmes must realize that community participation is not a magic solution to development and health problems every where and always. Community participation counts on the resources of the poor, i.e. their time, energy and enthusiasm, and looked at realistically these resources are limited ! Not everybody is able to participate in programme activities beyond being recipients of the services. Only some of the people are in a position to conribute some of their energy and time at certain stages in their lives. For instance a mother of 14 children in rural Colombia whose husband objected to family planning throughout the marriage, volunteered her services to the FPA's (PROFAMILIA) community based family planning programme after the death of her husband. Her youngest child had entered school and her eldler sons contributed to the family's income; this enabled her "to help other women not to suffer as much as I did ". This woman would have benefitted from a community based family planning programme if it had existed in her time. However her contribution could only have been as a recipient of services until she was freed from a total involvement in household duties.

No doubt most communities do have some resources of spare time, energy and enthusiasm which can be tapped. However, to be successful the community centred development approach must learn and understand what can or cannot be done under different conditions. Above all, development agencies need to ensure that no conflicting and overburdening demands be made on the people in the decade ahead.

The existence of community organizations as channels for family planning activities

In some areas of the world, particularly in Asia, there is a long tradition of group action to achieve a common goal. Such actions vary widely and are pursued by groups which range from highly structured organizations to informal, temporary groups. There are numerous and varied examples of participation by such groups in family planning promotion and service delivery, either for their own benefit or for that of the community at large. This approach of working through existing community channels has proved to be highly acceptable, cost-effective and efficent in terms of manpower.

However, community channels suitable for integration with family planning do not exist in all situations. The fringes of large cities which receive immigrants from the surrounding areas, are particular examples of where local structures are either non-existent or they are in a state of perpetual flux and change. In societies where by tradition women are kept secluded in their homes, organizations with a sexually mixed membership just do not exist and exclusively female organizations are rare. Not surprisingly it has proved to be far more difficult to generate community participation in family planning programmes where working in a group is unusual and no suitable community structures exist.

In such cases the involvement of the community may still be achieved, for instance through participation of key local individuals in the family planning activities or throuth the generation of new groups. The individuals participating may be traditional health providers such as TBAs, healers etc. or they may be people who have had no previous involvement with health but are trusted and well-known in the community. Also family planning and related activities initially provided by outsiders, can generate support from clients to such an extent that active participation result. "Acceptor clubs" initiated in that way frequently branch out in mutual assistance groups and undertake a variety of activities benefitting the members and their families.

There is a need to carry out and carefully analyse different approaches to involve communities in programmes in order to identify promising ways of achieving this. Experimentation will be required with a built-in capacity for research and feedback.

Political vulnerability of popular movements

While there is a strong case for community participation in all development activities, such

involvement can also go beyond the immediate objectives of the programme. People who have become aware of their needs, and have proved to themselves that they can act to meet these needs, also learn to recognize the barriers and obstacles put in their way by structured system. For example, nutrition education generates a regular demand for a variety of foods. The landless and jobless, confronted with the problems of obtaining those foods in sufficient quantity, might question why their needs cannot be satisfied and demand jobs or land. Small scale community participation projects might develop into popular movements. Such participation, going beyond the immediate objectives of programmes, can be channelled in a positive way leading to meaningful development. In many cases this will require a restructuring of socio-economic and political systems which might involve loss of power by some social classes.

Often, therefore, popular movement (i.e. community participation on the larger scale) are tolcarted while they are still powerless but are seen as a threat by some social classes when they grow in skills and influence. Ultimately, such realities have to be faced and accommodated.

Liaison/co-ordination at the local level between government and NGOs.

While NGOs are often community based or have a high level of local autonomy, government decision-making tends to be more centralized. Althouth there are numerous exampleas of good co-operation between the two, where the best possible use is made of resources, in many instances the full potential of co-operation is not achieved because of structural conditions. Local action aims to achieve results quickly. Local government workers are often not free to participate in collaborative efforts because they receive instructions from departments not involved in the particular programme and their loyalities understandably are with their particular departments. Therefore much can, and should, be done to reomove the obstacles to collaboration through national and international consultations between governments and NGOs.

Community participation in family planning programmes: some implications of the new approach

The community participation approach to development has profound implications for all aspects of programme planning and management. In order to harness the potential of the approach and to stimulate its expansion, policy makers and programme planners need to adapt manne ement structures and administrative procedures as ell as develop training programmes and informat on systems appropriate to the taks ahead.

It would be unwise to assume that any one management model or programme design can be appropriate for all country and cultural situations covering the requirements of all situations the problems involved are too diverse and, to some extent, time and culture bound. However some common areas that need attention are pointed out here for consideration and discussion.

Management

The community-centred approach requires a decentralized management system and greater decision making authority at the community level. Managers and donors will need to release progressively more responsibility while maintaining the overall co-ordination and logistical support to the programme. Back-up services and technical expertise must be provided to supplement the community activities. Managers need to provide the structures in order to avoid duplication and to respond to community needs in an integrated fashion.

Middle-level managers and field co-ordinators must acquire or improve skills which stimulate rather than stifle community self-help activities. They may have to assume the role of catalysts to make communities aware of their own potential, and stimulate self-reliance rather than dependence. Middle-level programme staff and administrators are the key people to be entrusted with maintaining a sound two-way information flow and to bridge the gap between grass-root perceptions and values and concerns of the wider society. They need to identify ways in which communities can be helped to meet their own needs e.g. training, supplies, loans, information and access to specialized skills. It is likely that middle-management more than before needs generalist rather than specialist skills in enhance integration.

Local programme managers may or may be of the local people. In some cases a newcomer with the right personal attributes can provide the wider perspective conducive to innovation and assertive action. In other cases the local community can provide its own leadership with the skills to

accommodate the requirements of the wider programme such as administration, finance and reporting. In either case, building up the capacity of the community to progress through self-help will be vital.

It is likely that discrepancies will arise between priorities as identified by the community and the expectations of policy makers and national planners. If so, allowance must be made for local perceptions and goals. It may take a community some time to decide on ways to proceed but, once the point has been reached when the community decides to act, progress will be on the basis of concensus and shared determination.

Policy decisions must also be made on whether or not community participants should be remunerated, receive incentives or volunteer their contributions totally.This decision has to be in line with the policies established for other development programmes such as rural extension, home economics etc. and will have major implications for the way the proramme will proceed.

Accountability

Governments and other donors are justifiably concerned that when people organize around viable local projects, they focus on narrow issues which are not clearly related to national or larger problems. For example, a government might have formulated a population policy on the basis of economic and other forecasts, which has set target totals for family planning acceptance rates. The logical consequence is that local action must fit into the broader national objectives and cannot be totally left to local perceptions and priorities. A balance has to be achieved and a partnership developed. The people must be made aware of the wider perspective without having views and solutions imposed on them from the outside.

Any institution that finances programmes and projects is accountable for what it sets out to do with its funds and for whether the objectives have indeed been met. This applies to governments as well as NGOs. If responsibility for programmes is devolved to the communities, then the funding agency's control is reduced; particularly as regards the day to day running of the project. This is as it should be but it carries certain obligations as the local level.

It is also particularly ironic that the new approach to development,i.e. through community participation, happens to coincide with a decline in the world economy. When financial resources are shrinking in real terms competition for funds tends to be fiercer. More than ever donors need to justify their expenditure and to ensure that the objectives of the funding have been met. They are therefore understandably concerned with targets and cost-effectiveness. While community participation may be the way to achieve this there is so far no hard evidence to support that assumption. Therefore, will donors be able to allow the operational flexibility required to stimulate and develop the new approach ? Time needs to be allowed to demonstrate and document the case for community participation in family planning.

Research and evaluation

The new approach to development which recognizes that meaningful action can only take place in partnership with the beneficiaries, also indicates that responsibility for information gathering be shared in such a way that the necessary feedback will be generated for the different levels involved. The usual information system i.e. programme statistics, scientific research and evaluation, must be adapted to and complement the community centred approach.

