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**BANGLADESH:
POPULATION SECTOR REVIEW**

by

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Glossary

ANE	Asia/Near East Bureau
A.I.D.	U.S. Agency for International Development
BAVS	Bangladesh Association for Voluntary Sterilization
BFS	Bangladesh Fertility Survey
CBD	Community-based distribution
CDSS	Country Development Strategy Statement
CPR	Contraceptive Prevalence Rate
CPS	Contraceptive Prevalence Survey
CYP	Couple years of protection
DA	Development Assistance
FP	Family planning
FPA	Family Planning Assistant
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
GOB	Government of Bangladesh
HA	Health Assistant
ICDDR,B	International Centre for Diarrheal Disease Research, Bangladesh
IEC	Information, education, and communication
IMR	Infant mortality rate
IUD	Intrauterine device
MCH	Maternal and child health
MOHFP	Ministry of Health and Family Planning
MWRA	Married women of reproductive age
NGO	Non-governmental organization
ODA	Overseas Development Administration
SMP	Social Marketing Project

TFR

Total fertility rate

USAID

U.S. Agency for International Development (mission)

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Executive Summary

Introduction

At the request of the Asia/Near East Bureau of the Agency for International Development, a three-person team was recruited to assist the USAID Mission in Bangladesh in reviewing its past and proposed assistance to population and child survival initiatives in light of its overall development assistance portfolio. The review was accomplished through pre- and post-travel briefings at the U.S. State Department in Washington, which were attended by various experts on population and Bangladesh; an extensive review of documents; and site visits and interviews with USAID staff, donors, and program participants in Bangladesh over a three-week period.

Review Findings

In 1971, when USAID initiated its family planning efforts with Bangladesh, the country had one of the world's highest total fertility rates combined with extremely low levels of literacy and per capita income. USAID managed to confound the experts who had classified the country as one in which demographic change was highly unlikely, and instead was able to achieve slow, yet clearly measurable progress on basic demographic indicators: Two Bangladesh Fertility Surveys (BFS) and five Contraceptive Prevalence Surveys (CPS) indicate that the total fertility rate has declined from 7.1 to 4.9; the Contraceptive Prevalence Rate (CPR) has risen from below 8 percent to the present level of 33 percent.

Continued external funding and technical assistance will be critically important to continue this momentum over the short run. USAID provided critical intellectual and financial support in the early days of the program; following this example, other donors have become increasingly involved in supporting the population effort. Everything that USAID and the rest of the donor community can do to sustain the program's momentum through increased access to improved contraceptive services should be emphasized in the next planning period.

Recommended Future Directions

The USAID mission's planned future strategy reflects a transition in funding emphasis which is characterized by 1) a change in priorities among the program components in population/child survival efforts, and 2) the decision to provide approximately equal funding for other, non-population development activities, which should, indirectly, also influence the absolute number of people consuming resources and increase the overall productivity of all consumers.

With regard to future population efforts in Bangladesh, each component of the national program should be carefully examined by USAID in collaboration with the GOB and other donors to determine specific objectives related to cost saving and institutionalization. This is an area in which past and future USAID-funded activities can demonstrate tangible results. For example, commodity logistics activities, long supported by USAID, are slated to become institutionalized by the end of the next USAID population project. By 1995, the GOB will assume full responsibility for commodity logistics activities now supported extensively by expatriate technical advisors, and provide all or proportionally larger government funding. Furthermore, USAID has positioned itself to transfer a large portion of contraceptive provision to other donors who can procure pills and condoms at lower world prices than those available to USAID, thereby effecting a considerable savings in the overall cost of the program.

With regard to the Government component of the program, future support should include better coverage of services through recruitment, training, and supervision of the field-level workers in the national program. USAID should carry out its plans to support the Government's intent to bring service delivery closer to the women in need through satellite clinics at the ward level.

Other inputs critical to the success of the program include provision of increased technical assistance to certain key components of the program including the commodity logistics system; management training for program managers at the national and local levels; increased efforts to decentralize the planning, implementation, and management of the program in order to bring the program closer to the people being served; and improved accountability through introduction of the revised record and service statistics system and through continued support for Contraceptive Prevalence Surveys every two years.

The SMP and NGO components of the USAID population portfolio should be reassessed with an eye to a possible revision of their scopes of work. It is recommended that the SMP prepare a five-year business plan in order to be able to forecast costs and expenses. This exercise and resulting program decisions may lead this newly privatized company to greater levels of self-sufficiency than in the past. Other activities proposed for the SMP include conducting market research on costs, use patterns, and use-effectiveness of products; increasing product lines to include other health-related products; and the possibility of collaborating with the GOB in commodity distribution, IEC activities, and training of field-level staff.

Suggestions for revisions in USAID-funded NGO activities are made in consideration of the limited prospects for medium- and long-term sustainability of any massive NGO involvement in routine service provision. Furthermore, the distinct advantage NGOs have in their flexibility and potential for innovation is not being fully exploited in many of their current activities. An early priority in fleshing out the NGO strategy should be a reassessment of the community-based distribution activities of these organizations and of whether these activities should be phased out in areas where they duplicate Government efforts and/or more highly focused on the harder to reach, lower prevalence areas. Other recommendations relate to focusing on ways in which NGOs might contribute to strengthening the Government's service delivery program through counterpart relationships that would draw on NGO experience in program planning, management, supervision, training, and high-quality service delivery. Support should be continued for other NGO activities that engage the involvement of special community groups in support of the national family planning effort as well as those that test NGO innovations aimed at the enhancement of the overall program.

1. Introduction

In recent years, approximately 50 percent of the U.S. Agency for International Development (A.I.D.) development assistance support to Bangladesh has been allocated to population and child survival activities. As USAID/Dhaka was beginning to plan its development assistance strategy for the next five years (1991-1996) through preparation of its Country Development Strategy Statement (CDSS), the Assistant Administrator for the Asia/Near East (ANE) Bureau and the USAID/Dhaka Mission Director agreed to undertake a family planning program review. This review was designed to assess the impact of the Government of Bangladesh's (GOB) National Family Planning Program on fertility over the past 15 years, the relative importance of USAID's contribution to this effort, and whether the past proportion of expenditures for family planning and child survival should continue over the next five-year period. The review was also to explore alternative approaches to provision of family planning services that would yield similar fertility reduction returns as well as other development initiatives that might also contribute to declining fertility rates. A three-person team composed of one A.I.D. staff member and two external consultants was identified to undertake this review. See Appendix A for the evaluation scope of work.

A pre-travel briefing held on January 12, 1990, at the U.S. State Department provided background about the Bangladesh program for the two U.S.-based team members (Huber and Norris). The briefing was presented by USAID-funded researchers, representatives of the World Bank, and staff from A.I.D.'s Office of Population. The field work for the program review was carried out between January 18 and February 9, 1990. The team was led by Sallie Craig Huber, who was in Dhaka from January 19 through February 9. She was joined on January 27 by Jerry Norris, Assistant to the Director, Office of Technical Resources, ANE Bureau, and on February 1 by John Cleland, a demographer who also had provided technical assistance in implementation of the 1989 Bangladesh Fertility Survey. Huber and Norris made several short field visits in and near Dhaka to GOB, non-governmental organizations (NGO) and Social Marketing Project sites (see Appendix B), in addition to reviewing documents detailing the USAID portfolio, in particular those about the family planning and child survival activities (see Appendix C). Mission briefings and meetings with other donors and various participants in the USAID population program rounded out the first two weeks of the review. The third week was spent in discussion and deliberation by the team -- among themselves, with USAID staff, and with others involved with development activities in Bangladesh. A debriefing was held for mission staff on February 8, 1990, for which debriefing notes were prepared and left with the mission. Huber and Norris also participated in an A.I.D. review of population program trends in Asia and the Near East which was held at the U.S. State Department on March 8, 1990. The Bangladesh program review was presented as a "case study" at that review meeting.

