

UNITED STATES OF AMERICA  
Agency for International Development  
Dhaka, Bangladesh

USAID/BANGLADESH CHILD SURVIVAL STRATEGY (CSS)

Introduction

This paper presents USAID's preliminary long-term (FY 86-92) strategy to achieve its child survival (CS) objectives in Bangladesh.\* We acknowledge that the strategy is in the formative stage, and a number of proposed interventions must be more fully explored during the design of the new Family Planning and Health Services Project (FPHSP, No. 386-0070) that will be authorized in FY87. The strategy reflects our experience with Bangladesh Government (BDG) and Non-Governmental Organization (NGO) programs. It is consistent with the BDG's maternal and child health (MCH) strategy as articulated in the recently drafted Third Five Year Plan (TFYP), as well as the BDG's and NGOs' institutional capabilities and constraints.

A number of key factors have strongly influenced this strategy. First, the strategy must be consistent with USAID's program priorities. Second, and perhaps most salient, is how USAID can best maximize its impact given the wealth of other donor contributions to CS and health interventions in Bangladesh. Third, we must acknowledge the BDG's limited absorptive capacity. Finally, our strategy must be consistent with the USAID's ability

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\*This strategy follows the format outlined in State 113737, and is drawn largely on recent assessments performed by USAID and by Dr. Stanley O. Foster, CDC/Atlanta (immunization), Dr. Julia Walsh, Harvard School of Public Health (ORT), and Dr. Nancy Pielmeier, PPC/PDPR. The assistance of these consultants in developing this strategy proved invaluable.

to manage a CS portfolio. . . In essence, as we more fully discuss below, given these program constraints, the USAID must respond to targets of opportunity, fill vital gaps left uncovered by other donors, and generally focus on improving the management of programs that are either on-going or proposed for funding by other donors. Our strategy is additionally directed at those areas in which AID has a unique capability to play a useful role.

Recognizing that rapid population growth compounds the difficulties in meeting other essential development needs, including improved health, agricultural production and employment, USAID will continue to assign priority in Bangladesh to our program goal of reducing human fertility. Yet we acknowledge that, as one of the world's poorest countries with among the highest incidence of mortality and morbidity, especially among infants and children, the woefully deficient health status of the great majority of Bangladeshis is one of this country's most intractable development constraints. A CS strategy must be a critical component of USAID efforts to reduce fertility and more generally to develop Bangladesh's greatest potential resource—its people. Thus, the provision of MCH services will be an important part of our Population and Health objectives. As we stated in our CDSS: "the ultimate end of any country's development program is to improve...the physical quality of life of its people. In Bangladesh, human productivity suffers from poor health."

USAID began a major child survival initiative in FY85 with an obligation of \$5.0 million for the introduction of ORS into the Social Marketing Projects (SMP) retail sales program. An additional \$4.0 million will be obligated in FY86 to support the Urban Volunteer project (UVP), which delivers basic CS interventions in the major urban slum areas of the country. (See D. for details of the UVP.) With the addition of centrally-funded CS projects, including Helen Keller International (HKI), Save the Children Federation (SCF), and the Salvation Army World Service Organization (SAWSO), the Mission's CS portfolio will soon exceed \$10 million—an auspicious beginning.

In the long-term strategy that follows, the Mission will augment its CS program where it appears to complement ongoing or planned CS efforts. There are presently major program initiatives in Immunization and Oral Rehydration Therapy (ORT) supported by other donors. Thus, USAID involvement will be in the interstices of other programs. The possibility of involvement in cost-effective nutrition interventions is limited, with the exception of Vitamin A supplementation, and AID will continue to provide significant assistance - through HKI - for Vitamin A efforts. We will focus our CS efforts on immunization and ORT. However, the CS intervention where the Mission will continue to play the largest role is child spacing.

The development and management of this program has staffing implications, and the Mission may need two full-time staff for CS activities (one USAID direct-hire and an FSN), and substantial

short-term technical assistance from AID/W centrally-funded projects.

### The Problem

Infant and child mortality rates in Bangladesh are among of the highest in the world. One of four children dies by age 5.