As a logical corollary, new methodological techniques indentified as 'participatory research and evaluation' are currently being developed. Examples of participatory research at the local level are not yet numerous and so far are not conclusive enough to provide general guidance for policy makers on effective measures to stimulate the participation of the people in information gathering.

However, progress in participatory action research so far made, indicates that enabling the people to analyse their own situation can in itself produce fundamental changes in their outlook on society and in the contribution they can make.

Participatory research departs from traditional scientific practice in as far as the tools of science i.e. the methods and techniques are no longer considered to be the monopoly of the specialist researcher.

The action researcher incorporates people from the social groups with which he/she works as active participants in investigative tasks. It is

supposed that participants, by so doing, recognize the power of research, master the basic approach to research and thus gain autonomy for their investigative needs. The action researcher is therefore fundamentally a trainer, his task as researcher is meant to become redundant through enabling the participants in his research task to become independent of his skills.

While the developments in the action research field are eagerly awaited, it must be understood that in action research the emphasis is mainly on understanding social reality througth direct human contact and empathy. Excellent qualitative data from the perspective of the people themselves may well result. However there will still be a need for quantitative data in the research and evaluation situation.

Qualitative data do not provide the programme manager with the information required for, for instance, estimating needed supplies or to measure impact on health, socio- economic situation etc. It will also take considerable time before the action research field has developed sufficiently to carry the knowledge acquired to more general levels of codification and theory, suitable for managers and policy makers.

It is therefore of importance to give equal emphasis to developing and refining socio-economic and health indicators which provide feedback on achievement on a regular basis. This kind of more traditional research should, however, more than used to be the case, work with and for the people. Research findings should be communicated and discussed with the people whose lives they affect and their views be sought on the validity and applicability of the findings.

Once again, the people–centred approach to development requires adjustment and change on the part of the professionals.

Conclusion

Of late it has been recognized that harmonious development can only be achieved if people are not seen as recipients of development activities but become full partners and active participants in the process. Participation is a vital factor in the acceptability of services, and in motivation and commitment on the part of the people.

Governments and NGOs both have a role to play in facilitating this partnership approach, working in co-ordination and co-operation. Joint initiatives, involving an increasing measure of decentralized responsibility to local levels, are essential if community participation is to gain momentum and impact.

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Bangladesh Family Planning Activities Over the Year

Performance of Different Contraceptives by years and methods

Financial Year	Sterilization			Injection	M.R.	I.U.D	Condom (in pieces)	Oral Pill (in cycle)	Emko (in vials)	Foam Tablets
	Vesectomy	Tubectomy	Total							
1972-73	240	129	369	-	-	15660	20265684	139771	72721	-
1973-74	446	1015	1461	-	-	27590	11239572	440973	99704	-
1974-75	14469	4707	19176	50	686	50391	9282576	1288472	99091	-
1975-76	37839	11076	48915	1908	4408	77840	54744540	5943055	124784	-
1976-77	75066	41246	116312	2548	6687	59421	35257560	4638597	59479	
1977-78	32643	44722	77365	4527	6135	40564	65366388	74877316	32224	-
1978-79	24705	81719	106424	11028	4412	22631	57541476	7120550	39051	-
1979-80	27534	171248	198982	26026	10479	21801	58380612	6227651	39127	-
1980-81	26296	232497	258793	112010	28044	41601	87111780	8137744	60786	5011074
1981-82	67824	235084	302908	81065	43444	83668	93230412	7751352	63549	4125979
1982-83	88315	274842	363157	72697	58579	117743	116821488	8257995	69634	5404417
1983-84	215665	336502	552167	122457	56728	303338	131096483	9725677	64249	4384707
1984-85	259210	232389	491599	165933	68609	432465	151939740	11552863	71795	3822201
1985-86	97665	78244	175909	116439	38832	214744	82655063	7095902	31016	1958360
	967917	1745420	2713337	720696	107241	1509457	839433374	85857918	102811	5180561

Source: MIS, Unit, Dhaka.

We have about 180 NGO working in Family Planning. The working methodology of some NGO's are described in the next few pages which will give some inside of those organization. We hope that this "Case Study" will be educative to other NGOs.

N.B. These case studies are prepared by the individual NGO concerned.

Case study

Association for Family Development (AFD) Mirpur, Dhaka

The organization was established in January 1983 by influencial residents of Mirpur.
It provides family planning motivation and contraceptive service delivery to clients at their own homes, and clinical family planning services from its office-based clinic.
Back-up medical support is also available to the family planning clients, by a part-time doctor and a paramedic. The clinic provides IUD insertions and contraceptive injections for people living out-side of the project area as well as for clients living in the project area.

During its first year of support the original Executive Committee resigned. They were attempting to restrict the clinical activities of the project to people living within the project area. TAF supported the Project Director in her belief that clinical services should be made available to all people attending the clinic, but that only family planning acceptors from within the project area should be counted as active users of contraceptives served by the project. The newly elected Executive Committee came into conflict with TAF at the end of the first years support after the purchase of unauthorized items of equipment. This conflict was solved, to the satisfaction of both TAF and AFD. During the past funding period no major problems have been observed in the projects administration, and the Executive Committee and the project staff are working together well.

Staff have been employed as per last years project proposal. During the coming year it is proposed to increase the number of motivators from 12 to 16, so that the total number of registered couples in the area can receive adequate services. The number of supervisors will be increased from 3 to 4, so that a high level of supervision can be maintained. As IUDs are a popular method in the area it is proposed to increase the number of paramedics from 1 to 2. This will allow IUDs to be inserted every day, and will allow better follow-up of IUD and injection clients. The staff list is shown below :
The project area consists of wards 4, 5, 6, and part of Ward 7. These Wards are located in the Mirpur area.
The charts below show the past, present, and projected family planning activities of the project :

September 30, 1984 Active Users		October 1, 1984-July 31, 1985		
		Target	Achievement	Percentage
Sternization	289	240	75	31
I.U.D.	560	360	556	154
Condom	312	480	409	85
Pill	932	480	1,314	274
Other	86	240	50	21
TOTAL	2,179	1,800*	2,404	134

* It should be noted that the targets for IUD, Condom, Pill, and others are 150% of the government targets.

The project has achieved 134% of the high target established at the beginning of the year. Recruitment for Pill and IUD insertion has been excellent, and Condom recruitment is satisfactory. Recruitment for sterilization and

contraceptive injections is not good. The monthly family plannin reports show that in the two months following the cyclone, during March 1985, only eight clients accepted sterilization. It may be possible that the high loss of life in the cyclone had the effect of detering people from accepting sterilization. During the past two months sterilization acceptance has increased, and 42 clients have accepted this method. Contraceptive injections are still not popular in this method. Contraceptive injections are still not popular in this area, however, those clients who have accepted injections are satisfied with them, and during the coming year these satisfied clients will be asked to motivated people in adjecent homes to use the method. This, plus the services of the additional paramedic, who will have time to provide contraceptive injections to clients in their own homes, may increase the use of contraceptive injections.

A total of 3,741 persons visited the clinic. Some 3,867 follow-up visits were made to the clinic bring the total number of visits to 7,608. The IUD insertion performance is very good, and the clinic takes good care of its IUD clients during follow-up visits. The 78 persons who had IUDs removed had had their IUDs inserted in other clinics, not the AFD clinic. The contraceptive injection performance is low. Efforts, as described earlier, will be made to improve performance during the coming year. Family planning motivation is provided to the vast majority of clients attending the clinic. Users of temporary methods are motivated to accept clinical family planning methods. All adults treated for general medical ailments are family planning acceptors.

During the past two years the Project Director, Supervisors, and Motivators have received training from Concerned Women for Family Planning. AFD has also held inservice training courses. The Project Director and the Office Assistant received training from the Family Planning Services and Training Center, and the Project Director and the Accountant received accountancy training from TAF. During the coming year training will be provided by TAF and other local experts on family planning.