2. Overview of the Current Bangladesh National Family Planning Program

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In 1971, when USAID initiated its family planning efforts with Bangladesh, the country had one of the world's highest total fertility rates combined with extremely low levels of literacy and per capita income. USAID managed to confound the experts who had classified the country as one in which demographic change was highly unlikely, and instead was able to achieve slow, yet clearly measurable progress on basic demographic indicators: Two Bangladesh Fertility Surveys (BFS) and five Contraceptive Prevalence Surveys (CPS) undertaken between 1975 and 1989 indicate that the total fertility rate has declined from 7.1 to 4.9; the Contraceptive Prevalence Rate (CPR) has risen from below 8 percent to the present level of 33 percent.

2.1 Program Strengths

When viewed against the background of the level of overall development in Bangladesh and the constraints imposed by its culture, the Government of Bangladesh is seen to have a strong and unique commitment to population and family planning efforts. Population is currently being promoted as the GOB's top priority development program, an effort heralded in the mass media as a "social revolution." The program has built a large, grassroots level female field-worker force and a dense network of health centers providing all methods of contraception, including sterilization. In addition, despite relatively limited GOB contributions from its revenue budget to the National Family Planning Program in the past, there is an indication of plans to increase contributions in future.

USAID support to the Bangladesh family planning effort is given high marks by the GOB and other recipients as well as by other donors. The ready availability of technical expertise and allocation of funds for the programmatic areas in which it has the best record of experience were cited as the particular strengths of USAID support. This assistance has been enhanced by the GOB's willingness to allow direct, bilateral funding for NGO efforts during the past two USAID population projects. Recently, the GOB has also taken steps to streamline the project approval process for all NGO project efforts.

In addition to providing support to GOB and NGO family planning efforts, USAID has supported the successful Social Marketing Project (SMP) in Bangladesh for about 15 years. In January 1990, the SMP was completely privatized, which will allow this component of the family planning program greater latitude to explore expanded activities leading to increased self-sufficiency. The GOB considers both the NGO and SMP components of the current USAID population project to be important to the overall national family planning program effort.

The present Minister of Health and Family Planning has a strong private sector/NGO background, a good programmatic track record, and solid ties to USAID's program. His continued support for USAID involvement can be assured for as long as he remains in his cabinet post. Other senior civil servants with responsibility for the family planning program are also said to be favorably disposed towards the USAID levels and areas of support to family planning and collaborate with USAID efforts as required.

2.2 Program Constraints and Weaknesses

Complex GOB administrative regulations and a complicated Ministry of Health and Family Planning (MOHFP) organizational structure combined with a lack of managerial skills at all

levels and poor field supervision of the family planning program adversely affect the implementation of planned program activities in the public sector. The existing weak management and administrative structures remain highly centralized despite the GOB's stated intent to decentralize more of the responsibility for planning and management of primary health care, including family planning, to lower administrative levels. Furthermore, the GOB has been unable to consolidate the integration of family planning and maternal and child health care despite an intent to do so.

In addition, the ever increasing funding which will be required due to an increasingly successful program will further strain what are already limited GOB resources. At the same time, the World Bank complains of the slow rate of expenditure of its present population project -- Population Project III. This project was originally funded at \$250 million over a five-year period; with less than two years remaining in the project, disbursements are less than \$100 million. Although the Bank is prepared to consider a fourth Population Project with a funding level of \$400-500 million, it is constrained from moving a new project forward at higher funding levels when present project disbursements have been so low. The Bank is sufficiently concerned with this situation to have put the GOB on notice that if disbursement levels are not significantly increased over the next six to eight months, the Bank will have to reduce the next project to a level which might well be below that of the current project.

This situation highlights the need for improved strategic planning as well as better monitoring systems to ensure the efficient and effective expenditure of both GOB and donor resources. There is also a need for a continued emphasis on the development and demonstration of innovative mechanisms for cost recovery within the program. In addition, several unresolved issues related to access to services -- physical, financial, and cultural -- must be addressed in forthcoming plans and projects.

3. Impact of Past Family Planning Program Efforts and Contributions of USAID and Other Donors

Assessing the impact of the Bangladesh family planning program and USAID's contribution to it raises fundamental issues that have long been the subject of divisive debate among academics and policymakers. In one camp are those who point out that family planning programs often have followed rather than initiated fertility decline. Within this perspective, the demographic impact of programs is thought to be rather modest, confined to reinforcing a trend towards smaller family sizes that is produced by economic and other developmental changes in the society. Strength of motivation is seen as the key factor: when couples are convinced that their own best interests are served by smaller families, they will actively seek ways to achieve this goal.

The opposing camp places much greater stress on the accessibility and acceptability of contraceptive methods and services as a determinant of fertility in the short- to medium- term. The underlying assumption here is that couples may wish to reduce their fertility but may be restrained from appropriate action by lack of knowledge, limited access, fear and suspicion; all of which may be exacerbated by religious and social conservatism. Thus, according to this view, by eroding these barriers, family planning programs can achieve a substantial demographic impact.

Convincing examples can be cited to support both of these interpretations of demographic change. In many countries, the trend toward lower fertility has been primarily the spontaneous by-product of social development, particularly educational advance. Government family planning programs have merely facilitated, and perhaps accelerated, a social change that has its own independent momentum.

Bangladesh is the single most clear-cut example of a society and a family planning program that does not fit the "development first" theory. Here, none of the preconditions for spontaneous fertility decline exist. Living standards remain extremely low; the vast majority of the population is illiterate; female participation in the labor force is negligible; the autonomy of women is severely curtailed by social restrictions on their mobility; and infant mortality is still in excess of 10 percent.

3.1 Impact of the Bangladesh Family Planning Program

3.1.1 Decrease in Fertility

Despite the above unfavorable circumstances, however, fertility has fallen from an average of over seven births per woman in 1975 to less than five births per woman in 1988, a decline of some 30 percent. Most of this drop has occurred since 1980. This short span coincides with a massive family planning effort by the GOB with assistance from foreign donors, including USAID. The change in fertility is almost totally attributable to the increased use of contraception which rose from less than 8 to nearly 33 percent between 1975 and 1989. (See Table 1). Moreover, the majority of users obtain their supplies and services from program sources.

Table 1

**Contraceptive Prevalence Rates
Bangladesh, 1975-1989**

Year	Source*	Prevalence Rate	Total Pop (mil)	MWRA (mil)	No. Using (mil)
1975	BFS	7.7 %	78.5	14.5	1.1
1979	CPS	12.7 %	85.6	15.8	2.0
1981	CPS	18.6 %	89.9	16.6	3.1
1983	CPS	21.7 %**	94.4	17.5	3.8
1986	CPS	29.8 %**	101.6	18.8	5.6
1989	BFS	31.0 %	108.8	20.1	6.2
1989	CPS	32.8 %**	108.8	20.1	6.6

* BFS-Bangladesh Fertility Survey; CPS-Contraceptive Prevalence Survey

** Working rate was obtained by interviewing male respondents about condom and vasectomy use.

The effect of other direct determinants of fertility has been minimal in Bangladesh. Although the mean age at marriage (which can have an impact on reducing fertility) increased from 16 to 18 years over the 14 years between the two fertility studies, the percent of married women of reproductive age (MWRA) who are widowed declined, thus cancelling out any impact the increased age of marriage may have had on the TFR. In addition, neither the prevalence nor the duration of breastfeeding, which is correlated with spacing and thus total fertility, changed over these 14 years.

The lack of socio-economic conditions favorable to fertility decline, the absence of any decline in fertility prior to the introduction of a family planning program, the timing of the decline in relation to the strength of the national family planning effort, and the dominant role of program supply sources strongly suggest that the USAID-supported program in Bangladesh has been the primary driving force behind the reduction in fertility. At the same time, it should be kept in mind that the deteriorating economic situation with its attendant increase in landlessness and urbanization as well as the concomitant push of both men and women into the wage labor force may also be playing a role in decreasing desired family size and increasing contraceptive use.

