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**FAMILY PLANNING CHALLENGES AND RESEARCH
PRIORITIES FOR THE 1990s**

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(Panel Session at the Second Annual Scientific Conference of the International Centre for Diarrhoeal Disease Research, Bangladesh, 17 January 1993)

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FAMILY PLANNING PROGRAM PRIORITIES IN THE 1990s

Second Annual Scientific Conference of ICDDR,B
January 17, 1993

A.K.M. Rafiquzzaman
Director General
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1. INTRODUCTION

Mr. Chairman, Ladies and Gentlemen:

It is a pleasure to speak at the ICDDR,B annual conference, especially since the Ministry of Health and Family Welfare and the Directorate of Family Planning have had very close association with the ICDDR,B in the field of family planning policy and program implementation. Since the early 1980s, we have been collaborating in joint endeavors to evolve appropriate policies and program strategies. I have personally been associated with some of the major policy initiatives in the past which have received research support from the ICDDR,B. The nationwide recruitment of 10,000 Family Welfare Assistants (FWA) and the introduction of the FWA Register have been accomplished in close collaboration with, and support from, the ICDDR,B. This collaboration is further continuing in the design of the National MIS training and the phase-wise expansion of the door-step delivery of injectable contraceptives. The present conference provides one more opportunity for us to work together to develop new ideas both for the program leaders and for the researchers at the ICDDR,B. I am, therefore, happy to participate in this conference.

I understand that the main purpose of this conference is to develop a constructive dialogue between policy makers and researchers. In that spirit, I will try to summarize briefly some of the program and policy issues and also suggest new areas which would require support from the research community.

2. PROGRAM HISTORY AND ACHIEVEMENTS:

The Family Planning program was initiated in the Pakistan period, but got off the ground only after 1975. However, it may help to look at various phases through which the program have evolved over the years.

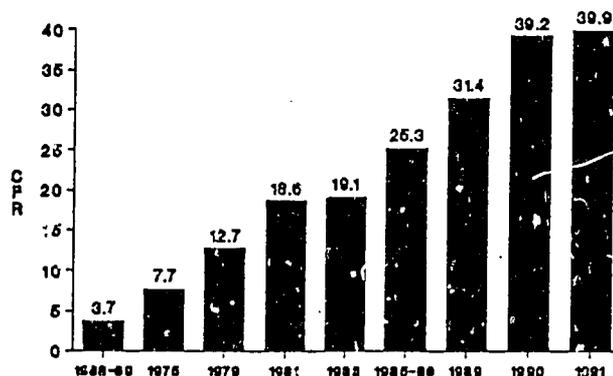
Phase I	:	1953-1965	- Voluntary and semi-government effort.
Phase II	:	1965-1971	- Field based government family planning program.
Phase III	:	1972-1974	- Integrated Health & Family Program.
Phase IV	:	1975-1980	- MCH-based multisectoral Program.

Phase V : 1980-1985 - Functionally Integrated Program.
 Phase VI : 1985-1990 - Intensive Family Planning Program.

Two of the major achievements of the program have been a rapid increase in the coverage of services through systematic expansion of the infrastructure and the steady increase in the contraceptive prevalence rate.

The Contraceptive Prevalence Rate (CPR) has increased from 3.7 percent of married women of reproductive age in 1968-1969 to 39.9 in 1991.

Contraceptive Prevalence Rate
in Bangladesh



Source: NIS 1980, BFS, 1975, 1989, CPS, 1979, 1981, 1982, 1985, 1989

The steady rise in contraceptive use has also impacted on the total fertility rate which was one of the highest (7) in the world in mid 1970's. It came down to 4.9 in 1989 and is estimated to be around 4.5 in 1991. The contraceptive acceptance (CAR) based on FWA registers in November 1992 is around 57%, and CPR is estimated around 45%, which is definitely a high level performance in the context of so many organizational inadequacies and unfavorable socio-economic conditions. Bangladesh is now widely recognized as a successful case of family planning achievements in a very poor/weak social setting characterized by high illiteracy, low women's status, and poor economic conditions.