Case Study

Integrated Family Planning Nutrition and Parasite Control Project

Family Planning and Control of growth rates is now one of the prime factor for the development of developing country. Providing adequate health care is no more an only humanitarian mission, but an economic necessity for these countries. An effective health programme enable the population to enjoy state of wellbeing because there will be fewer disesases and greater chance of survival. Integrated Family Planning Nutrition and Parasite Control Project is one such innovative approach. The Integrated project in Bangladesh is in operation for the last six years which was launched in mid 1979 with the assistance and technical Co-operation of Japanese Organisation for International Co-operation in Family Planning (JOICFP).

The immediate objective of the Integrated Project is to increase the credibility of the family planning workers through parasite control activities, which with immediate and visible results stimulate community trust in family planning workers. Family Planning works through parasite control activities get opportunity to come in close contact with the family and the community and impress upon them that family planning is necessary for health and that health is a basic requirement for all members of the family for full development. The Project through health education also arouses awareness of the people regarding the problem of worm infestation and its prevention and provides knowledge about nutrition.

The long term objective of the Integrated Project is to reduce parasite infection rate, infant mortality rate, and improve health with better environmental sanitation and nutrition through health education facilities and also to enlighten the people towards life (rationalism) and to bring happiness to the family.
The Project areas are situated in four geographical areas in four Division of the country as follows :

3.1. Panchdona Union	:	Norsingdi Upazilla, Norsingdi District. Dhaka Division.
3.2. Noldanga Union	:	Sadullapur Upazilla, Gaibandha District. Rajshahi Division.
3.3. Boyra Ward	:	In the Suburb of Khulna City, Khulna Division.
3.4. Nayapara	:	Madhabpur Upazilla, Habiganj District, Chittagong Division.

Government F P workers in project areas deliver Family Planning and parasite control services to the community by door to door visits. During home visit for mass-deworming treatment the F P workers collect stool and bring it for pathological test. They motivate the eligible couples for Family Planning and distribute contraceptives during home visit. For clinical and medical services F P workers refer the clients to the clinic. Integrated Project staff and F P workers are initially given one week's training on programme objectives, nutrition, Parasite control and other related issues. Project personnels are also briefed about the importance of involving the community leaders for achieving the desired result. Visit to other project areas are also arranged to enable the workers to exchange views and experiences. Local volunteers are given training on parasite control, Nutrition and environmental sanitation. School teachers and students are also provided with basic informations and education on parasite control and nutrition.

Fortnightly immunization programme is also a part of the Project activities. T.T. injection for pregnant mothers are also on the programme schedule. People suffering from diarrhoeal diseases are provided with ORS Packets. Training is also given to mothers on "How to make home-made ORS." Mass-deworming treatment is provided to all the population of the project area. All these works are being carried out by F P workers.

Further to disburse the knowledge of the project to other adjoining areas of programme is running on to train Family Planning field workers of the adjoining unions of the Upazilla and also to give deworming treatment to children of at least four schools, outside each project area.

Project has earmarked on a programme to construct sanitary latrine locally and people are being supplied sanitary latrine from the project office at subsidised rate of Tk. 300.00 per set. So far 300 sets of sanitary latrine have been distributed.

The performance in all the sectors of the programme is very encouraging. The Parasite infection rate has dropped from 91% to 50%; CPR rouse to about 63% against national CPR of about 24% IMR being 91 per thousand and TFR being 2.44.

Whithin its sphere of 6 years of operation the Integrated project has proved its effectiveness in terms of success on family planning and parasite control and community awareness.

The Integrated approach of Parasite control with family planning has proved to be an appropriate partners of integration, since these are simple, deeply related to people's life, their effects are immediate and visible and do not require great deal of investment and technology. It has an advantage of creating credibility and confidence of parents by offering Parasite Control and Nutrition service as incentives. Besides Parasite Control has relevence to all members of the family and can arouse the interest of the whole community, generate the awareness towards personal hygiene and environmental sanitation and helps fertility control.

Case Study

Firoza's Potential

International Union for Child Welfare and Department of Social Services joint effort

Kashba is plainland but during rainy season, most of the village are flooded. Being border area of Bangladesh and India, 90% of the people are illiterate and 5% are living in the Kashba town area.

The main communication system between upazila headquarter, unions — people are mainly dependent on argiculture. During rainy season the boat is the only transport. The only cemented road is from Upazila H.Q. to CMB main Road. About 6 months in a year, the farmers and the labourers are unemployed.

Firoza Begum, 23 years old, a women worker at the Action Bag production centre in Hakre/Kalikerpur village under Kashba proper Union answered to a question that, "With my own pursuation, I have come here to become a producer of these action bags "I come from a landless family" "Although before attaining first menstruation I was married to Firoz Mia - it was my parent's decision", and after having one child who is luckily a son, I started to take pill. "My son is now 5 years old. For last 3 years and 7 months I'm taking pill".

She has also answered to a personal question that, "I tried hard to convince my husband to use condom supplied by Husneara, USW and Mannan. However, I have failed. But my personal idea is to agree him to use condom in future". "Why do you have this idea? "as I asked, she told, "Because I believe until husband does not come forward to share in every work, wife cannot claim to have full satisfaction of child bearing and other house hold works".

"I learned all about the good effects of family planning in the mothers training classes"— she answered to one of the question and told "being poor, my parent could not afford to send me to school. Now I am attending free literacy classes and mothers training classes, I come to know lots of good ideas "even I can write and read". "I always sign to receive sewing charges of bags". "In our society it is believed that children are the economic asset of the Family, why don't you believe it and taking pills, and how long after you are going to have your second child"? ——"I believe that my family welfare can be achieved only by my husband and myself -- if we share together our happiness and sorrows— less number of children is number one factor for to achieve that". She also told with a proud smiles that, "If I can save some money and send the son to school, my dream being mother will be fulfilled". I do not want child for another four years".

Hypothesis of this case was, how and when can we claim to have achieved our all efforts successful. My expectation is that the time is very near.

Case study

Family Planning Activities in Chanpara

In the field of family planning, World Vision started its program by recruiting 12 motivators form among the local people under the supervision of a World Vision personnel designated Family Planning Program-in-Charge reportable to Medical Co-ordinator of the project, another World Vision personnel. Besides Family Planning motivation in the clinic and houses, special counselling was offered by these 12 trained motivators to male adults who were found to be the main hin-drance to family planning activites. Through this program, World Vision provided all sorts of family planning services and logistic supplies came from CHCP. Periodical sterilizations (ligation and vasectomy) were performed by CHCP mobile team until 1982. Afterwards such activities were being performed weekly on a regular basis by Govt. teams from Rupganj THC.

Time came when World Vision felt that these activities should be handed over to the Govt. agency so that the organization can spend its resources in some other productive field for the benefit of the people. It began to negotiate through Rupganj F.P. authority in early 1984 for peaceful handing over. Finally, on the 2nd June, 1985, this family planning program along with its establishments was handed over ot the Rupganj F.P. authority. According to the agreement made earlier, all World Vision personnel involved in FP activities were retrenched and the Govt. authority appointed 4 staff (Medical Assistant-1, FWV-1, Ayah-1 and MLSS-1) for ensuring smooth functioning of the set up.

Now, let's look at the comparative statistical information on performances between pre and post handing over of the program: Total number of eligible couples was 2854 at the time of handing over the program and approximately 20% of them were recipients of contraceptive methods. Percentage of receptors of different methods at that time (June 2, '85) were as follows:-Oral Pills 13.87%, injection 2.97%, sterilization 2.17%, Condom 0.6%, IUD 0.2% and M.R. 0.19%. According to the statistics collected recently (1st week of March, 1986--9 months of Govt. operation) the percentages of current acceptors of various methods are as follows--oral pills 2.83%, injection 1.7%, Sterilization 0.3%, Condom 0%, IUD 0.08%, M.R.0.38%, which imply 5.29% eligible couples are recipients of F.P. services. This comparative presentation reveals that:

1. the rate of drop out of recipients is almost 75%.
2. the rate of M.R. has greatly increased.
3. the rate of sterilization has remarkably fallen.
4. no one uses condoms now.
5. the rate of injection users has decreased.