#### Some Statistics:

- Deaths in infancy are concentrated in the first month of life with an estimated neo-natal mortality rate of 80/1000 live births.
- Principal causes of neonatal death are tetanus (59 percent), birth trauma and prematurity (32 percent), and pneumonias (9 percent).
- Remaining infant deaths occur in the succeeding eleven months and are due to late emerging tetanus (24 percent), respiratory infections (25 percent) and diarrheas (29 percent).
- Infant mortality is estimated at 132 per 1000 live births.
- In the second year of life, leading causes of death are diarrheal disease (43 percent), respiratory infections (14 percent) and measles (7 percent).
- Child mortality (1-4 years) remains at an estimated 23/1000 population.
- In the 2-5 year age group, diarrheal disease accounts for 63 percent of deaths.
- Maternal mortality is estimated at 6/1000 live births, about 100 times higher than rates for developed countries. The principal causes of maternal mortality are complications of

labor, eclampsia and infections arising from septic abortion and unhygienic delivery.

- Malnutrition\* makes a major contribution to mortality in infancy and childhood.
- Maternal malnutrition is significant in rural areas and results in fetal growth retardation and a high frequency of low birth weight.
- Vitamin A deficiency is particularly severe in Bangladesh and approximately 30,000 children are blinded each year.

Risk Factors and Intervention Feasibility in Bangladesh:

Reduction of infant/child mortality and improvement of child health requires an assessment of mortality risk factors, the availability of technically feasible interventions and their potential for effective implementation in Bangladesh.

Based on current knowledge of under five mortality in Bangladesh - and data are significantly better due to the presence in Bangladesh of ICDDR,B - the following risk factors are thought to be the most important. Factors are listed chronologically in a child's life: prebirth up to approximately five years of age.

\* Statements on malnutrition are excerpted from the January 31, 1985 World Bank Study: Bangladesh Food and Nutrition Sector Review.

<u>Risk Factors*</u>	<u>Intervention</u>	<u>Implementation Feasibility</u>
(a) Short birth interval (pre-birth and post-birth)	non-permanent contraception	low to moderate
(b) Non-identification of high-risk mothers	referral	low
(c) Un-attended delivery	TBA training	low
(d) Neonatal tetanus	TT to women of reproductive age	high
(e) Acute Respiratory Infection	(Unknown: ongoing BOSTID** research at ICDDR,B will be monitored.)	(undetermined)
(f) Pertussis	Immunization	high
(g) Measles	Immunization	high
(h) Under nutrition	-Improved weaning practices	low
	- Vitamin A	moderate
(i) Dehydration	Oral rehydration	moderate to high

\*Risk factors in Child Survival is taken from Stanley O. Foster's CS report to USAID/D, May, 1986. The listing does not specifically include Low Birth Weight, which is a significant risk factor (approximately one-third of all infants weigh less than 2,501 grams at birth in Bangladesh). However, in the absence of a referral system for high risk pregnant women throughout the country, cost-effective prevention for Low Birth Weight is not possible at this time. An effective family planning - child spacing program, however, is feasible and can impact on Low Birth Weight to some extent.

\*\*Board on Science and Technology for International Development (BOSTID); a research grants program of the U.S. National Academy of Sciences. BOSTID is AID/W funded through the office of the Science Advisor.

Given the above risk factors and the feasibility of implementing successful interventions in Bangladesh, USAID's CS strategy will be based on the following minimum package: Child Spacing, Immunization, ORT and Nutrition (Vitamin A).

Specific Interventions:

A. CHILD SPACING

The main objective of the Mission's ongoing Family Planning Services Project (FPSP) is demographic; however, family planning - as is well known - has a significant positive impact on MCH. In a recent speech the AID Administrator stated that "The health and survival of mother and children provides a second important reason for family planning. We know that one of the most serious consequences of women having many children in quick succession is that more children and mothers die. There are dramatic statistics that family planning saves lives: it is a critical component of mother and child survival."\*

Data from AID and USAID-supported ICDDR,B projects at Matlab and the Aboynagar/Sirajganj Extension Areas indicate that, in the treatment areas, a major reduction in fertility (25 percent as measured by general fertility ratio) was followed by a 15 percent decline in the mortality rate for children 1-4 (Phillips, 1984 Swenson (1977) pointed out that in Matlab, fetal death rates are highest for pregnancies that started less than one year after the previous pregnancy ended. She further stated that "if all birth intervals were longer than 24 months for all second

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\*Speech on Population presented to the American Enterprise Institute, November 25, 1985 (State 386573).