In a recent study conducted by Mauldin and Ross (1992), the authors compared 88 developing countries on the strength of family planning program effort between 1982 and 1989, and found that Bangladesh is the only country which ranked strong in family planning program efforts with low socio-economic settings. This has been possible because of the systematic program effort to build the organizational strength from the national level down to the grass root level:

- The National Population Council, headed by the Honorable Prime Minister, is the highest policy formulating body.
- The Ministry of Health and Family Welfare is responsible for formulating and executing policies and providing overall administrative guidance.
- The Directorate of Family Planning headed by the Director-General, is responsible for implementing the MCH-based Family Planning Programme throughout the country.
- The operational units working under the Director-General and national headquarter are: Administration; Information, Education and Motivation (IEM); MCH; Clinical Services; Audit; Finance; Planning; Logistic and Supply; and Management Information System (MIS), each headed by a Director.
- There are four Divisional Offices, each headed by a Director; 64 District Offices, each headed by one Deputy Director; 464 Thana Offices headed by Thana Family Planning Officers/Medical Officers (MCH-FP) assisted by Assistant Family Planning Officers and Sr. Family Welfare Visitors and, these operate under overall control of the Director General. There are MCH-FP coordination committees at all levels to supervise the activities.
- At the field level there is one Family Planning Inspector (FPI) in each union and one Family Welfare Assistant (FWA) in each unit having a population about 4,000-5,000.
- To impart training and conduct research, a separate organization named The National Institute of Population Research and Training (NIPORT) was established in 1979. This institute provides training at the national headquarters and through Regional Training Centers (RTC) and Family Welfare Visitors Training Institutes (FWVTI).

Service Outlets

A wide range of service outlets have been established throughout the country to deliver services.

National Level:

- Azimpur Maternity and Child Health Training Institute, Dhaka.
- Mohammadpur Fertility Services and Training Centre, Dhaka.
- Two Model Clinics attached to two Medical College Hospitals.

District Level

- 6 Model Clinics attached to Medical College Hospitals.
- MCH-FP Clinics at district hospitals.
- Mother & Child Welfare Centres (MCWC).

Union Level

- Family Welfare Centres (FWC).
- Rural Dispensaries (RD).
- Mother & Child Welfare Centres.

Ward/Unit Level

The Family Welfare Assistants (FWA) through home visits motivate mothers for MCH-FP services and supply primary health care services. The Family Planning Inspectors (FPI) at union level supervise the activities of FWAs at the ward/unit level.

Satellite Clinic

Satellite Clinics, twice a week, are being organized by Family Welfare Visitors (FWV) from each Family Welfare Centre to bring family planning and MCH services to the door-steps of the people. Similarly, Medical Assistants organize Satellite Clinics for health education. The Satellite Clinic program has been proved to be very effective in providing services at the grass root level.

The Maternal and Child Health (MCH) based family planning program of Bangladesh encourages the emergence of the welfare-oriented family through adoption of small family norms. The MCH program has been given top priority in this context. For accelerating the process of building welfare-oriented families, seven additional components (beyond family planning) have been added to the main family planning service. This has been termed "Family Planning Plus" in 1992.

Major Family Planning Services:

- (a) Vasectomy
- (b) Tubectomy
- (c) Condom
- (d) Oral Pill
- (e) Injectable
- (f) IUD
- (g) Norplant

Family Planning Plus Interventions:

- (a) Safe delivery
- (b) Immunization for mother and children
- (c) ORT for control of diarrhoeal diseases
- (d) Nutrition (Distribution of Vitamin-A Capsule)
- (e) Literacy program for mothers
- (f) Construction of sanitary latrines
- (g) Tree plantation

Measures taken to improve quality of services and performance in 1992:

1. Filling up vacant posts of FWA and FWV.
2. Promotion and regularization of high level positions.
3. Fixed schedule of satellite clinics on Monday.
4. Compulsory supervision of work of field workers and service centers by district and Thana level supervisors at the field level on every monday.
5. Motivational meeting and education for illiterate mothers on Saturday.
6. EPI service at the FWC every Tuesday.
7. Meeting of DDs every two months at STET divisional headquarters.
8. GOB and NGO co-ordination meeting with DG (once in every 3 months).
9. Local Initiatives Program (LIP), Shwanirvar and Depot Holder program to involve local volunteers and community leaders.
10. Decentralization of IEC activities to Thana level.
11. Strengthening of Divisional office with one A.D. and Project Officer (TBA).
12. Utilization of MCWC as Training Centre for Sterilization and Norplant.
13. Service Charge by NGOs for contraceptives.
14. Provision of funds and medicine for satellite clinics.
15. Rewards and allowances for depot-holders and unit leader of female VDP.