3.1.2 Decrease in Desired Number of Children

Several findings from the recent BFS provide a further indication that the Bangladesh family planning program is having an impact on fertility desires as well as on behavior. Between the two Bangladesh Fertility Surveys (1975 and 1989), desired family size decreased from 4.1 children to 2.9. During the same time span, the percent of all MWRA who reported already having more children than they desired increased from 11 to 23 percent.

In addition to this survey research, in-depth anthropological studies have shown consistently that Bangladesh couples do not want or need large families. Even though an appreciable proportion of births are unwelcome, there are severe obstacles to the expression of these preferences. Initially, these obstacles were lack of knowledge and an ambivalence towards the concept of fertility regulation, based partly on concerns that it was incompatible with religious beliefs. An effective government public information effort and media campaign has now made awareness of methods and supply sources almost universal and there is also evidence that religious opposition has waned. Recent research has demonstrated that poor access is now the key barrier.

3.1.3 Increased Service Provision Linked to Contraceptive Use

The limited mobility of Bangladesh women acts as a severe restraint on the exercise of reproductive choice. Because most methods are used by females, access to advice and services traditionally has implied travel by women to the nearest clinic. Such journeys require prior agreement by the husband and/or other senior family members and the woman must be accompanied by a companion to guarantee respectability. In the 1989 BFS, only 39 percent of married women said that they could visit a health center without being accompanied. Thus, what in other societies is a trivial undertaking becomes in Bangladesh a major exercise in persuasion and logistics. When these access costs are eliminated or reduced by bringing services to the community and to the doorstep, substantial and sustained increases in contraceptive use occur. In areas with highly accessible services, levels of contraceptive use of 50 percent or higher and fertility rates of about four births per woman have been recorded. This link between service provision and reproductive outcomes at the local area level proves beyond reasonable doubt that program factors have been the main cause of fertility decline in Bangladesh.

3.2 The USAID Contribution

3.2.1 Programmatic Initiatives

A number of factors may have had a bearing on the above demographic changes. Certainly the contraceptive prevalence rate could not have changed to the extent it has in the absence of programmatic efforts, one of the most important of which has been the contraceptive commodities themselves that have been provided almost exclusively by USAID over the past 15 years. Furthermore, technical assistance provided by USAID for the development of systems for managing these commodities has assured both workers and users of an uninterrupted supply. The expansion and extension of services through training, research, provision of equipment, and technical expertise have also played an important and perhaps critical role. Efforts in the area of information, education, and communication (IEC) about small family norms as well as about where and how to receive free or commercially available supplies (provided through the USAID-funded Social Marketing Project), have played an important role in motivating clients to seek and utilize family planning services.

3.2.2 Financial Support

USAID's contribution to program achievements has been very large, although it is impossible to quantify with any precision. Over the period 1976-1989, USAID has been the single largest contributor to program costs, accounting for about 50 percent of all disbursed foreign aid or approximately 40 percent of total expenditures, including GOB inputs. The USAID share of total costs was considerably higher prior to 1980 and has fallen gradually with the advent of large scale assistance from other donors, in particular the World Bank. In the financial year 1989-90, USAID's share of foreign assistance is estimated to be about 30 percent of total assistance to the Bangladesh program. This is equivalent to about 25 percent of total expenditures on population.

USAID's real contribution to the program is, however, greater than that implied by these proportionate expenditures. The strong commitment by USAID in the early years of the period under consideration, before any evidence of success, strengthened government resolve to curb population growth despite the realization that no quick and easy results would be achieved. USAID's example also encouraged other donors to enter this arena, particularly as the first signs of impact became evident in the 1980s.

It can also be demonstrated that skillful investment in the overall family planning program by USAID has exerted influence on contraceptive use and fertility that is disproportionately large in relation to dollar costs. In financial year 1989-90, USAID calculates that between 40 and 45 percent of all modern method use can be attributed to USAID inputs, compared to USAID expenditures that amount to 25 to 30 percent of total expenditure. One reason for the high relative cost-effectiveness is USAID's support of the Social Marketing Program and the NGO sector to which USAID provides 95 and 80 percent of total funding, respectively. These components of the program have been considered by some measures to be relatively more efficient than the government component, where USAID's share of funding is only 11 percent.

3.2.3 Intellectual and Research Leadership

The intellectual and research leadership provided by USAID has also been a critical program ingredient. USAID has sponsored much of the research that has guided the design, implementation, and management of the program. For instance, all the Contraceptive Prevalence Surveys undertaken since the Bangladesh program began, as well as the 1975 BFS, were funded by USAID. (The 1989 BFS was supported by the World Bank project.) The current shift in program emphasis towards bringing services nearer to communities and households is largely attributable to USAID-funded research findings by the Maternal and Child Health/Family Planning Project of the International Centre for Diarrheal Disease Research, Bangladesh (ICDDR,B) which has demonstrated that access barriers could best be overcome in this way. Similarly, the current reorganization of the workloads of female outreach workers, Family Welfare Assistants (FWA), and the adoption of couple registers resulted from the pilot work done by USAID-funded research activities.

3.2.4 Indirect Contributions of USAID's Overall Development Portfolio

In addition to direct, programmatic initiatives supported by USAID, several developmental variables may also have started playing a role, albeit a less direct one, in motivating the increased use of contraception in recent years. Because it appears that providing increased educational and economic opportunities for women may have a positive, albeit indirect, impact on increased contraceptive use, the USAID population program, as well as its broader development portfolio, has focused on the importance of involving women in all aspects of development in Bangladesh. This includes having had designated Women in Development staff in the Mission since 1975. In addition, the family planning program is a major employer of women in Bangladesh. Through the extensive work force of government and NGO female outreach workers, the program itself is also beginning to provide role models for the next generation of females throughout the rural and urban areas of the country.

3.3 Growing Involvement of Other Donors

For many years after Bangladesh's independence in 1971, USAID provided the majority of donor assistance and, in fact, was the sole donor in the population sector in the earliest years. Now, other donors have not only entered the program, but provide funding at levels above that of USAID. Indeed, in the future, USAID's intellectual leadership may be more important to the National Family Planning Program than the level of funding it provides to the effort.

USAID's leadership and long-term commitment to family planning along with its willingness to stay the course on an extremely complex and often controversial development issue has influenced donor policies and thinking in three critical areas:

- The need for patience in spite of disappointments; e.g., the targets set for population by the GOB frequently have been unmet because they were unrealistic.
- The importance of viewing family planning as a long-term development effort with persistently complex demographic and economic consequences in spite of what appears to be limited progress on reducing the growth rate. For instance, in 1985 when the growth rate was 2.5 percent, 2.5 million people were added to the population base of 101 million. By the year 2030, when the population growth rate is projected to have declined to 1.2 percent, an even larger absolute number -- 2.8 million people -- will be added to the even larger population base of 238 million projected for that year.
- The necessity to internalize within the national program components once supported with extensive donor funding and other technical assistance, such as the contraceptive supply and logistics system. (By the end of the next five years, for example, USAID and the GOB have planned that the latter will have assumed complete responsibility for the logistics system.)

USAID's assistance has also had an indirect impact on donors' ability to participate more fully in the Bangladesh national population program. For instance, USAID technical assistance in areas such as commodity forecasting, procurement, and training of field staff in proper storage, distribution, and record keeping has helped to strengthen the entire logistics system, thereby protecting multi-mission dollar contraceptive commodities investments from other donors. USAID IEC efforts have also provided a vital underpinning to key program elements supported by all donors, and innovative program delivery schemes have created a wide range of information on which other donors can rely in designing and supporting large-scale program expansion.

USAID has made a critical assessment of the course and direction of the national program and has taken several important steps to position certain elements of its past funding for conversion to more cost-effective support by other donors. These activities will have an impact both in the short run -- during the balance of the current Population and Health Services Project - - as well as into the new CDSS period. For example, much of USAID's very expensive investment in commodities is being handed over to other donors who can purchase the required commodities at lower prices on the world market. This is occurring at the same time that increasing demand for commodities is pushing this program component to an ever increasing share of the overall population budget.