Before handing over, the focus of this program was primarily on the Chanpara people. According to recent informations, peoples of neighbouring localities are enjoying most of the benefits of this program. This detrioration of the program demanded identification of reasons for such and following are identified:-

1. Irregularity of clinic staff is the main reason for such high rate of drop out.
2. Inadequate supply of logistics.
3. Corruption of mid-level supervision and management.
4. Due to lack of motivation and counselling, the use of condom has stopped completely.
5. Poor campaign as well as irregularity of the sterilization team from Rupganj caused the low rate of sterilization.

No NGO can continue its program in one area for long. So, its a general principle of almost all NGOs to work in co-operation with the respective Govt. agency/institution. Keeping this principle in mind World Vision handed over the F.P program to the appropriate Govt. authority. Now, if we look at the situation of the study area in the context of 3rd Five year plan where population control is given no. 1 priority, what will be the lesson for other NGOs ? Change in the policy of the Govt. in this regards so that the NGOs working in this field can extract more co-operation/attention/coordination for making positive contributions which will enable the nation to achieve its goals outlined in 3rd FYP ?

Case Study

Sobhanbag Mohila Club, Sobhanbag, Dhaka

Sobhanbag Mohila club is a local womens organisation established in 1985 at Sobhanbag Colony, Dhaka for the welfare of the mothers of the colony and the adjacent area. Initially it was confined to co-operative based activities. It has also undertaken School for destitute children, sewing and music classes. Through these activities the club have earned a good name in the area. The organisation has different social welfare activities in the project area with the involvement of local working ladies, house wives and social wokers. Now the organisation has been successfully implementing community based family planing services projects since October 1979.

So long family planning activities of the club is confined to be Sobhanbag, Sukrabad, Tollabag, Mohammadpur, Agargaon, Sankar, Monipuri Para, Jute Research Institute area, Shere Bangla Nagar and in a portion of Dhanmodi area, having the population of 1,20,000 (one lac twenty thousand) in 8 (eight) wards of the Dhaka Municipal corporation since 1st, October 1979. There is no family planning workers of Government and other voluntary agencies in those areas.

A Medical back-up service component was added to the CBD programme in December, 1980. Since then the service has grown.

To day medical backup service including general health care for the mothers and their children, treatment of different types of contraceptives side effects, and immunization programme in co-operation with the E.P.I. personnel and facilities for the insertion of I.U.D. in the office premises of the project is going on. As a part of this service this project also distributes large quantities of medicines among its clients.

The Sobhanbag Mohila Club is a non-Govt. organisation who have sholdered many social activities and responsibilities for providing family plannig services in the Metropolitan Dhaka city without substantial help from governmental agencies. If the resource constrain is met by any Govt. or semi-Govt. agencies, the activities of the club will further be enhanced. A voluntary club needs timely help from Govt. or any other agencies for its programming and existance. Timely availability of fund helps the club to chalk out its programme before hand and its success dependes on availability of fund and material help.

In fine it may be recall that the services of voluntary organisation like Sobhanbag Mohila Club helps the poor people, and nation at large. They need Govt. support to fulfil it's programme and planning.

Case Study

Sterilized Women's Welfare Samity Mymensingh

The sterilized Women's Welfare Samity project in Mymensingh was initially planned to help women who had already been sterilized. It is a good example of how an FPA, sensitive to the economic needs of the poverty stricken women who had already accepted sterilization, started a women's development project in the Kewat Khali Union in the Mymensingh district comprises five villages with a population of 22,023 among whom 3668 are eligible couples. The socio-economic conditions are similar to the overall pattern of Bangladesh: subsistence living standards, a high percentage of landless labour, high unemployment, low per capita income and a large young population. Over 85% of the adult population are illiterate. Ten primary schools and four high schools serve the Mymensingh area.
The objectives of the project was to promote a small family norm by utilizing the integrated approach to family welfare, combining information about better and more porductive farming methods wtih family planning information and service delivery, nutrition and maternal and child health. The project also aimed to demonstrate the feasibility and cost effectivenss of working with other institutions and NGOs to achieve wider coverage. Specifically, the project sought to promote effective integration and collaboration with the Agricultural University out-reach efforts.
The project has shown the feasibility to collaboration with another institution on a cost effective basis and of an intergrated approach to meeting the needs of the community. This experience has contributed to policy and programme development of the BFPA.
The Project is meeting its revised objectives and promoting the small family norm, improving the status of women throutgh equipping them to engage in econmic activities and contributing to the overall welfare of individual faimilies. Sterilization figures are rising and women with fewer children are accepting this methods.
The collaboration between the BAU and the FPA has proved workable because of special factors which may be particular to this project. These include the BAU's previous credibility in providing and asisting in better farming and its strong administrative base from which to carry out the project activites. Additionally, the willingness of the BAU Directors and adminstrators to expand outside of "agriculture only" activities into wider health and community development concerns for the benefit of local communities is a crucial factor in the porject's success. The availability of BAU's medical facilities for MCH, provision of premises for the sterilized Women's Welfare Samity's activities together wtih the administrative back up for loans have also contributed substantially to the positive response of the women. The BFPA's contribution of funds for skill training, field workers and other related expenses complemented that of the BAU.

Another element contributing ot the success of the project was the contribution of the Honorary Project Director-cum-chief Medical Officer. His organization ability, dedication, consistent and enthusiastic interest and supervision of all aspects of the porject provided the direction. It needed and ensured that the women's develoment and family planning components reinforced each other.
The staff of project has been welltrained, and following the example of the Director, provide the same dedicated service. The Sterilized Women's Samity is at present closely guided and supervised by the project personnel. At present the members depend on them to a substantial extent. It is important to initiate leadership

training among the members and phased handing over of some responsibilities.

As a result of the project both the FPA and the Government recognise the validity of the integrated family planning and women's development approach. Its replication is being sought for other unions through the Self relince Movement". For the BFPA, this successful collaboration is a breakthrough, as previous efforts with NGOs have not been as effective. Careful selection of a partner is seen as the fundamental and first requirement of such collabration.

Case Study

Islamic Sociological Bureau Bangladesh

The Islamic Sociological Bureau, Bangladesh, fuctioning since 1979 established officially on may 26, 1984 with the objectives most important of which is to carry on intensive studies and thorough researches, on teachings of Islam in the area of Development, Health, Education and population, and to promote, develop, manage and establish organisations, for educating, training and producing cadres of manpower to motivate and educate masses to develop families, communities, according to teachings of Islam, free from illiteracy, health hazards, poverty and unemployment so as to create self inspired, self reliant, prosperous and peaceful growth of responsible welfare families as basic tiers of prestigious community and Nation.
It is most gratifying to mention that this first ever religious organisation of its type enjoys the approval and support of the Ministry of Religious Affairs, Govt. of Bangladesh and most eminent authorities on Islamic studies and Theology of the country. Particular mention may be made the name of Dr. Serajul Huq, prof. Emiritus, Deptt. of Islamic Studies of the University of Dhaka who Chair's the Research Cell of this Bureau.
From the very inception, the concept of 'Islamic Sociology 'was popularised through public lecture series, Workshop/Seminars in different places in and out side the country.

The primary and principal programme of the Bureau embrace to educate and motivate the masses, according to teachings of Islam, in favour of Family Welfare planning and making family planning socially accepted. To implement this programme the Bureau undertook to energise the people about the need for family planning, dispelling prevalent superstitions, misconceptions and misinterpretations of the problems and of possible solutions there of. In doing so Bureau organised/arranged/participated as many as 16 Seminars/Workshop in 1984, 22 Seminars/Workshop in 1985, graced by the policymakers, Theologicians, Academicians, Sociologist, Scientist, Economists, Demographists, Medical Experts, Religious leaders and leading Ulemas of the country and Ambassadors of some of muslim countries in Bangladesh and thereby creating a welcome climate for implementing a massive programme with willing acceptance of the people in the area.
A collective and coordinated programme with Islamic ideological moorings of the NGO's working in Family Planning, will undoubtedly accelerate the pace of Progress to improve the over all quality of the life of the people and to facilitate easier introduction of the Family Planning Programmes undertaken by the Govt. of Bangladesh and different NGO's.