order and higher pregnancies, post neonatal mortality would be expected to decline by about 44 percent.\*\*

According to the Center for Population and Family Health, Columbia University, approximately 32 percent of all children in Bangladesh are born at intervals of less than two years apart; if all birth intervals were at least two years, infant mortality could be reduced by 27 percent.\*\*

Whatever data are used, there is conclusive evidence that greater child spacing would significantly reduce infant and child mortality. Based on data from Chile as a guideline (where a 40 percent drop in the Crude Birth Rate led to a 60 percent drop in the Infant Mortality Rate), the Mission estimates that 220,000 infant deaths could be averted annually with an effective child spacing program. The Mission believes that child spacing can have the greatest potential impact on child survival in Bangladesh.

By the end of FY86, the Mission will begin intensive design of the new FSESP. In the new project, emphasis will be placed on temporary methods of family planning for child spacing. This Child Survival activity, however, will be funded from the Population account, and it will be further elaborated in the FPHS project paper.

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\*Cited in Health Benefits of Family Planning, S. Harbison, USAID Research/Evaluation Adviser, Dhaka 1985.

\*\*Child Spacing and Child Survival, Center for Population and Family Health, 1985.

## B. IMMUNIZATION

### 1. Scope of the Problem:

Four diseases preventable by immunization have significant morbidity, mortality and disability effects on Bangladeshi children. Table 1 provides an estimate of 1986 disease cost of non immunization.

TABLE 1\*

DISEASE PREVENTABLE BY IMMUNIZATION - BANGLADESH 1986			
IN MILLIONS			
DISEASE	CASES	DEATHS	DISABILITY
Neonatal Tetanus	0.1-0.2	0.09-0.18	-
Measles	3.6	0.07-0.18	0.03-0.09
Pertussis	3.2	0.02-0.03	0.01-0.02
Polioomyelitis	0.02	0.002	0.01
Diphtheria	- (unknown)	-	-
Childhood TB	- (unknown)	-	-

In summary, an estimated 200,000 to 400,000 Bangladeshi children die annually of diseases preventable by immunization. Fifty to 75 percent of these deaths, 100,000-300,000, can be prevented if BDG immunization coverage targets are achieved. Current (1985) coverage is estimated to be about 2 percent in rural and 1 percent in urban areas.

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\*Data above collected by Dr. Stanley O. Foster (5/86) from both published and unpublished studies which offer a wide range of estimates for morbidity and mortality.

2. Status of Programs and Policies:

Immunization in Bangladesh is being administered as part of Primary Health Care. The EDG, in cooperation with WHO and UNICEF, has developed a national plan to achieve by 1990 an 85 percent immunization coverage of infants by their first birthday and women of child bearing age.\* UNICEF is the lead agency in terms of donor technical cooperation with the Bangladesh EPI program.

Although the accelerated EPI program has just begun, some progress has already been made. The need for EPI is well established. The low level of current coverage is recognized. A draft plan has been developed. A committed, competent Ministry of Health and Family Planning (MOHFP) EPI Project Director is in place. Staff support to the EPI Project Director is being increased. A WHO Technical Officer is working with the Project Director to strengthen EPI Management and Logistics. A national commitment has been established. Financial resources to meet current projected needs have been identified (See below). A realistic approach to use NGOs to support the EDG program in some rural areas is being developed. There is excellent coordination between the BDG and the large number of donors supporting the program.

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\*Draft Project dated 12 December 1985.

Financial resources committed and/or planned are summarized in Table 2.

TABLE 2  
FINANCIAL SUPPORT FOR BANGLADESH EXPANDED PROGRAM ON  
IMMUNIZATION: 1985 - 1990

SOURCE OF FUNDING	US DOLLARS IN MILLIONS
GOVERNMENT OF BANGLADESH	3.0
WHO	1.2
UNICEF	4.5
UNICEF FUNDED BY SIDA	10.0
WORLD BANK	1.4
CARE FUNDED BY NORAD	1.0
BRAC (EPI COMPONENT)	2.0
TOTAL	23.1

Current program implementation calls for a phased expansion of immunization by Upazila to cover the entire country by 1990, Table 3.