USAID has demonstrated the effectiveness of working with NGOs as partners in the national effort. The British Overseas Development Administration (ODA) has now earmarked for work with NGOs a proportion (approximately \$5 million) of its support to the present World Bank project. This effort is a first for the ODA and, based on the success realized to date, ODA proposes to double the amount for NGOs in the next Bank project.

4. A Strategy for the Future

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4.1 Overall Considerations

The current levels of contraceptive use and the corresponding decline in the fertility rate in Bangladesh indicated by the two 1989 surveys are very impressive. These changes are especially remarkable given the relatively limited improvement (some would say there has been an actual decline) in most other economic and social indicators. In view of such favorable signs, the family planning program in Bangladesh has an optimistic future, but only if (1) the relatively fragile momentum in program growth displayed over the decade of the 1980s can be maintained through continued support to the appropriate elements of the national family planning effort, and (2) a positive political climate which supports the rational planning and program activities necessary to continue the gains made to date in this critical sector can be maintained. Potential short-term leveling of contraceptive use patterns, which are experienced in all large programs, can be anticipated. If this occurs, however, it should not deter continued funding since experience elsewhere indicates that such plateaus in CPR are temporary and usually can be reversed.

All of USAID's continuing and planned new efforts for family planning in Bangladesh are and should be designed with the specific intent of improving the management and cost-effective delivery of family planning services so that greater gains can be made in increasing contraceptive prevalence rates and reducing fertility rates. Coinciding with the development of USAID's CDSS, plans are being laid for the Fourth Five Year Plan of the Government of Bangladesh. The next World Bank Population Project is also in the formative stages. This fortunate juxtaposition in the timing of these three critical planning documents places USAID in an excellent position to assert the intellectual leadership for which it is known in the Bangladesh population community, to the benefit of all three plans and to the programs which result from each.

Alternative and complementary program approaches which may have an impact on reducing fertility, such as increasing female education, have been tested and otherwise assessed by USAID. Educational interventions are, of course, to be commended for their own merit. However, USAID/Dhaka has felt them to be too expensive and the payoff too far in the future to render them reasonable alternative approaches to family planning services for the purpose of rapid fertility reduction, which is the GOB's short-term objective. The members of the project review team were divided on this issue.

4.2 Assessment of the Potential Contributions of the GOB, SMP, and NGO Program Components

Just as USAID sees its contribution to population efforts in Bangladesh to be part of an overall development assistance package, it is vitally important that USAID reaffirm, at every opportunity, that it is not funding individual family planning activities or projects in Bangladesh for their own sake or in competition with other efforts, but rather as part of a well-coordinated, collaborative contribution to the national population program. Any references to the SMP, NGO, or private enterprise activities that also present these activities as doing better, more, or something different than the GOB instead of acknowledging their contributions to the national family planning effort may, in fact, undermine USAID's overall contribution to family planning in Bangladesh. The CDSS presentation should reflect this reality as should the next population project paper and all other documents presenting USAID's population efforts in Bangladesh.

This being said, using service statistics and other data provided by USAID, the project review team assessed the relative program contribution provided by the three program

components -- GOB, SMP, and NGO -- supported by USAID over the past eight years. This was done not so much to compare past performance as to assess future directions for each component. Table 2 indicates the relative couple years of protection (CYP) provided by each component. From a high of 71 percent in 1981, the GOB share dropped to 58 percent of total CYPs provided in the program by 1988. The NGO share rose from 11 percent to almost one-quarter of all CYPs during the same eight years, while the SMP began with an 18 percent share which fell to 13 percent at mid-decade and then rose again to 18 percent by 1988.

Table 2
Active Users/Couple Years of Protection
Attributable to Provider
1981-1985*
and
1986-1987**

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

- * Source: USAID Mission, Dhaka, Bangladesh. The reference table used couple years of protection as a proxy for active users hence the term in the title and heading of this table.
- ** From "Overall Market Share by CYP" produced by Program Review Team, February 1990.

A further breakdown of the CYPs for the three most recent years for which data are available into the most effective (sterilization, IUD, and injectables) and less effective¹ (pills and condoms) methods (see Table 3), however, shows that the GOB services provided between 78 and 82 percent of the most effective CYPs and 37 to 44 percent of the less effective CYPs, placing this program component far and away ahead of the other two components in overall programmatic impact. Thus, Bangladesh could be said to be following the normal pattern of a maturing national program in which private sector activities often lead the way in getting services started until such time as the government infrastructure is in place to provide the bulk of the services. These data also assist in determining future directions for the three major program components.

¹Effectiveness in this case is related to use-effectiveness rather than theoretical effectiveness.

Table 3

**Overall Market Share of CYPs by Program Component and Method
for the Bangladesh National Family Planning Program
1986-1988**

<u>MORE EFFECTIVE METHODS</u> (Sterilization, IUD, and Injectables)						
<u>Program Component</u>	<u>1986</u>		<u>1987</u>		<u>1988</u>	
	<u>CYPs ('000)</u>	<u>%</u>	<u>CYPs ('000)</u>	<u>%</u>	<u>CYPs ('000)</u>	<u>%</u>
GOB	2,624	78%	2,086	82%	1,869	80%
NGOs	723	22%	473	18%	468	20%
Total	3,347	100%	2,559	100%	2,337	100%
<u>LESS EFFECTIVE METHODS</u> (Orals and Condoms)						
<u>Program Component</u>	<u>1986</u>		<u>1987</u>		<u>1988</u>	
	<u>CYPs ('000)</u>	<u>%</u>	<u>CYPs ('000)</u>	<u>%</u>	<u>CYPs ('000)</u>	<u>%</u>
GOB	728	40%	901	44%	877	37%
NGOs	361	20%	524	25%	655	28%
SMP	733	40%	633	31%	839	35%
Total	1,822	100%	2,058	100%	2,371	100%

The data for this table come from actual commodities distributed to the various program components as recorded by the Logistics Management Information System (LMIS) for all methods except sterilization. LMIS data cover the months March through February of the reference year. Data for sterilization come from the GOB service statistics and cover the months July through June of the reference year. In the absence of better information, the market share of sterilizations attributed to NGOs is 25 percent of the total and the balance is attributed to the GOB.

Couple years of protection (CYP) are calculated using the USAID/Dhaka conversion factors as follows:

Oral contraceptives=13 cycles/CYP
Sterilization=7.75 CYPs/sterilization
Condoms=150 pieccs/CYP

IUDs=2.45 CYPs/IUD
Injectables=5.5 doses/CYP

Although a similar analysis, based on cost per CYP, would be useful, the financial data available were insufficient to perform such an analysis. Other studies, however, including information on earlier projects in Bangladesh, have demonstrated that, based on costs per CYP, social marketing and clinical services concentrated on sterilization are the two most cost-effective service delivery modes and community-based distribution of non-clinical methods is the least cost-effective (Huber and Harvey, 1989). USAID/Dhaka does plan to sponsor (with funding from the present population project) a critical cost analysis of the entire national family planning program to demonstrate, both to donors and the GOB, the impact of increased program success on program costs. It is hoped that this initial exercise will result in a co-funded effort to explore, test, and implement structural changes in the program to enhance overall cost-effectiveness.

4.2.1 GOB Activities

USAID has positioned itself to continue several important contributions to the efforts of the GOB in planning, managing, supporting, and evaluating implementation of family planning services. Plans are also well under way for institutionalization within the MOHFP of critical program elements over the next few years. Thus far, the GOB has designed a comprehensive system for the delivery of both clinical and non-clinical services; however, various elements of the system need further development and refinement to which USAID can make an important, and perhaps critical, contribution. A number of these contributions will require collaboration or assistance from the other components of the USAID support package to the national family planning effort.