Case Study

Bangladesh Women's Health Coalition

The Bangladesh Women's Health Coalition was set up as a non-profit women's organization in May, 1980 with the encouragement and support of the International Women's Health Coalition and the Population Crisis Committee of the U.S.A. The Coalition works towards the improvement of the lives and status of women in Bangladesh through a multifarious approach with the main emphasis being on delivery of high quality, low cost clinical family planning and medical services.

The Bangladesh Women's Health Coalition has now embarked upon a three year program, from September 1985 to August 1988 with funding from The Ford Foundation, Swedish International Development Assistance and the International Women's Health Coalition.

The Coalition Clinics are situated at Dhaka, Narayanganj, Tangail, Mirpur, Palash and Bolara (Manikgonj). Services at all six clinics are identical being: MCH, general basic helth care for women and children upto the the age fifteen years, immunizations, group lectures on hygiene, sanitation and allied subjects, counselling on family planning, menstrual regulations, IUDs, injectable and conventional contraceptives and referrals for sterilizations and treatment of the more complicated diseases. The Coalition Clinic, Dhaka also provides electric cauterisation services. An adult literacy program has also been taken into hand. At the Coalition Central Office and coalition Clinics Narayanganj and Mirpur weekly legal lectures are given by women lawyers.

In 1980-1981 the Coalition, from providing only family planning services in three clinics, now in 1986 provides both MCH and family planning services from six facilities and from March 1986 a maternity Unit began operation at Tangail. In between this period, an incomegenerating scheme for women was experimented with through the running of a training/production sewing center. This proved unsuccessful and

was closed down after three years. Another income generating scheme in the form of a block/screen printing and tailoring project is planned. B.W.H.C. also provides practical hands on training to student Family Welfare Visitors (FWVs) and refresher training for government in-service F.W.V. as training manual, in Bangla, for clinical workers is widely distributed.

Through trial and error the Bangladesh Women's Health coalitin has found a balanced approach to improve women's lives.Family planning on its own is not sufficient to meet the multiple needs of the average woman in Bangladesh. Family Planning as well as the health facilities for both women and their children are being provided alongside adult fuctional litteracy, legal lectures and free legal aid and support to women in distress through referral to other women's agencies. The philosphy of the organization is to maintain a high standard of work and expand only gradully. Cooperation with other NGOs and the Government of Bangladesh is very good and it is envisioned with confidence that the Bangladesh Women's Health Coalition will slowly but surely improve not only the status of women's health but also their status in society.

Case Study

MCH -Based Family Planning Project—Munshiganj

The MCH-based Family Planning Project Munshiganj (MCH means "Maternal and Child Health") was commenced in 1979 with the view to assisting the Ministry of Health and Population Control (MOHPC) in its efforts to set up an efficient program for Primary Health & Family Planning services in the rural areas. The district of Munshiganj was chosen as testing and implementation area.

The aims of the project are :

— to develop in Munshiganj district a model family planning program that combines the governmental health and family planning services with community oriented activities and — to prepare recommendations for the national population program based on the experiences made in Munshiganj.

Material inputs from the Federal German Government -apart from the costs connected with program implementation in Munshiganj-included the construction of 14 Union Health and Family Welfare Centres (UH & FWCs) in this area and the supply of oral contraceptive pills to the MOHPC for nationwide distribution. This supply covers half of the requirements distributed free annually through government services.

The "Munshiganj Project" was planned and started at a time when the broad- scaled nationwide population program was just running for 3 years.

The project engaged in two main activities which complement each other :

to create more awareness among the rural people about preventive health care and family planning, which will lead to an increased demand for governmental services and

to improve and make better avalilable governmental health and family planning services to meet this increasing demand of the people.

In several respects, the project has a pilot character :

for the first time, a wholé district with its different administrative levels was taken as project implementation area.

the project engaged primarily in the MCH-component of the program the UH & FWCs and their services which was little developed in 1979

the project activities, targetted to create awareness for health and family planning issues among the rural people- the co-community oriented activities and the Mothers' Clubs — were developed under the Ministry of Health and Population Control for the first time.

new communication media to transfer the messages of preventive health care and family planning were tested.

During an initial phase the services rendered in Health and Family Welfare Centres by regular Government staff were investigated and improvements were made.

In close co-operation with Directorate of Information Education and Motivation (IEM Umt), new teaching materials were tested in the field and a puppet show program and folk signer groups as indigenous media to transfer the messages of health and family planning were just implemented in the project.

As a second major activity on the motivational side, Mother's Clubs were founded to provide an opportunity for women to meet outside their houses, to discuss their interests and problems and to earn income by getting training in handicraft or through small loans. Teaching on the prevention of common diseases and on the benefits and methods of family planning is a common feature of these clubs. At present 70 clubs with about 3500 members are working in 2 of 6 upazilas.

Most Members of the Mothers' Club come from families who earn their living by vegetable cultivation or vegetable business. The fact that some of their fathers and husbands are very religious (Some of them are even members of a

Muslim federation called "tablig") does not hamper their membership in the mothers' club.

There are three main activities in the clubs: "health" "income generation" "access to family planning methods".
The emphasis of the health programme is on information, prevention and need assessment. The main activity in this field is health education. Mothers are also encouraged to give their own ideas about health and Family Planning, which helps us to work out our teaching material and training lessons with very close contact and continuous feed back from the target group.

The income generating programs sewing, jute and bamboo work are based on the assumption, that an independent income will raise the status of a woman in family and society. The experience shows that the sewing program is the most attractive program for the women in our mothers clubs. Some women just save money by sewing for their families others earn a little bit extra money, and some even earn real income after attending the sewing course in the club.

In the first years the project also used to give loans, for instance for chicken raising. The field of loan and saving is now looked after by the local women cooperative, that is run by the Bangladesh Rural Development Board (BRDB) under the Ministry of Social Welfare and Woman Affairs and closely linked with the mothers club. Meanwhile 28 women - cooperatives under BRDB are cooperating with the project's mothers' clubs.

How does membership in the mothers' clubs influence Family Planning ?
About half of the married mothers' club members adopt family planning methods (46%). One important factor contributing to this high rate in the work of the depotholers. These are club members who are keeping stocks of non-clinical contraceptives in their homes. They distribute these devices and also refer those who are interested in clinical methods to the health and family welfare centres.

Family Planning
Third 5 Year Plan (1985-1990)

The third 5 year plan launched in July 1985. Health and family planning is an important component of this plan document.

The following information will give a good insight of the Family planning activities of this period.

Contraceptive Prevalence Target (1985-90)

	Modern	Traditional	Total
1984-85 (Base year)	18	5	23
1985-86	21	5	26
1986-87	24	5	29
1987-88	27	5	32
1988-89	31	5	36
1989-90	35	5	40

Population Projection 1985-2000

Year	Population size (thousand)	CBR	CDR	NRG	% couples to practice contraception
1985-86	100, 947	37.7	14.7	2.30	26
1986-87	103, 387	36.4	14.3	2.21	28
1987-88	105, 009	35.1	13.8	2.12	31
1988-89	108, 222	33.8	13.5	2.03	34
1989-90	110, 330	32.5	13.1	1.84	37
1990-91	112, 238	31.2	12.7	1.85	40
1991-92	114, 857	29.8	12.4	1.75	43
1992-93	116, 926	28.6	12.0	1.66	46
1993-94	118, 794	27.3	11.7	1.56	50
1994-95	120, 464	26.0	11.4	1.46	54
1995-96	122, 192	24.6	11.0	1.36	58
1996-97	123, 911	23.2	10.7	1.25	62
1997-98	125, 487	23.2	10.7	1.25	62
1998-99	127, 005	23.2	10.7	1.25	62
1999-2000	128, 477	23.2	10.8	1.24	62

Quantum of services under maternal and child health

1. Regular antenatal and postnatal care form trained F.W.V.

Population covered	Upazila	357×2000 = 714,000
	MCWC	93×2000 = 186,000
	UHFWC	2400×200 = 4800,000
		5700,000

At 40 deliveries per year per 1000 population the number of mothers who will get antenatal and postnatal care during the plan period will be-

5x40x5, 700,000 + 1000 = 1,140,000

In addition the pregnant women receiving tetanus toxoid immunization s from population outside the adove areas will also receive some antenatal care.