16. Introduction of rewards and punishments since the year 1991-92.
17. FWV brought under review budget (Phase-wise)
18. Sr. FWV made self-drawing officer
19. National supervisor's visit to low-performing Thanas/Districts
20. Every Sunday, a radio talk by DG-FP for communicating with the field functionaries and community leaders on different issues of MCH-FP program.
21. Introduction of village block family planning committee.
22. Orientation of Union Parishad chairman on family planning in low performing districts.

3. ASSESSMENT AND ISSUES FOR THE FUTURE:

We have achieved considerable progress in developing the organizational structure and service in Bangladesh. This has resulted in substantial gains in contraceptive prevalence. We have also strengthened management through training, development of new supervisory cadres, provision of adequate transport allowance to grass-roots level female workers, and innovative management development efforts such as the MDU and LIP. The nationwide implementation of FWA registers and the reporting system is another strategy for management strengthening. Thus basic infra-structure in terms of service facilities and management structure is now well developed. The main challenge in the next decade is to improve quality of services, improve productivity of workers and supervisors, and continue to seek innovative strategies for the low performing areas such as the Chittagong Division and underserved populations such as the younger age group. I would suggest the following areas for further research and policy development in Bangladesh.

- 3.1 How to increase coverage in underserved areas? I understand that the ICDDR,B has conducted a diagnostic study in Chittagong Division. The results of this study should be quickly disseminated, and a national workshop should be held to evolve a divisional level strategy.
- 3.2 How to reach underserved groups of clients such as young couples and males? For long we have focussed mainly on the woman clients. The males have been neglected. We need innovative strategies to reach males and make them an equal partner in this effort.
- 3.3 How to rehabilitate some of the long-term methods such as sterilization and the IUD? (AVSC, 1992). However, there is

need for small scale field research to try out some of the ideas suggested by the AVSC mission.

- 3.4 How to improve the quality of services? This question is closely linked with the previous issues, as one of the major reasons for the fall in the IUD program has been the fear of side-effects and the poor quality of counselling and technical services. The role of the Family Planning Clinical Services Team (FPCST) is being expanded to include quality assurance and training. Close collaboration is needed between FPCST and research institutions such as the ICDDR,B to develop and test quality standards; and more importantly, to find ways of institutionalizing quality, monitoring and supervision in the system.
- 3.5 How to make the role of the FWA more effective? FWAs are increasingly being assigned new roles in MCH, Health, Nutrition and Welfare programs. Ideas such as Family Planning - Plus and EPI - Plus need to be tested on small scale to see what impact the expanded role of the FWA will have on the performance of the program. There is also a need to clarify what roles in MCH the FWA can play? Are the current role assignments useful? I understand that one of the scientific sessions is going to discuss the prospects and limitations of screening for high-risk pregnancy. We will look forward to their conclusions and recommendations.
- 3.6 How can we fully and effectively utilize the front-line supervisors, especially the FPIs, Sr.FWVs, AFPOs, MO(MCH) and TFPOs? How can we establish accountability for supervisory performances? The FPI Diary field tested in the Extension Project areas is one promising strategy. However, we need more studies of FPIs, Sr. FWV, AFPO, MO(MCH-FP) and TFPO to improve their effectiveness.
- 3.7 How can we utilize and improve the condition of households where satellite clinics are being held and how can we encourage the house owner?
- 3.8 In the MIS field, we have achieved substantial progress but still have much to be done. Some of the future tasks are:
 - Development of feedback system
 - Training of supervisors in performance planning and assessment.
 - Developing methods to assess validity of reported data
 - Development of indicators for both FP and MCH services beyond the CPR.
 - Integration of the performance and logistics data in MIS reporting.
 - Design of methods to set more realistic targets and also to set quality of services targets.