Management and supervision. Management and supervision are critical aspects of GOB service delivery which need attention. General improvement of management at the central level (MOHFP) will be addressed through several efforts. For example, the USAID plan for the phased introduction of the new field-level record keeping system which was piloted by the USAID-funded Maternal Child Health-Family Planning (MCH-FP) Extension Project, if introduced as planned, could make a vast improvement in the collection and analysis of program-wide service statistics for use in better program management. This new system is based on contraceptive prevalence and continuation rather than on new acceptors and commodities as in the past. Another USAID objective, the training of upper- and mid-level managers, is to be partially addressed through the mission's Development Management Training Project. USAID is also committed to providing funding and technical assistance to move the GOB towards complete in-house management of the national system for contraceptive logistics. The experience of the SMP in nationwide distribution of commodities offers the possibility of complementing GOB efforts in this area, if additional assistance is required for distribution through the GOB system. USAID project support could also assist in improving management and supervision at the lower levels in the GOB family planning structure through utilizing the NGO capabilities developed in these areas over the past 10 years.

Clinical services. The clinical services provided by the GOB are slated for USAID assistance over the next five years in order to improve service quality, train clinicians, and move clinical services closer to the clients' doorstep. These commendable activities are critical to the continued expansion of the most effective contraceptive methods. One USAID-supported NGO, the Bangladesh Association for Voluntary Sterilization (BAVS), has provided training in sterilization to GOB clinical teams in the past. USAID should explore additional mechanisms to link NGO experience in clinical services with assistance to the GOB in fulfilling objectives in this area. Neither USAID's past contribution (through CARE) to improved clinical training for Family Welfare Visitors (FWV) nor the entire outreach training effort has been assessed to determine whether there are ways USAID can improve these activities. NGO expertise could also be tapped to assist in this effort.

Information, education, and communication. Since recent surveys document the very high level of knowledge about family planning, the GOB IEC effort does not warrant a great deal of additional support from USAID. However, male motivation activities and more specific information about methods and location of services could enhance acceptability and accessibility to services, and could be explored on a small scale.

Grassroots outreach and service provision. The present GOB system of grassroots outreach and service provision has several serious and long-recognized weaknesses. In particular, the supervision of FWAs (all of whom are women) by male workers (FPA) is very weak, and the basic male health workers (HA) are ineffective. These two areas require additional attention through technical assistance and perhaps additional funding during the next strategy period, especially as clinical services are extended into the community through satellite clinics.

4.2.2 SMP Activities

SMP activities should be accorded the highest priority because they represent one of the most cost-effective and sustainable ways in which the growing contraceptive use rates in Bangladesh can be served. Over the past several years, substantial progress has been made in the SMP, both in terms of its program impact in expanding the availability of reversible methods (condoms and pills) and, more recently, in graduating from a government-sponsored program to one registered under law as a private corporation. In January 1990, a new SMP Council was appointed composed completely of individuals from the private sector, including a chairman who is a former Minister of Agriculture.

Since 1984, the SMP has recovered an average of 9 percent of its total costs (including commodities) per annum. All commodities were provided by USAID as in-kind contributions and marketed through approximately 76,000 retail outlets and pharmacies. In order to ensure access to its products, SMP has sold its contraceptives at very low prices. SMP prices for oral contraceptives have not changed in eight years even though commercial pills, which compete with SMP pills, sell for Taka 20-31 while SMP pills sell for Taka 2-4.

The USAID decision to cease provision of condoms to the SMP by 1992 is appropriate. The SMP should be positioned by that time to move to lower world market prices for condom supplies (currently \$0.025 per condom) thus reducing the overall cost of the program. The World Bank's Population Project is slated to pick up condom purchases for the GOB as USAID phases out of this activity. It is uncertain if the SMP can avail itself of these World Bank supplied condoms as an in-kind contribution, however, because of its new private company status. The unit value of the A.I.D.-supplied condom is \$0.075, and SMP currently recovers less than \$0.01 on sales. Thus, if SMP has to purchase condoms from the World Bank at world market prices rather than receiving them free of charge from A.I.D. as at present, it will have to raise its prices considerably to the consumer.

During the next CDSS period, the SMP must establish itself as an organization that is moving towards a position as a fully independent company well on its way to self-sufficiency through some of the activities that are recommended in Section 5 of this report.

4.2.3 NGO Activities

USAID-supported NGOs, through a broad range of activities, play a vital role in the national family planning effort. USAID should continue to support these organizations; however, a reappraisal of their contribution is appropriate at this juncture. Specifically, the trend towards greater NGO involvement in routine community-based distribution (CBD) of non-clinical contraceptives should be gradually reduced. Instead, NGO activities should be more specialized and complementary to government-run services.

There are three main reasons for this proposed new direction. First, evidence cited by several individuals met during this assessment suggests that the advent of NGO CBD services into areas already served by GOB workers and vice versa generally results in a reduction or duplication, rather than an enhancement of government services. Second, the prospects for medium- and long-term sustainability of massive NGO involvement in routine service provision are not good. NGO involvement is and will continue to be almost totally dependent on foreign donor support. Third, the distinct advantage of NGOs -- namely their flexibility and potential for innovation -- is poorly exploited by asking them to provide services that, in essence, differ little from those offered by the GOB.

Section 5 of this report discusses the five areas in which NGOs, subject to cost and feasibility considerations, might play a more specialized role that would complement the mainstream government activities.

4.3 Required Levels of Future Donor Assistance

The funds allocated by the GOB to family planning and maternal and child health (MCH) for financial year 1989-1990 amount to about \$140 million. The relative shares are GOB - 25 percent; USAID - 25 percent, and other foreign donors - 50 percent. These funds support a program designed to serve about 20 million married women of reproductive age and about 22 million children under five years of age. Thus, the sum represents planned expenditures of \$3.40 per capita for this time period, if grossly divided.

Because of the integration of family planning and MCH, any attempt to separate family planning expenditures from MCH expenditures is bound to be arbitrary and is certainly beyond the scope of this review. However, the order of magnitude of current planned expenditures on family planning can be crudely estimated by assuming that 75 percent of total expenditures goes specifically to family planning rather than to MCH. In terms of annual expenditures per family planning user, the estimate is about \$20, based on survey findings that imply a total of 5.2 million users of modern methods in 1989. These per capita expenditures are in line with estimates from other countries.

In the next Five Year Plan period (1990-1995) the number of married women of reproductive age will increase from 21.2 to 24.9 million, a 17 percent increase. An increase in the CPR for modern methods from 25 percent in 1989 to 34 percent in 1995 -- an ambitious but nevertheless realizable goal -- implies that the absolute number of users will grow from 5.2 million in 1989 to 8.5 million by 1995 (an increase of 63 percent). A huge direct effect on the commodity bill is unavoidable, although the total bill will be partially mitigated by the planned transfer of some commodity costs to other donors who are free to purchase at lower prices on the world market and can thus reduce certain unit costs.

Assuming that the overall annual average expenditure per user (\$20) remains constant, the total cost of the family planning program will rise from its present level of about \$105 million to \$170 million by 1995. Of course, not all costs will increase in direct proportion to the number of contraceptive users. In addition, modest improvements in cost recovery can be made. The major components of the family planning budget, however, are the salary costs of service providers, construction and maintenance of health centers, and commodities. Merely to sustain the current ratios of staff and facilities to clientele implies increased expenditures over the period 1990-1995 that would not fall far short of \$170 million per year by 1995, even after allowing for greater cost recovery. Steps to improve the coverage of services would imply annual expenditures of above \$170 million by 1995.