TABLE 3  
PROPOSED IMPLEMENTATION OF EPI IN BANGLADESH 1985-1990

Year	Number Upazilas		Coverage in percent
	New	Cumulative	
85-86	8	8	3
86-87	60	68	15
87-88	120	188	35
88-89	272	460	80
89-90		460	85

In rural areas, immunizations will be delivered at established health facilities by Medical Assistants (MA) and Family Welfare Visitors (FWV) and at peripheral level outreach clinics by Health Assistants (HA) and Family Welfare Assistants (FWA), thus utilizing both health and family planning workers.\* These workers will be supervised by EPI technicians and Medical Officers stationed at the Upazilla level. The BDG will be assisted by two large NGOs, CARE and the Bangladesh Rural Advancement Committee (BRAC), in delivering the immunization program to approximately 50 percent of the country.

The EPI implementation strategy for major municipal centers (Dhaka, Chittagong and Khulna) has not received as much attention as the implementation strategy in rural areas and district towns. The municipal strategy is based on utilization of hospitals, a small number of BDG and NGO MCH centers, and the few municipal fieldworkers available. (There are 10 Municipal Government EPI centers and an inadequate number of field workers in Dhaka to deliver immunizations and other interventions to a population of over 4.0 million.) Funds for EPI operations mainly come from the municipal budget and not from the Central Government.

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\* The Mission is concerned that the BDG/UNICEF strategy to use FWAs (female) in the delivery of EPI will detract from their family planning responsibilities and could have a negative impact on the contraceptive prevalence rate. The Mission is discussing a study to assess the impact of alternate EPI delivery strategies with the BDG.

Municipal funds for health per capita have been declining in real terms over the last few years.

3. Major Problems:

Although actual implementation of the accelerated EPI program has only recently begun, it does appear that the proposed implementation schedule (Table 3) is overly ambitious. Problems include: (a) numerous unfilled BDG positions at the service delivery level; (b) insufficient ratio of MOEFP field workers to population to deliver assigned family planning and health services, including EPI; (c) inadequate transportation at the peripheral level; (d) delay in posting four long-term, critical UNICEF EPI advisors; (e) absence of a municipal service delivery strategy; (f) absence of a strategy for community mobilization and training in the Dhaka and Chittagong Divisions (BRAC and CARE are supporting the BDG in the other half of the country); and (g) inadequate supervision at all levels.

4. GAPs in the Immunization Program:

Following discussions with municipal and BDG authorities and with other donors, at this point in time, the Mission has identified three possible unmet needs for assistance: (a) overall assistance to the EPI program in the municipal areas of Dhaka, Chittagong, and Khulna; (b) support of NGO assistance to the BDG rural immunization program in community mobilization, communications and possibly, in service delivery, in the Dhaka and Chittagong

Divisions; and (c) short-term technical assistance (S-T TA) in Communications/Mobilization, Epidemiology/Monitoring/MIS, Finance/Cost Sharing, Program Implementation, Operational Research and Impact Evaluation.

5. Priorities and Strategy for USAID assistance in the EDG's National Immunization Program:

a. Municipal Immunization:

Assist the EDG EPI implementation efforts in Dhaka, Chittagong and Khulna Municipalities.

- (i) Undertake initial study in Dhaka (end FY 86/early FY 87) to assess in detail current and potential resources for urban immunization (EDG/NGOs);
- (ii) Develop an urban strategy and a sub-project\* proposal covering 3 municipal areas on a phased basis (early to mid-FY 87).
- (iii) In conjunction with the Urban Volunteer Program, test the implementation strategy in Dhaka and decide on expansion (mid-FY 87 to mid-to-end FY 88);
- (iv) Execute suitable implementation strategy in municipal areas of Dhaka, Chittagong and Khulna (FY 89-91). (Costs: \$3.0 million)

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\*CS activities, funded FY 87 and beyond, will be incorporated in the new FPHSP project.

- b. NGO support to rural EPI: The Mission has begun to work with a large NGO ("Swanirvar") to design an FPHS subproject to determine a suitable strategy to augment the EDG rural immunization program with NGO volunteers in the Dhaka and Khulna Divisions (FY 86). Implementation will begin with funding from the ongoing FPSP (late FY 86/beg. FY 87). Implementation of the chosen strategy in the two divisions will begin with development of a subproject under the new FPHSP. The FPHSP is expected to be approved in mid-FY 87. Implementation of the subproject (mid-to-late FY 87). (Costs: \$3.0 million).
- c. Provision of short-term TA in areas given in Section 4 above. (Total cost Dol.500,000.)