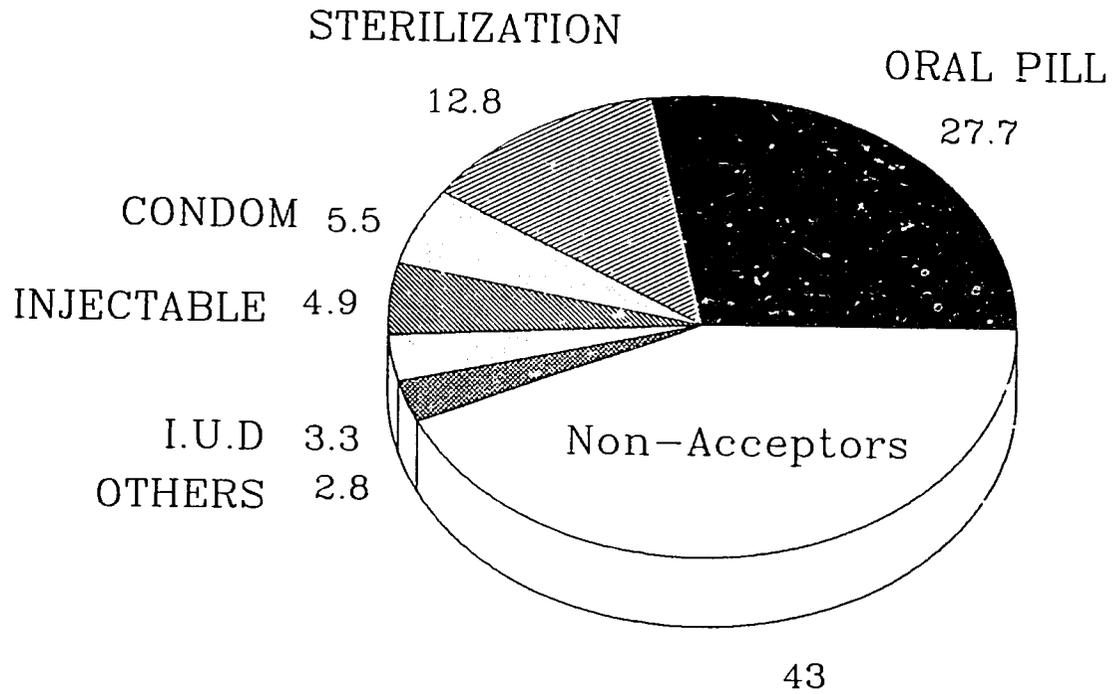
- Utilization of data on birth and death in FWA Register.
 - Uniform record book for both GOB and NGO workers.
 - Linking of MIS data with supervision.
- 3.9 Ways to improve collaboration and synergy between the GOB and the NGOs.
- 3.10 While we have done a lot in developing mass media strategies for IEC, we have not done enough to strengthen the grass-roots level organization of IEC activities. For example, we have one mobile film van per Division. Now this is not adequate. Also, there are no personnel at the Thana level specifically trained and exclusively responsible for planning and evaluating IEC activities. We need to look into this.
- 3.11 How to ease and increase mobility of field workers (provision of Bicycles, motorcycles).
- 3.12 Reorganization of the Directorate of Family Planning to deal effectively with multiple projects, 1,067 NGOs, multisectoral agencies and Donors.
- 3.13 Decentralization of powers and functions between the Ministry and the Directorate and between the Directorate and the field.

I think these are the major issues which we would face in the next decade. Of course, the historical issue of functional integration between health and family planning still remains unresolved.

The experiences of Indonesia, China, Thailand, and Srilanka may be utilized to resolve the issue over time. But experience in many countries dictates that after achieving CPR over 40 percent there is a need to have well coordinated multisectoral approach supported by strong political commitment (which we have), community participation, and proper accountability (which is poor) at all levels.