A reduction in costs per user can be expected in the longer term. Currently, the program places a major emphasis on house-to-house visits for counseling and contraceptive supply. This approach is expensive but is required for two main reasons. First, acceptance of modern contraception by illiterate couples is still tentative. A great deal of counseling, reassurance, and follow-up is needed to assuage residual suspicions and fears. Second, the social restrictions on the mobility of women represents a serious access barrier that can best be overcome by domiciliary visits. These barriers are eroding, and there will be a point when demand for family planning services is largely self-sustaining and is not inhibited by the seclusion of women within their homesteads. Because this process of change is gradual, it is difficult to predict when it will be possible for the government to reduce per capita family planning expenditures without jeopardizing freedom of reproductive choice. Perhaps when use of modern contraception reaches about 50 percent, a certain degree of retrenchment should be considered.

This long-term perspective is largely irrelevant to the period 1990-1995. Over the next five years, there are no grounds for believing that the effort put into the delivery of family planning services can be reduced without damaging demographic prospects, or that program costs per user will fall. The implication is that family planning budgets should rise broadly in line with the increasing target population and planned increase in the number of clients. Any shortfall is likely to have an appreciable effect on the impact of the program, both from the viewpoint of family welfare and macro-economic progress.

5. Recommendations

5. Recommendations

Both the level of family planning funding proposed in the mission's Country Development Strategy Statement for the next five years and the percentage of that funding vis-a-vis the mission's total Development Assistance (DA) account are appropriate. In addition, the CDSS correctly reflects the transition in USAID's emphasis, both in terms of (a) a shift in the proportions of population funding provided directly to the MOHFP relative to funding levels provided to the NGOs and the SMP and the concomitant emphasis being given to institutionalization and self-sufficiency in certain aspects of the population program, and (b) placing relatively equal weight on ways to limit the absolute number of people consuming resources and on increasing the productivity of all consumers. Thus, the CDSS addresses the basic needs of an expanding population while maintaining its focus on the demographic consequences of an expanding population base. This is reflected in the levels of funding proposed for a range of project activities in economic development (51 percent), with the remainder of the DA account devoted to family planning (44 percent) and child survival/health (5 percent) activities.

USAID might also want to consider ways in which it can assist in facilitating the implementation of population activities that are funded by other donors but which complement USAID efforts. As stated in Section 2.2, the present World Bank Population Project has experienced disbursement delays in the project's funding. USAID has not encountered this problem in its funding of population efforts, perhaps because of the design of the USAID project and its limited requirements for counterpart local currency funding. However, because USAID has local currency funding available from PL 480 and Title III, USAID should review its policies with regard to the local currency generated from food resources to determine if a portion of these funds can be made available to the GOB as counterpart funding for those activities under the current World Bank project which are complementary to activities being funded by USAID. A successful policy dialogue in this area would lessen the impact on the GOB that the MOHFP appears to be receiving a smaller proportion of USAID population funds in the upcoming CDSS relative to the other population components (NGOs and SMP), and would enable USAID to leverage its food assistance funding to increase future World Bank fiscal inputs to the national population effort.

The following specific recommendations are made for USAID's current and future population and child survival activities in Bangladesh.

5.1 Government of Bangladesh

The following recommendations focus on the ways in which USAID can assist in the improvement and institutionalization of various aspects of the GOB's management of the national program and its service delivery activities.

5.1.1 Management

- The presently planned assistance for the phased introduction of the national field-level record keeping and service statistics system should be vigorously pursued and continued until this system is firmly in place.
- The GOB and USAID should take advantage of every opportunity to provide training and other support necessary to improve the management skills of the upper-level leadership in the MOHFP.
- The movement to institutionalize the family planning logistics management system is commendable and is an important part of the CDSS. The potential role for SMP

to assist as a subcontractor in the GOB commodity distribution system should be explored.

- The GOB interest in establishing an NGO Implementation Assistance Team to provide technical assistance to the MOHFP in each of the four geographic divisions of the country should be seized upon and the NGOs should be encouraged to accept this challenge with USAID support. Possible areas of assistance include practical, hands-on training (mentoring) in outreach techniques; development and use of workplans and schedules; staff supervision; and the use of the new data collection and record keeping system.

5.1.2 Clinical Services

- USAID plans for inputs to GOB clinical services are on target, and the intent to move these services closer to the community through satellite clinics is commendable. NGO expertise provided through the Implementation Assistance Teams referenced above or through other special arrangements, e.g., BAVS training of GOB clinicians on a tuition or contract basis, deserve further exploration.
- Training for FWVs and FWAs should be assessed for possible USAID technical inputs to improve the skills and performance of these two cadres.

5.1.3 Information, Education and Communication

- Additional USAID inputs to the GOB's IEC efforts are not warranted at this time except for possible exploration of additional ways to motivate males and educate clients about specific methods and direct them to service sites.

5.1.4 Community-Level Outreach and Services

- USAID and the other health and family planning donors should continue efforts to persuade the MOHFP to reappraise the role of the basic field-level male workers -- the FPAs and HAs -- before finalization of the Fourth Five Year Plan.
- Phased replacement of HAs by female equivalents should be speeded up and the possibility of placing the responsibility for supervision of FWAs with female FWVs instead of the male FPAs should be explored.

5.2 Social Marketing Project

The following recommendations for the SMP are made in light of the project's new private sector status. Some of these activities may already be in the planning stages, in which case they are strongly endorsed.

- The board and management of the SMP is encouraged to develop, as soon as possible, a five-year business plan to forecast costs and expenses of operations. The plan should include exploration of the following:
 - percentage of cost recovery if commodities are supplied in-kind by the World Bank,
 - cost recovery if commodities are purchased at world market prices, and

- estimates of cost recovery, in either case, if retail prices are increased from present levels by factors of 25 percent, 50 percent, etc.

In addition, the SMP should carry out the following activities as soon as possible, with guidance from the new board and with technical assistance funded by USAID if required:

- Conduct improved market research at point of purchase to determine use patterns and customers' knowledge of effective use of purchased condoms and pills.
- Determine price sensitivity to condom and pill products.
- Determine the feasibility of increasing product lines, both condom and pill commodities and value-added, health-related products to promote retail sales, e.g., soap and water purification tablets. Some of the new products could be sold at a profit to improve overall cost-recovery while others could be subsidized because of their public health value.
- Reexamine carefully the potential for the planned Community-Based Sales as a new SMP activity. In the next five years, SMP may not be able to afford the costs and risks of this new venture and its implementation may constrain SMP from its central mission of responding to the existing demand through retail outlets.
- Enlist NGOs as retail outlets on a formal basis, both to extend coverage and to permit easier research on client compliance.
- Determine whether SMP can be a contractor for the GOB's logistics system, and, if so, how this should be done.
- Examine the SMP's potential to orient GOB FWAs to the concept and the products of the SMP. This group can be an important link to ensure continuation through the use of SMP products if GOB stock-outs occur and clients can also be educated about the availability of alternative sources of supply.
- Since SMP motivational films now reach 11 million people per year, examine ways SMP can participate in the GOB's IEC efforts, especially as a subcontractor.
- Establish planning mechanisms to move SMP away from its dependency on USAID and towards multi-donor support. In addition to the recommendation noted above, explore the expansion of product lines from contraceptives only to other commercial products.

5.3 Non-Governmental Organizations

Although NGOs have made an important contribution to the overall national family planning effort in Bangladesh, the time has come for retrenchment and consideration of alternative roles for this group of program participants. The following recommendations are made to assist in this exercise.

- USAID and the NGOs should consider, in collaboration with the GOB, reassigning NGOs wishing to continue in CBD activities to those geographic areas that are very poorly served by the GOB. This would represent a marked change of emphasis from the existing situation in which NGO CBD activities seem to be largely concentrated in high use, well-served areas.

- In keeping with the GOB's interest in establishing NGO Implementation Assistance Teams, the NGOs together with the GOB and USAID should explore ways in which the NGOs could provide inputs to strengthen mid-level management and supervision of GOB services, a major weakness of the GOB-run services and one in which the NGOs have demonstrated considerable expertise.
- NGOs have considerable skills and could assist the GOB in various aspects of training. This direction represents a continuation of the training role that NGOs have already assumed; however, NGOs should be established as commercial subcontractors to the government in carrying out this recommendation, e.g., NGOs should charge tuition for training GOB employees or for providing other services to the GOB.
- NGOs are already active in attempts to engage the involvement of special groups, e.g., religious leaders and local government officials, in the promotion of family planning. These community involvement efforts of NGOs should continue because the imagination and flexibility they require are most likely to be found in the NGO sector.
- Lastly, NGOs should be encouraged to continue their involvement in high risk and innovative activities -- the unique potential of NGOs is obvious in this area.