2. Safe delivery services by trained T.B.A.

30% of all deliveries heppening in the rural areas, every year.

3. Immunization of pregnant mothers by T.T.

Population covered Upazila Health

Complex	357x2000 = 714,000
MCWC	93x2000 = 186,000
UHFWC	1400x20,000 = 40,000,000
	48,900,000

Number of pregnant mothers at 40 deliveries per year/1000 population for 5 years.
5x40x48,900,000 + 1000 = 9,780,000
or 10 millions

Expected coverage with two doses - 6 millions

4. Immunization of children against diptheria, tetanus and pertusses.

Population covered - Same as for antenatal care 5,700,000
No. of children to be immunized-
Children under 2 years at the beginning at
9 % population 513,000
Add new born over the period 1985-90 1,140,000
(mortality not considered)

Total 1,653,000

Coverage at 60 %-991,800 or 1 million

An average

Summary of cost estimates

1985-90 (TFYP period)

SL. No.		Amount in million Taka	% of total outlay
1.	Service Delivery	6400.00	55.3
2.	Manpower Development and Training	510.00	4.4
3.	IEC Activities	300.00	2.6
4.	Research & Evaluation	68.00	0.6
5.	Management Development & Logistics	91.00	0.8
6.	Women's Program	225.00	2.0
7.	Beyond Family Planning Program.	378.00	3.3
8.	Field Staff salary and allowances union level and below	1600.00	13.8
9.	Block allocation to corp: a) Award system b) Innovative projects c) Contraceptive plant d) Cost escalation etc. e) Unforeseen expenses	2000.00	17.2
	Total :	Tk.11,572.00	100.0
10.	Non-Governmental Sector project	Tk. 2,000.00	14.7%

Grand Total Tk.13572.00 million

World Leaders Concern & Commitment Regarding Population Sterilization

This document signed by the heads of states including President Ershad, President People's Republic of Bangladesh. It was sunmitted to the Secretary General Mr. Perez De Cueller at the 40th anniversary of the founding of united Nations. Majority of the signatories were present during the handing over ceremony at United Nations H. Q. on 24th Oct. 1985.

Statement on Population Stabilization by World Leaders

Mankind has many challenges : to obtain a lasting peace between nations ; to preserve the quality of the environment ; to conserve natural resources at a sustainable level ; to advance the economic and social progress of the less developed nations ; and to stabilize population growth.

At present there are 76 million more births than deaths on our planet each year. If present rates continue, by the year 2000, there will be 100 million more births than deaths. A billion people have been added in the last 13 years and the next billion will be added in 12 years.

Degradation of the world's environment, income inequality, and the potential for conflict exist today because of over-consumption and over population. If this unprecedented population growth continues, future genertations of children will not have adequate food, housing, medical care, education, earth resources, and employment opportunities.

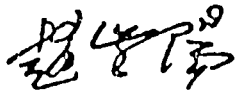
We belive that the time has come now to recognize the world-wide necessity to stop population growth within the near future and for each country to adopt the necessary policies and programs to do so, consistent with its own culture and aspirations.

To enhance the integrity of the individual and the quality of life for all, we belive that all nations should paticaipate in setting goals and programs for population stabilization. Measures for this purpose should be voluntary and should maintain individual human rights and beliefs.

We urge national leaders to take an active personal role in promoting effective policies and programs. Attention should be given to setting realistic goals and timetables; encouraging active participation of communities in designing and implementing their own programs; and developing appropriate economic and social policies.

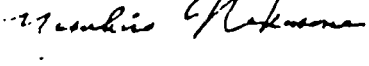
We call upon donor nations and institutions to be more generous in their support of population programs in those developing nations requesting such assistance.

Recognizing that early population stabilization is in the interest of all nations, we earnestly hope that leaders around the world will share our views and join with us in this great undertaking for the well-being and happiness of people everywhere.



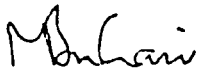
ZHAO ZIYANG
Premier of the State Council, People's Republic of China

RAJIV GANDHI
Prime Minister, India



YASUHIRO NAKASONE
Prime Minister, Japan

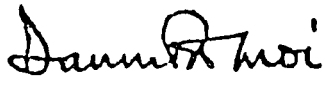
HUSSAIN MUHAMMAD ERSHAD
President, People's Republic of Bangladesh



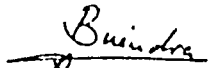
MUHAMMADU BUHARI
Head of State, Federal Republic of Nigeria

GENERAL PREM TINSULANONDA
Prime Minister, Thailand

MOHAMMED HOSNI MUBARAK
President, Arab Republic of Egypt



DANIEL T. ARAP MOI
President, Republic of Kenya



BIRENDRA BIR BIKRAM SHAH DEV
King, Kingdom of Nepal

JR. JAYEWARDENE
President, Démocratic Socialist Republic of Sri Lanka

ROBERT MUGABE
Prime Minister, Republic of Zimbabwe

HABIB BOURGUIBA
President, Republic of Tunisia

SALVADOR JORGE BLANCO
President, Dominican Republic

JUVENAL HABYARIMANA
President, Republic of Rwanda

HIS MAJESTY KING HUSSEIN I
King of the Hashemite Kingdom of Jordan

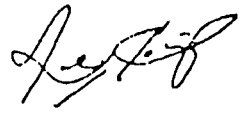
EDWARD PHILIP GEORGE SEAGA
Prime Minister, Jamaica

JOAO BERNARDO VIEIRA
President, Republic of Guinea Bissau

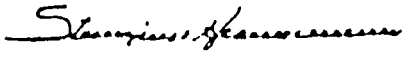
ANEROOD JUGNAUTH Q.C.
Prime Minister, Mauritius

SPYROS KYPRIANOU
President, Republic of Cyprus

AGATHA BARBARA
President, Republic of Malta



LIONEL S. CRAIG
Acting Prime Minister, Barbados



STEINGRIMUR HERMANNSSON
Prime Minister, Republic of Iceland

SIR ALLEN M. LEWIS
Governor General, St. Lucia, West Indies

HERBERT A. BLAIZE
Prime Minister, Grenada

FATAFEHI TUTPELEHAKE
Hon. Prime Minister, Kingdom of Tonga

CLARENCE AUGUSTUS SEIGNORET
President, Commonwealth of Dominica

FRANCE ALBERT RENE
President, Republic of Seychelles

[Signatures collected as of 30 June 1985]
Listed according to population sige.

Voluntarism in Family Planning Program of Bangladesh

It was in 1976 that, for the first time, a population policy was outlined, operational strategies were worked out, specific field programs were developed, and organisational, administrative arrangements were made for implementing the program. These were better incorporated into the Second Five Year Plan (1980-85).

The Government's broad demographic goal is to achieve a not reproduction rate of one by 2000 AD under a prospective plan, with targetted reduction of birth rate through a series of intermediate five year plan.
The Third Five Year Plan (1985-90) aims at reducing the existing birth rate to 1.8 percent by 1990 by raising the present contraceptive prevalence of around 26 percent to 40 percent by integration of Health and MCH-FP service delivery system at the periphery by :

- Provision of a wide variety of contraceptive choices on voluntary basis.
- Enlistment of community support and participation through involvement of non-government voluntary organisation.