C. ORAL REHYDRATION THERAPY (ORT):\*

1. Scope of the problem:

A recent EDG/WHO/UNICEF survey\*\* stated that there are about 4 episodes of diarrhea per child per year in Bangladesh. Therefore, roughly 60-70 million episodes of diarrhea per year may occur in children less than age 5. There are, in addition, at least this many more episodes in all the older ages (ages 5 plus).

According to a 1983 morbidity and mortality survey,\*\*\* mortality for children of 0-4 years was 46.08 per 1000 population and, of that, 29.16% was due to diarrhea. The current 0-5 year of age population in Bangladesh is approximately 17 million, therefore, the estimate of mortality from diarrhoeal disease in this age group would be about 230,000 in 1985.

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\*This Mission has chosen an ORT strategy not a Control of Diarrhoeal Disease (CDD) strategy. However, while USAID/D believes that ORT is a most important intervention of CDD, we also believe it is important to endorse further research in other CDD interventions. Recent, unpublished ICDDR,B research indicates that: "ORT cannot avert deaths due to complications of diarrhea other than dehydration. These include systemic bacterial infections (i.e. typhoid fever), and protracted illness (i.e. chronic diarrhea) and other medical and surgical complications (i.e. from shigella infection). Data from 2 large diarrheal hospitals in Bangladesh suggest that less than 1/3 of deaths which occurred there were due to dehydration." The Mission intends to support other CDD intervention research and implementation through the Urban Volunteer Project.

\*\* Comprehensive Review of Diarrhoeal Disease Control in the People's Republic of Bangladesh, 13 April - 4 May, 1986

\*\*\* Dr. M.A. Khan, et. al., 1983

## 2. Status of Programs and Policies

With assistance from UNICEF and WHO, the BDG has developed a strategy to deliver ORS through MOHFP facilities and via major NGOs. ORS packets are distributed to diarrhea patients by health and family planning workers at all MOHFP facilities.

USAID is providing support for an ORT Social Marketing Project (SMP). In 1985 USAID signed a \$5.0 million Cooperative Agreement with Population Services International (PSI) to promote ORT and distribution of ORS through the ongoing FP - SMP distribution system. By 1990, 15 million half-litre ORS packets per year, with distinctive SMP packaging, will be purchased by PSI/SMP from local producers. Mass media and other forms of communication will be employed to educate mothers, physicians and retailers about prevention of diarrhea and to encourage them either to prepare appropriate, inexpensive rehydrating solutions from home ingredients ("lobon-gur") or to purchase packets at readily-accessible sales outlets throughout Bangladesh. The ORT- SMP project will utilize the existing, extensive nationwide SMP network of salesmen and over 100,000 sales outlets.

Since 1980 BRAC has taught villagers the management of diarrhea through the use of lobon-gur. BRAC has sponsored mass communication programs and has used community-level workers to encourage proper use of this homemade solution. Three of the four divisions of

the country have been covered by this program. In the latter half of 1986, BRAC will begin its ORS program in the remaining division (the northwest) and the ORS program will be coordinated with three other CS components: immunization, nutrition education and vitamin A distribution, and training of TBAs in safe delivery.

The International Center for Diarrheal Disease Research, Bangladesh (ICDDR,B) has a long, outstanding record in diarrheal disease research, development of methodologies for assessment and treatment of diarrhea, training of health personnel, and testing of various for the management of diarrhea.

Several hundred other NGO's distribute and promote ORT in the country; they range in staff strength from five to hundreds.

### 3. Major Problems:

More than 70% of Bangladeshis are aware of the use of oral rehydration for diarrhea; however diarrheal disease mortality remains high. Incorrect usage of ORS is probably common. The EDG/WHO/UNICEF report\* noted that stated usage exceeded available supplies of packets and, more importantly, that diarrheal disease mortality has not changed in more than a decade. Several areas remain for improving the effectiveness of the ORT/ORS:

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\*Ibid

(a) ORS Production

In 1985, approximately 21 million half liter packets of ORS were available in Bangladesh. (At present all procurement of ORS must be from local production.) If usage increases to 3-4 packets per child diarrheal episode the demand could rise to more than 100 million packets annually. From test marketing, SMP feels that demand for its product could increase several fold and it is in the process of identifying reliable long-term sources of supply. Substantial unused production capacity exists within the private sector, but SMP has not yet been able to negotiate long-term contracts.