Appendices

Appendix A
Scope of Work

Appendix A

Scope of Work

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INCOMING TELEGRAM

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ACTION A10-00

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WITH PAM JOHNSON. THESE, ALONG WITH DOCUMENTS SENT EARLIER FOR THE AWE/TR/HPM BRIEFING BOOK, SHOULD PROVIDE A BEGINNING FOR YOU AND OTHER TEAM MEMBERS.

ACTION OFFICE ANTR-06
INFO ANSA-03 PPDC-01 ANMS-01 OMB-02 SAST-01 POPR-01 PPPB-02
GC-01 GCAM-02 FVA-01 ANPO-05 ES-01 PRE-06 STHE-03 STPO-01
POP-04 MNS-09 RELO-01 AMAD-01 /052 AB

I ALSO RECOMMEND THAT THE TEAM PLAN ON SPENDING SOME TIME IN THE FIELD AFTER INITIAL BRIEFINGS AND MEETINGS WITH OTHER KEY DONORS IN ORDER TO GAIN FIRST HAND EXPERIENCE OF THE FAMILY PLANNING PROGRAM IN BANGLADESH. WE CAN EASILY ARRANGE 2 OR 3 DAYS IN THE FIELD TO VIEW THE PROGRAM AND ITS VARIOUS COMPONENTS.

INFO LOG-00 AMAD-01 OES-09 /010 V
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PLEASE LET ME KNOW YOUR RESPONSE TO OUR COMMENTS ON THE SOV SO THAT WE CAN BEGIN TO PREPARE RELEVANT MATERIALS. WE WILL ALSO BEGIN TO ARRANGE A TENTATIVE SCHEDULE, WHICH CAN BE FIRMED UP ONCE YOU NOTIFY US OF THE TEAM COMPOSITION AND DATES OF YOUR TDY IN BANGLADESH. PLEASE CONVEY THE FINAL SOV, TEAM MEMBERS, DURATION OF TEAM VISIT, AND ETA VIA CABLE.

R 091006Z JAN 90
FM AMEMBASSY DHAKA
TO SECSTATE WASHDC 9279

WE LOOK FORWARD TO YOUR VISIT.

UNCLAS DHAKA 00228

SINCERELY,

AIDAC

GARY COOK
DIRECTOR
OFFICE OF POPULATION AND HEALTH
USAID/DHAKA

FOR AWE/TR

E. O. 12356: N/A

SUBJECT: POPULATION - MORRIS TEAM REVIEW OF BANGLADESH POPULATION PROGRAM

REF: A) COOK/JORDAN TELCON DN 1/6/90; B) AID LETTER NO. 2079 SENT BY FAX ON 12/27/89 TO JERRY MORRIS

1. AS DISCUSSED IN REF A, THE FOLLOWING ARE THE CONTENTS OF REF B. QUOTE:

DECEMBER 27, 1989

MR. JERRY MORRIS
AWE/TR/HPM
RM. 4720 NS
AID
DEPT. OF STATE
WASH. D.C. 20523

DECEMBER 27, 1989
USAID/DHAKA

BANGLADESH FAMILY PLANNING PROGRAM REVIEW
SCOPE OF WORK (DRAFT)

FAX (202) 647-6962

DEAR JERRY:

OBJECTIVES

- 1. ASSESS THE IMPACT OF THE NATIONAL FAMILY PLANNING PROGRAM ON FERTILITY OVER THE LAST 15 YEARS, AND, TO THE EXTENT POSSIBLE, ASSESS THE RELATIVE IMPORTANCE OF USAID'S CONTRIBUTION TO THIS EFFORT.
2. ASSESS USAID'S PROPOSED POPULATION SECTOR STRATEGY FOR THE COMING COSS PERIOD AND THE PROBABILITY THAT IT WILL HAVE A POSITIVE IMPACT ON CONTRACEPTIVE PREVALENCE AND FERTILITY. AREAS OF EXAMINATION INCLUDE:
- BROAD STRATEGIC FOCUS
- LEVELS OF INVESTMENT RELATIVE TO STRATEGY
- ALTERNATIVE AND OR COMPLEMENTARY PROGRAM APPROACHES TO BRING ABOUT REDUCED FERTILITY, IE: FEMALE EDUCATION, EMPLOYMENT, CHILD SURVIVAL, ETC.

THANK YOU FOR YOUR DECEMBER 15TH FAX AND DRAFT SOV FOR THE BANGLADESH FAMILY PLANNING PROGRAM REVIEW. MY STAFF AND I HAVE REVIEWED THE SOV AND WOULD LIKE TO SUGGEST SOME MODIFICATIONS WHICH WE THINK WILL MAKE IT EASIER TO GET AT THE REVIEW'S MAJOR OBJECTIVES WITH THE LIMITED TIME (TWO TO THREE WEEKS) WE UNDERSTAND TO BE AVAILABLE. WORKING FROM THE DRAFT SOV, WE FIND THE QUESTIONS CAN BE GROUPED INTO FOUR MAJOR AREAS OF INQUIRY:

THE FOLLOWING ARE THE MAJOR AREAS OF INQUIRY IN ORDER TO ADDRESS THE REVIEW OBJECTIVES:

- 1. BANGLADESH POPULATION PROGRAM IMPACT/USAID CONTRIBUTION
2. FUNDING LEVELS/SUSTAINABILITY
3. DONOR INTERFACE
4. PROGRAM DELIVERY MODES

- 1. POPULATION PROGRAM IMPACT/USAID CONTRIBUTION
A. EXAMINE THE CURRENT DEMOGRAPHIC SITUATION IN BANGLADESH INCLUDING TRENDS IN DESIRED FAMILY SIZE, FERTILITY, AGE OF MARRIAGE AND CONTRACEPTIVE USE; AND DETERMINE WHICH PROGRAM FACTORS CONTRIBUTED TO THESE TRENDS.
B. ESTIMATE CURRENT LEVEL OF DEMAND FOR CONTRACEPTION IN BANGLADESH (RURAL AND URBAN) AND FUTURE TRENDS RELATIVE TO

WE HAVE TRIED TO MAINTAIN THE OVERALL INTEGRITY OF THE QUESTIONS IN THE ATTACHED REVISION. IF YOU FIND THAT THERE ARE CONCERNS OR ISSUES NOT ENCOMPASSED, PLEASE LET US KNOW. WE DO THINK THAT, EVEN AS CONSOLIDATED, THIS IS AN EXTREMELY AMBITIOUS SCOPE. AFTER ARRIVAL IN DHAKA THE TEAM MAY WANT TO FURTHER RE-ASSESS AND PRIORITIZE THE AREAS OF INQUIRY.

FOR ALL OF THE QUESTIONS POSED IN THE ATTACHED SOV, THE MISSION WILL PREPARE RELEVANT BRIEFING MATERIALS TO EXPEDITE THE TEAM'S REVIEW. BY NOW I HOPE YOU HAVE RECEIVED THE BRIEFING MATERIALS WE SENT BACK

Handwritten mark/signature

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INCOMING
TELEGRAM

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- COVERAGE LEVELS AND THE PROGRAM POTENTIAL TO
- RESPOND TO HIGHER DEMAND.

C. DETERMINE CRITICAL NATIONAL PROGRAM INPUTS,
AND SPECIFICALLY USAID INPUTS, ESSENTIAL TO
CONTINUED SUCCESS OF THE FAMILY PLANNING
EFFORT IN BANGLADESH.