The program's service component offers both contraceptive and MCH services at no cost to the acceptors. The contraceptive service provides, under a cafetaria approach a wide a variety of methods both for limiting and spacing. A contraceptive method-mix, formulated on the basis of past demand pattern, is in use; but it is tentative and provisional, the weightages are given to its different constituents being subject to adjustment on the basis of review of use pattern. Unfortunately, hitherto, it has not been possible to provide MCH services at the desired level, mostly for lack of institutional and service facilities. Appropriate attention is being given to the area under the third five year plan.
The population control program uses a network of service delivery facilities, both static and domiciliary, down to the grassroot level, to provide FP-MCH services.
Apart from the Ministry of Health and Population Control which has been designated for implementing the population control program nation-wide, major developmental Ministries are also engaged in population control activities. Besides, a total of 136 non-government voluntary organisations implement and complement governmental efforts.
A high-powered body- called the National Council for Population Control (NCPC), headed by the President of the country with twelve cabinet Ministers as Members, provides policy guidelines, directives, approves programs, strategies and measures from time to time. The NCPC is assisted by an executive committee headed by the Minister for Health and Population Control, with The Secretary, External Resources Division, the Secretary, Ministry of Finance, Concerned Member of the Planning Commission and the Secretary, Ministry of Health and Population Control, as its members.

Program Safeguards, Monitoring, Research Findings Regarding Voluntarism

To ensure voluntarism a number of structural safeguards have been built into the program itself. These includes :

Information & Education (I&E) :

The information and education component of the program is designed to promote awareness and knowledge of use of a variety of contraceptives through both the mass and the inter-personal communication media. State-owned Bangladesh Radio and Bangladesh Television run regular features on different aspects of the Population Control Program and present balanced information including contraceptive services, MCH and nutrition.
Beside-, about 40,000 field workers provide I & E along with delivery of conventional contraceptive services at the door steps of the eligible couples according to latters needs and choice.

Family Planing Services :

The program's service components ensure availability of, and accessibility to, a wide variety of contraceptive methods both temporary and

permanent , under a "cafetaria approach" so that the couples may choose the methods that suit them best. The program, however, from time to time reviews the pattern of demand for contraceptives, and based on it, adopts appropriate measures for expansion of service delivery with necessary adjustments in the weightage of the contraceptive method-mix.

Training :

The training component of the program has been designed to fully equip the staff concerned with supervision, motivation and service dispensation with appropriate knowledge and skills. Particularly, the training contents for the medical and field staff directly involved in sterilization services include section on voluntarism, counselling, clients screening and follow-up.

Informed Consent :

Eligible couples seeking sterilization services are required, after they have been screened and found eligible for sterilization, to document their consent to the surgical operation and the fact that they possess the basic knowledge concerning sterilization and its effect. It is compulsory for the service provider to obtain the informed consent of the eligible couples before the operation is done. A form has been developed for this purpose. Routine checks by the senior officials and specially designated sterilization Surveillance Teams of the Government and the quarterly audits of the USAID appointed Audit Teams ensure strict compliance with the requirement of obtaining informed consents in prescribed forms.

Monitoring Mechanisms

The program has also established several mechanisms to monitor the effectiveness of program safeguards in ensuring voluntarism. The principal mechanisms are :

Mobile Sterilization Surveillance Team (MSST)

For monitoring the quality of sterilization services nationwide, the system consisting of 4 teams for the 4 administrative divisions, has been in operation since 1982. While the principal focus of the teams efforts is on improving medical quality, they also monitor clients' "recruitment" counselling, screening, and informed consent practices at service points throughout Bangladesh to ensure that voluntarism is being maintained.

Quarterly Evaluation of the National Sterilization Program :

Quarterly evaluation conducted by an independent private sector Bangladeshi consulting firm (M A Quasem & Co), based on a nationally representative sample of male and female sterilization clients and service providers. The evaluation permits, among other things, monitoring of payments, extent of use of informed consent forms, client characteristics, notably age and parity and verification of reported performance.

On-going surveillance :

In addition to formal mechanisms, program and donor agency staff continuously monitor voluntarism by, for example, conducting field trips and by reviewing key service statistics, such as sterilization incidence, method-mix, rejection rates and their reasons, and referral patterns.

Access to Services :

The 1983 CPS included several questions designed to gauge the degree of access to different contraceptive methods. While women generally knew where to get a tubectomy, most perceived logistical difficulties ; for example, the mean travel time to a clinic was almost two hours ; most women said they would require transport to reach the clinic (CPS, pp. 214-227) and , as noted on page 201, most women would either have to postpone their operation or use another method if the compensation payment were not available. It would appear then, that for many women in Bangladesh, there continues to be financial and logistical barriers impeding access to sterilization services. Also to be considered are the intangible cultural and psychological constraints faced by women in a conservative Muslim culture when contemplating an end to their fertility by what for most will be the only surgical procedure of their lives in, what for many will be, an unfamiliar clinic in a district town they are unlikely to have visited due to culturally-imposed isolation. Clearly, those who cope with such a formidable set of constraints must be highly motivated.

Mehtod Mix and Contraceptive Choice :

Present method mix has been discussed and , illustrated in various sections of the paper. There is no evidence either from within the program or

when comparing the Bangladesh program to that of other developed or developing countries that mix is not "proper" or that Voluntary Sterilization (V.S.) prevalence in inappropriately high.

Findings regarding voluntarism :

The Government of Bangladesh takes the issue of voluntarism very seriously the preeminent importance of maintaining a purely voluntary program is often extolled in documents, meetings and speechs. Efforts to ensure voluntarism include the establishment of programmatic safeguards, monitoring mechanisms and evaluations mentioned in Section 3. 1 in addition, government response to the isolated problems which have occured have been prompt and appropriate.
One area in which additional efforts may be needed is in operationalizing lessons learned from recent evaluations of sterilization services to further strengthen programmatic safeguards and further imporve client satisfaction.

Satisfaction :

Clients reporting "satisfaction" following the sterilization operation strongly suggests that the decision to choose sterilization was made in voluntary and informed manner. The findings of recent survey and focus group research indicate that satisfaction with the sterilization operation is virtually universal among male and female respondents. Satisfaction rates of 96-98 percent are reported (Mitra, pp.77 ;P&M pp. 123-155, 392) and the main reason reported for this high level of satisfaction is the freedom from future pregnancies conferred by the operation (P&M,p.392).

Reasons for Choosing Sterilization :

Nearly all clients surveyed stated that main reason for their being sterilized was to limit the size of their families. Inherent in this rationale is a knowledge of the operations effect and permanence. No one stated that they had been compelled or deceived into being sterilized (Mitra, p.29).

Decision-making :

Nearly all married women of reproductive age (MWRA) reported knowledge of female sterilization and the oral pill. The majority also know of the condom, injection and vasectomy as methods of contraception (CPS, p. 89). Knowledge among women in the BAVS study is even more widespread; 92 percent knew more than two alternatives to tubectomy (Mitra,P.35). The sources of information on which this knowledge is based are varied but the vast majority of female sterilization clients reported that "other sterilized women" were their first source of sterilization-related information and, along with husbands and family planning field workers, furnished the "most" information. The elements in the decision-making process which may most directly relate to the issue of voluntarism, include the following :

- Women enter into the serious consideration phase already knowledgeable about sterilization and alternatives.
- During the serious consideration phase, women discuss their intention to be sterilized with two or more significant others.
- Ready access to satisfied acceptors appears to allow women to reline and confirm the information on which they base their sterilization decision.
- The sterilization decision is not made in isolation but rather in connection with a network of social ties.
- The duration of the decision-makine process for sterilization appears to allow sufficient time for premeditation.
- The logistics of service delivery create a de-facto "waiting period" allowing time for reconsideration.
- The sterilization decision, triggered by a third-order birth and involving the counselling and consent to key family members, appears to have a certain predictable structure to it largely resistant to external influences.