Plans for SMP to develop an independent production unit will be reviewed as experience develops in contracting for local production and SMP procurement.

(b) Management, Logistics and Supply Packets

Drugs and other supplies vary in availability at MOHFP facilities and are generally found in inadequate amounts. Health and family planning workers do not know how to obtain supplies, and supplies do not reach the village level through current BDC channels, although NGOs have had more success in logistics and supply.

(c) Evaluation and Use-effectiveness

Limited capability exists to evaluate the system to identify bottle necks and to measure effectiveness and impact of ORT on diarrheal disease.

4. Gaps in the ORT Program:

Since many agencies are involved in facilitating ORT and the MOHFP has recognized it as a priority, additional USAID involvement will be in the interstices of other programs.

5. Priorities and Strategy for USAID assistance in the EDG's national ORT program:

Village Supplies: ORS packets are increasingly available in large markets and health centers, but these may be several kilometers from the village. Use of village women to sell ORS packets (along with some instruction), soap and other household items, may provide both income-generation and improved ORS supply.

- (i) With the Ministry of Social Welfare, Directorate of Women's Affairs, develop a prototype ORS village depot/income-generating project to test in one division. If successful expand nationwide (Total cost \$1.5 million).

(ii) The on-going USAID-funded ORT-SMP may establish ORS distributorships by village women. (Within the existing \$5.0 million obligated in FY 85).

D. INTEGRATED CHILD SURVIVAL INTERVENTIONS

USAID has been and will continue to work with NGOs to develop projects that provide integrated packages of CS interventions. Generally their packages include at a minimum ORT, immunization, FP and Vitamin A.

Priorities and strategy for USAID assistance in supporting integrated CS interventions include:

1. The Urban Volunteer Project (UVP): USAID expects to obligate \$4.0 million in FY86 (and an additional \$0.5 in FY87) in support of the UVP. This is an on-going project (in Dhaka) that delivers basic CS interventions in the major urban slum areas of the country. It uses a community-based network of slum-dwelling women as volunteers to identify and treat, and/or refer, for basic childhood diseases such as diarrhea, scabies, vitamin A deficiency, and malnutrition. The volunteers also refer mothers and children for immunization, and counsel and refer for family planning. The project will expand to cover 95% of the slum areas of Dhaka, Chittagong and Khulna, a population of over 4 million, by 1990. (Total costs \$4.5 million.)

2. The Bangladesh Association for Voluntary Sterilization (BAVS) child survival/FP project: Presently BAVS has 33 clinics, each with its complement of outreach workers, scattered in most of the urban areas of the country. BAVS facilities now provide clinical contraceptive services as well as some temporary family planning methods; however, BAVS has also been experimenting with the delivery of MCH services in 7 of its clinics. The provision of the MCH services is provided by essentially the same staff. USAID is working with BAVS to develop a proposal to focus its health services toward children and expanding its CS services to 33 clinics for possible funding in FY 87. (Estimated project cost \$700 thousand.)

3. Possible other CS projects with USAID-funded FP NGOs: The Mission will work with NGOs which are presently funded for family planning activities to promote the delivery of a integrated package of CS interventions. (Possible costs \$0.5 million.)

E. VITAMIN A (NUTRITION)

1. Scope of the Problem

Vitamin A deficiency has been recognized for many years as a serious health problem in Bangladesh. Nutritional blindness among pre-school age children in Bangladesh is near the highest levels in the world: 30,000 children are blinded each year, of whom 50 percent die within a few months of the blinding episode.

A 1982/3 AID-funded survey\* showed that each year 900,000 children less than six years old suffered some form of xerophthalmia, inspite of the current BDG Vitamin A capsule (VAC) distribution program.

2. Status of Programs and Policies.

In 1973, the BDG established the Bangladesh Program for the Prevention of Blindness (BPPB), supported by UNICEF with TA from HKI. This program has been responsible for the twice-yearly national distribution of Vitamin A megadose capsules to children ages 0 - 5. UNICEF supplies all Vitamin A capsules for the BDG program. Assessment of the current VAC supplementation program through the BPPB showed that 46 percent of 8 million children receive at least one capsule per year; however, actual coverage varies widely, ranging from 7 percent to 90 percent. A quarter of the sites examined had less than 25 percent coverage. Also, specific high risk groups such as children living in urban slums, landless families, severely malnourished children and those less than one year of age are less likely to receive capsules.