While we have to aim at resolving these big issues, I believe, in the next five years we should concentrate on consolidating the gains and building on the success so far achieved. We should not adopt any policy which would cause a setback to the program at this stage. We are poised for a new era of exciting development. Let us join hands in this journey for a two-child family, increase the proportion of more effective methods, and improve the quality of care. Our aim for 1993 is to encourage FWAs to attain CAR above 60 percent, CPR above 50 percent and reduce CBR below 30/1,000 and devote our efforts for FP Plus program.

CONTRACEPTIVE ACCEPTORS BY METHOD (IN %)
NOVEMBER 1992



THE RELEVANCE OF RESEARCH TO THE FAMILY PLANNING PROGRAMME

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I would like to follow Mr. Rafiquzzaman's exposition of the challenges facing the national family planning program with some thoughts on what those challenges mean for those of us who do research.

First I will talk about the types of research that we do and how they relate to policy and programs. I will give, not an exhaustive list, but an illustrative list, drawn from recent ICDDR,B work. This is not to imply that we are the only institution doing this work here, but these are the projects I know best.

Then I will discuss some current and planned projects, and show how they respond to what we understand are some of the major issues facing the family planning program in the coming years.

II. RECENT RESEARCH AT ICDDR,B RELEVANT TO THE FAMILY PLANNING PROGRAM

There are a lot of different distinctions one can draw, between basic and applied research, demography and behavioral research, and so forth. I found this set of categories useful (Figure 1). Some research revolves around our field demonstration projects, some deals with the needs and behavior of the people whom the family planning program is meant to serve, and some looks at "supply-side" issues, how to organize the services so they have the most effect without bankrupting the country.

Demonstration Projects:

Demonstration Projects basically answer the question "Can a particular service work in this setting?"

The best known instance from our work is undoubtedly the whole Matlab MCH-FP project, which has shown that high rates of contraceptive use, and corresponding fertility decline, can be induced even in quite conservative parts of the country, where there has been little economic progress or social change. You can see from this next slide that the proportion of eligible women using contraceptives has climbed steadily in Matlab and is now about the same as that reached in Asian countries like Thailand, Sri Lanka, and Japan, that started the fertility decline much earlier (Figure 2). This is an important lesson, largely because in the late 1970s the weight of academic and professional opinion