2. FUNDING LEVELS/SUSTAINABILITY

- A. CONDUCT RETROSPECTIVE REVIEW OF USAID
- FUNDING LEVELS AND INPUTS IN THE POPULATION
- SECTOR OVER THE LAST TEN YEARS, AND ANALYZE
- FERTILITY DECREASE DURING THE SAME TIME
- PERIOD.

- B. EXAMINE THE PROPOSED LEVEL OF USAID
- INVESTMENT IN THE POPULATION SECTOR FOR THE
- NEXT COSS PERIOD RELATIVE TO THE TOTAL CONDOM
- EFFORT NEEDED TO SUSTAIN FERTILITY DECLINE,
- INCLUDING CALCULATION OF PROJECTED
- INCREASED INVESTMENTS FROM OTHER DONORS.

- C. DETERMINE PROBABLE PROGRAM IMPACT IN TERMS
- OF CPR AND TFR THROUGH 1995 BASED ON THREE
- SCENARIOS: 1) CONSTANT DONOR INPUTS;
- 2) INCREASED INPUTS (CORRESPONDING TO
- INCREASED POPULATION AND HIGHER DEMAND);
- AND, 3) DECREASED INPUTS.

- D. REVIEW GOVERNMENT REVENUE AND DEVELOPMENT
- BUDGETS FOR ALL MAJOR SECTORS, DETERMINE
- GOVERNMENT PER CAPITA EXPENDITURES FOR THE
- POPULATION SECTOR AND A BREAKDOWN OF
- GOVERNMENT/DONOR SUPPORT FOR THE POPULATION
- SECTOR. DETERMINE IF, AND BY WHAT MEANS,
- THE BANGLADESH GOVERNMENT COULD TAKE A
- GREATER FISCAL RESPONSIBILITY IN THE FAMILY
- PLANNING PROGRAM.

- E. EXAMINE CURRENT AND PLANNED MISSION EFFORTS
- IN PROMOTING COST-RECOVERY AND
- SUSTAINABILITY OF ITS FP PROGRAM. IS THERE
- MORE THAT CAN BE DONE, AND WHAT?

3. DONOR INTERFACE

- A. REVIEW MAJOR DONOR CONTRIBUTIONS TO THE
- POPULATION SECTOR INCLUDING THE WORLD BANK,
- UNFPA, FEDERAL REPUBLIC OF GERMANY, AND CIDA
TO DETERMINE THEIR COMPLEMENTARITY AND
INTERFACE WITH USAID SUPPORT; AREAS OF
OVERLAP OR NON-COMPLEMENTARITY TO USAID
EFFORT.

4. PROGRAM DELIVERY MODES

- A. EXAMINE CURRENT AND PLANNED USAID PROGRAM
- MIX AND SUPPORT THROUGH 1995 IN THE THREE
- AREAS OF THE GOVERNMENT PROGRAM, NGOS AND
- SOCIAL MARKETING. HOW WELL DOES EACH
- COMPONENT AND THE OVERALL PROPOSED MIX
- ADDRESS IMPACT AND SUSTAINABILITY?

- B. EXAMINE THE PROGRAM'S EFFECTIVENESS IN
- STIMULATING DEMAND FOR FAMILY PLANNING,
- DIFFERENTIATING AMONG PROGRAM MODALITIES
- SUCH AS FACE-TO-FACE FIELD WORKER VISITS,
- SOCIAL MARKETING, AND MASS MEDIA/
- COMMUNICATION EFFORTS.

- C. EXAMINE CURRENT AND PLANNED INVESTMENTS (BY
- USAID AND OTHERS) OUTSIDE THE POPULATION
- SECTOR WHICH HAVE THE POTENTIAL TO IMPACT ON
- FERTILITY, EG, FEMALE EMPLOYMENT, EDUCATION,
- CHILD SURVIVAL ETC. ASSESS THE LIKELY
- DEMOGRAPHIC IMPACT OF THESE AREAS,
- DIFFERENTIATING BETWEEN SHORT AND LONGER
- TERM EFFECTS AND IDENTIFYING THE EXTENT TO
- WHICH THEIR IMPACT IS DEPENDENT ON OR
- INDEPENDENT OF ACCESS TO FAMILY PLANNING
- SERVICES.

REVIEW OUTCOME: RECOMMENDED FUTURE PROGRAM TRENDS

BASED ON THE REVIEW OUTLINED ABOVE COMMENT ON USAID'S
OVERALL STRATEGY FOR PROMOTING FERTILITY REDUCTION,
AND PROPOSED AREAS OF EMPHASIS RELATIVE TO AVAILABLE
RESOURCES, USAID'S AREAS OF COMPARATIVE ADVANTAGE,
AND OTHER ANTICIPATED DONOR AND GOVERNMENT
RESOURCES. THE TEAM IS ALSO REQUESTED TO COMMENT ON
THE PROPOSED SOW FOR THE CURRENT PROJECT'S MID-TERM
EVALUATION: THE EXTENT TO WHICH IT COVERS AREAS
NEEDING MORE IN DEPTH REVIEW, AND ITS UTILITY AS
GUIDANCE IN DEVELOPMENT OF A FOLLOW ON ACTIVITY.
UNQUOTE.

2. PER REF A TELCON, WE UNDERSTAND THAT MORRIS AND
SALLY CRAIG-HUBER ARE ARRIVING DHAKA JANUARY 22 FOR A
3 WEEK STAY THROUGH FEBRUARY 12, 1990. PLEASE
CONFIRM ETAS SOONEST BY CABLE AND PROVIDE RESPONSE TO
ABOVE SOW SO THAT MISSION MAY PREPARE RELEVANT
BRIEFING MATERIALS AND DEVELOP TEAM SCHEDULE.

3. MISSION NOTIFIED BY JOHN CLELAND THAT HE PLANS TO
ARRIVE EARLY FEBRUARY 4 TO JOIN TEAM UP TO FEBRUARY
11. SHOULD YOU NEED ANY FURTHER CLARIFICATION ON
CLELAND COMMITMENT OR ETA, SUGGEST ANE/TR CONTACT
POPTech TO FIND OUT MANILA CONTACT FOR CLELAND SINCE
HE IS PRESENTLY IN THE PHILIPPINES.

4. PER DHAKA'S 0058 IT IS IMPORTANT FOR TEAM TO
LEAVE BEHIND A DRAFT VERSION OF THEIR FINDINGS FOR
THE MISSION TO WORK WITH TO MEET OUR COSS REVIEW
SCHEDULE. PLEASE CONFIRM THAT THIS IS ACCEPTABLE.
DE PREE

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Appendix B

List of Persons Contacted

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U.S. Ambassador to Bangladesh	Willard A. DePree
USAID/Dhaka	Priscilla Boughton Malcolm Purvis Frank Young Gary Cook Jenny Sewell Dana Vogel Sheryl Keller Brenda Doe Jatindar Cheema Ann Larson Katie McDonald
World Bank	S.K. Sudakar
UNFPA	Jay Parsons
Overseas Development Administration (UK)	Fiona DUBY
Social Marketing Project	Phil Hughes Shahadat Ahmad Waliur Rahman Ghulam Sarwar Khan Shamsuzzaman Khan Mohammad Anwar Amjad Ali
Concerned Women for Family Planning	Mufeweza Khan Dr. Neelima Ibrahim Fatima Mobin
Family Planning Services and Training Center (Sobhanbagh Mohila Club)	Abdur Rouf and staff
Bangladesh Association for Voluntary Sterilization	Dr. Sultana Begum and staff
Association for Voluntary Surgical Contraception (Dhaka Office)	P.E. Balakrishnan Dr. Penny Satterthwaite Ahmed Al-Kabir
Pathfinder Fund	Dr. Mohammed Alauddin
ICDDR,B	Dr. Mike Koenig and staff at Matlab field station
Kaliaganj Upazila	Health complex and assorted field staff
Associates for Community and Population Research	Ghulam Mustafa Kamal

Appendix C

List of Documents Consulted

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