HKI was awarded an AID/W centrally-funded grant of \$660,000 (FY85) to assist the BDG-BPPB to increase significantly the present coverage rate of 0-5 with VAC.

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\* Bangladesh Nutritional Blindness Study, 1982-83, Helen Keller International and Institute of Public Health Nutrition (Dhaka 1985).

HKI has recently submitted a \$1.2 million FY86 Vitamin A proposal to AID/W; FVA/PVC for consideration.

USAID is in the process of developing a homebased gardening activity, through USAID's agricultural research project, which begins to fill a gap in the EDG's program and constitutes an effort to diminish the EDG's dependence on the distribution of UNICEF - supplied Vitamin A capsules.

The Mission sees no need for additional inputs in Vitamin A at this time.

Funding Implications:

USAID funded the ORT-SMP in FY85 under the FPS Project (\$5.0 million) and will shortly fund the LVP in FY 86 under an OPC (\$4.0 million in FY86, and a planned \$0.5 million in FY87).

The proposed additional funding for CS assistance-as outlined in the above strategy - will be incorporated as part of the new FPHSP to be authorized in FY87. In addition to Population Account funds for child spacing, this would include:

- (a) Urban immunization projects with the municipal governments of Dhaka, Chittagong and Khulna;
- (b) NGO EPI support to the EDG's rural immunization program in Dhaka and Chittagong divisions;
- (c) The provision of TA to the EDG for immunization;

- (c) A project with the Ministry of Welfare and Women's Affairs for the establishment of ORS distribution using village women as depot-holders; and
- (e) Integrated CS intervention projects, such as the UVP.

The Mission's existing and proposed funding for CS is summarized below:

- USAID-funded:

(a) Child Spacing:

Birth spacing activities in the new FPMS (to be funded from the Population Account).

From the CS/Health Accounts

(b) Immunization:

- (i) Municipal immunization: \$3.0 million (FY87)
- (ii) NGO - EPI support: \$3.0 million (FY87)
- (iii) TA: \$0.5 million (FY87-92)

(c) ORT:

- (i) ORT/SMP: \$5.0 million (FY 85)
- (ii) Womens Affairs' ORS Depot-Holders: \$1.5 million (FY87)

(d) Package of CS Interventions:

- (i) Urban Volunteers: \$4.5 million (\$4.0 m. FY86; \$0.5m. FY87)
- (ii) BAVS: \$0.7 million (FY 87)
- (iii) Other FP NGOs: \$0.5 million (FY87/88)

Subtotal: \$18.7 million (\$13.7 million for FY86-88)

- Present/proposed AID/W Centrally-funded CS Projects  
in Bangladesh:

(a)	SANSC	:	\$0.22 million (FY85)
(b)	SCF	:	\$0.20 million (FY85)
(c)	HKI	:	\$0.44 million (FY 85) and \$1.2 million (proposed in FY 86)
(d)	UNICEF/RED CROSS: (Child Alive)	:	\$0.50 million (FY85)
	Subtotal	:	\$2.56 million
	Total	:	\$21.26 million

6. Staffing Implications:

The Mission's Population and Health (P&H) Office consists of four full-time and one part-time USAID direct hire employees. Two of the direct-hires spend approximately 50 percent of their time on CS in order to manage the Mission's presently-funded CS activities. The P&H Office cannot spare additional staff time as it is responsible for the ongoing and management-intensive \$150 million FPSP, and will be shortly responsible for the new \$140 FPHSP (both funded under the Population Account).

The Mission, given staffing constraints, will attempt to develop its CS program to minimize the degree of Mission management required. USAID also plans on drawing upon AID/W centrally-funded projects to provide S-T TA in design and evaluation. The Mission is investigating mechanisms for long-term TA for management as

well. One possibility would be to contract with a firm to manage all proposed CS projects and activities. However, in order to manage development and start-up of the above-described CS program, the Mission sees the need for a full-time USAID direct-hire and a full-time FSN in the PGN Office.