Informed Consent :

Documentation of informed consent in USAID approved forms is, with axceptions, universal in the Bangladesh program (99% P& M,p.217, 98% ,Quasem, p. 26 Q 2'85). Existence of signed consent forms, on which are listed the basic concepts requesters should possess prior to undergoing the procedure, does not alone constitute proof of voluntarism and informed consent. Signed forms, when considered relative to other indications, however, contribute to the

likelihood that informed consent was given. For example :

- 0 Knowledge of sterilization is nearly universal among eligible couples.
- 0 Knowledge of sterilization and more than two alternatives was nearly universal among women interviewed in connection with the BAVS study.
- 0 Knowledge of sterilization's permanence was virtually universal among women interviewed at post-sterilization follow-up (Mitra, p. 27)
- 0 Prior to their operation, the vast majority of women discussed sterilization with another women who had the operation (Mitra).
- 0 Reversal requests or regret cases based on the claim that clients did not consent to or were insufficiently informed about sterilization have not occured.

Rejections :

Not everyone who asks for a sterilization in Bangladesh is given one. Due to the application of eligibility criteria designed to minimize morbidity and regret, a portion of all those who request sterilization are "rejected". Most facilities in which sterilization services are available can document the screening process with rejection records. Records from BAVS show the rejections within the government system. Currently, eligibility requirements in Bangladesh appear realistic and do not appear overly restrictive.

As it is evident, ineligible males have in rare cases received the vasectomy operation they request. Screening -out of all such cases is probably impossible in a program which operates in a country with no vital registration system and with no way of certifying the validity of socio-demographic information supplied by requestors other than the personal testimony of referrers. In addition to continued attention to imporving the quality of screening procedure and personnel, the best defence against this king of abuse of the program is to further strenghthen the community-based approach to sterilization service delivery to ensure to the extent possible that requestors are known to the service provider, at least by its field workers, and punish service providers who knowingly abuse the system.

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* Source : Voluntarism in Family Planning Program of Bangladesh.

Key Note

Achievements and Constraints of Family Planning NGO's in Bangladesh

Dr. Azizur Rahman

What is Non-Government organization:

These are organization formed by the initiatives of individual to undertake broad based development activities outside government system but controlled and regulated by government ordinance. Each NGO has its own constitution & by Laws which govern its modus operendi.

NGO if wishes to undertake development activities it must register with the Administrative Ministry, and the Directorate of Social Welfare. And if the NGO wishes to receive foreign donation it must obtain special permission from Social Welfare Directorate under the Foreign Donation Regulation Ordinance. This is in brief the definition of Non Government organization in our country.

History of NGO activity in Family Planning :

A detail history of NGO movement in Family Planning is given in another article- so only a short resume will be given here.

Family Planning activity was initiated in this part of the world in 1953 by a group of concerned Individual. They formed EPFA. EPA was based in Dhaka and their activities were :

1. Breaking the ice, regarding Social Taboos and Prejudice against Family Planning.
2. Lobibying Government to adapt Family Planning as an official programme.

Their early activition wore mainly motivation & education in Family Planning.

In 1958 after 5 years of their formation - The Pathfinder Fund donated a sum of Tk. 10,000/-.

In the next year EPFPA accorded IPPF approval and the same year the then Pakistan Government provided a sum of 50 lac for family planning by voluntary basis.

Things were moving very slowly. In 1965 official Family Planning programme was launched by formation of **Family Planning Board.** But Family Planning NGO did not come up for a long time except EPA.

After the war of liberation many International agencies came for assistance of Bangladesh in its initial reconstruction efforts. Some of them were IPPF and afterwards took up programme on health and population activity and started **assisting local NGO's.**

The actual birth of many NGO in Family Planning took place during 1st **Five Year Plan period (73 - 78)**

They are : BAVS (1974)
OHCP (1974)
CWFP (1978)

During this period, Ministry of Health & Family Planning took a special project "Use of V.O. in MCH-FP with the assistance of World Bank to promote and support NGO in MCH-FP.

FPCVO was thus established in 1978 & are to ensure effective promotion of VO. Next year a cell was formed outside the Ministry to assist V.O - called FPSTC (1978)

During the next few years we saw the phenomenal growth of FP NGOs. The reason for this was mainly due to favourable support of the international community, particularly US based International Agencies in the Health Population Fields.

Today we have more than 180 exclusive NGO engaged in Health, Family Planning & MCH activities.

They can be classified in following categories :

A. **National level NGO**
Having atleast 10 branches or projects.

B. **Local level NGO** having no branches but employing 10 persons.

C. **Foreign organisation in F.P.** MCH these V. Organisation comes from outside the country but working in BDG.

Area of operation

For Family Planning activities the NGO were allowed to operate only in the urban area.

exception :- For innovative and income generating activities NGO are allowed to work in **rural areas.**
— Restriction now being removed.

Table - 1

National level NGO's	Branch
1. Family Planning association FPAB (1953)	20 C. 4 NC.
2. Bangladesh Association for Voluntary Sterilization (BAVS) 1974	33 Clinical 17 Non-clinical
3. Community Health Care Project (CHCP) 1974	20
4. Concern Women of F.P. Project (1976)	12
5. Palli Shishu Foundation (1980)	10
6. BAMANEH (1981)	12

BDSC & BWHC having 8 and 4 branch respectively.

Table -2

Local level NGO's According to location (Division wise)	No
1. Dhaka Division	44
2. Chittagong Division	22
3. Rajshahi Division	19
4. Khulna Division	16
Foreign	27

Table - 3

NGO's provide following services

A. Clinical
B. C.B.D.
C. CBD- Clinical
D. MCH,EPI and Nutrition
E. Integrated Program
F. Training
G. Research and Evaluation.
H. Innovative + (Incomme Generation).

Table - 4

Achievement As Service provider
Measurable achievement in this fields are:-

A. Sterilization	-	30.49%	Of the
B. IUD	-	13.76%	National
C. Pill	-	48.49%	achievement
D. Condom	-	71.93%	
E. Injectable	-	42.23%	

Total: 40% of the National Programme
(According to 1984-85 MIS Report)

In Motivation
All NGO has motivation programme but difficult to quantify the achievement.

Table -5

In Training
All Training of the NGO personnel are done by NGO themselves.

Important Training Programme of NGOs

- o CWFP
- o FPSTC — Non Clinical
- o BAVS — Clinical
  Sterilization
  Counselling
  Nurse / Paramedics

Offered to other NGO and to GOB.
GOB Physician Training:
- And
  - o Comprehensive
  - o Refresher

To other NGO
- Physician Training
- Counsellors Training
- Paramedical training in clinical contraceptive

Problems/Constraints General

- o Resource Mobilization
  - * Dependant on Donors + GOB
  - * Local resources - (difficult)
- o GOB - Clearance
  Line Ministry
  E R D
  H.M.
  N.B.R.
- o Supply and Logistic
- o Cost consciousness
- o Local & field level

Intra - Organization
Volunteers:
- o Development
- o Creation of New
- o Orientation & continued education of Vol.
- o Activities to strengthen commitment
- o Skill development

In other countries activities are undertaken to achieve above mentioned objection (Volunteers Training Programme)

Staff
- o **Proper Training**
- o **Skill development**
- o **Strengthen commitment.**

Inter-organization

- o **Cooperation**

to be strengthen

- o **Coordination**

Duplication of service - to be adjusted
- o Service improvement
- o Standardization

Service
Opportunity
Benefit

This are some of the achievement /problems/ constrains - I have tried to identify are of general in nature.
I have intentionally ommitted problem of individual nature which only have to be solved on individual basis.
Inspite of the innumerable problem- identified - I can say that the co-operation and coordination is continuously improving. To–day we the NGOs in general, enjoying more respect and credibility.
Of course the respect and credibilities depends upon our activity and performance.
This are some of the achievement/problems–constrains - I have tried to identify are of general in nature.
I have intentionally ommitted problem of individual nature which only have to be seleleted on individual basis. This is my own perception.
Inspite of the innumerable problem - I have identified - I can say that the co-operation and coordination is continuously improving. To-day we the NGOs in general enjoy more respect and credibility.

Of course the respect and credibilities depends upon activity and performance.