1. TYPES OF RESEARCH

Demonstrations

Market Research

Diagnostic Studies

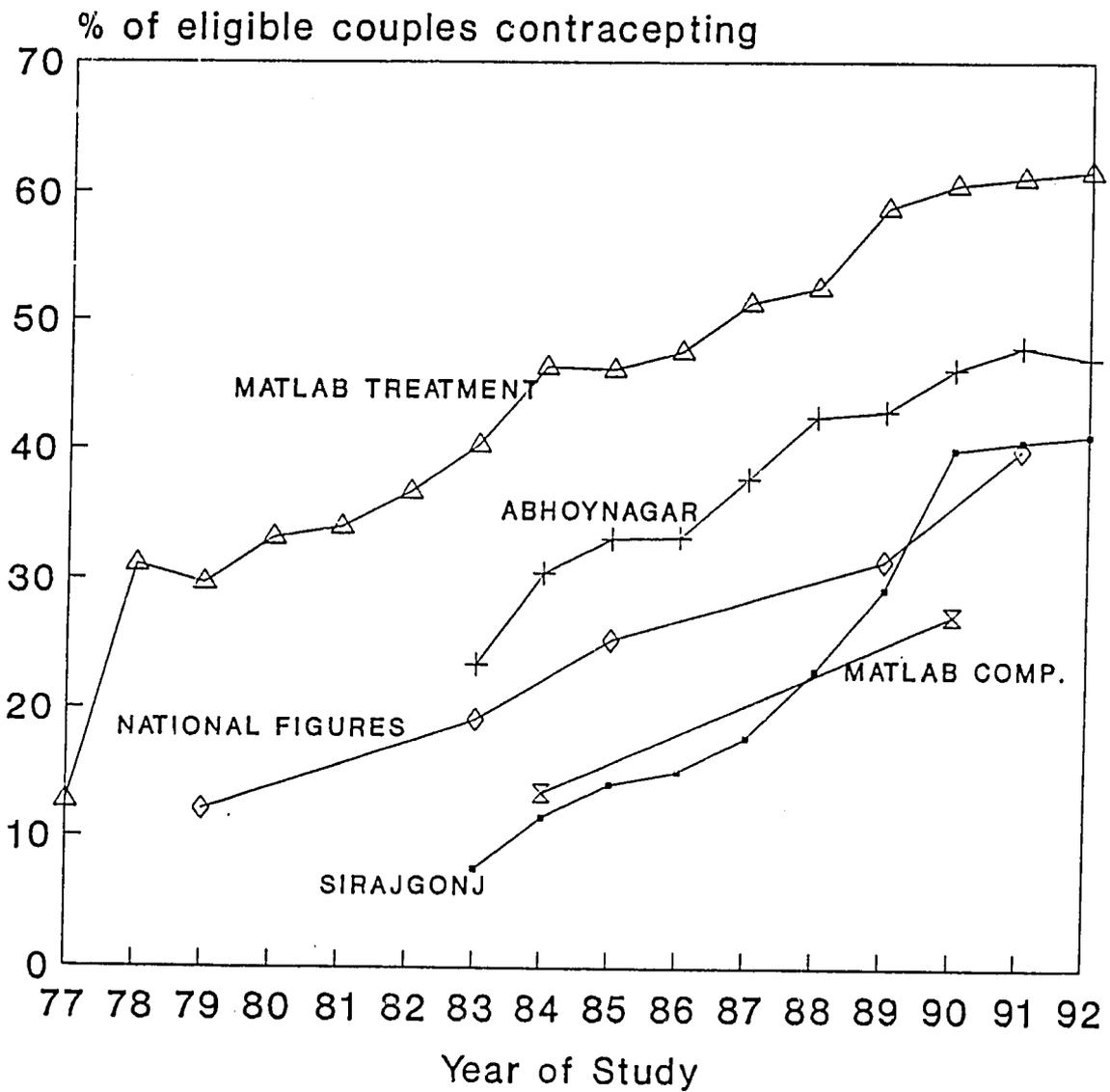
Operations Research / Evaluations

**Implementation Research/
Technical Assistance**

Policy Analysis

FIGURE - II

INCREASING CONTRACEPTIVE USE MATLAB, EXTENSION & NATIONAL



- | | | |
|------------------|------------------|-------------------|
| —●— Sirajgonj | —+— Abhoynagar | —◇— National Est. |
| —△— Matlab Treat | —⊗— Matlab Comp. | |

was that the order had to be reversed. Family planning enthusiasts were considered naive to think that just delivering contraceptives would overcome the lack of the presumed preconditions.

The usefulness of Matlab demonstrations is hardly over. The national program has achieved a remarkably high CPR, higher than in India or Pakistan, but has a long way to go before reaching its demographic or health targets. Another way to look at the Matlab project is to say that it has been eight years ahead of the national program; we need to learn from current experience and experiment with measures to lift CPR to the next level.

Many people think, for example, that there is a limit to fertility decline posed by the strong preference for ensuring survival of at least one son into old age. In a paper to be presented later, Dr. Bairagi argues using Matlab data that this undoubted preference is unlikely to prevent further fertility decline in the next decade (Bairagi, 1993).

Rural Bangladesh is a diverse place, and it is important not to limit our work to one field site. It is very encouraging to note the progress in family planning that is reported in another paper by our colleagues working in Teknaf (Munshi, et al., 1993). One does not claim that this success is unique within Bangladesh. What is particularly valuable is combining service delivery with a reliable, independent system of data collection so that we can see how things worked, or how they went wrong, not just read the final scores of the match.

The MCH-FP Extension Project was designed to test ways to introduce some elements of the Matlab project into the regular government program, without major infusion of additional resources. This has been partly a demonstration program, showing that the family planning field workers can use client-oriented records, can implement some of the MCH activities that the government relies on them to perform. Some, at least, of these program inputs are transformed into higher rates of CPR in previously backward regions where we have worked.

One of the tests of success for this sort of research is whether, a few years after publication, one hears the complaint that the research was unnecessary; "Everybody knows" that such-and-such can happen. Professor Greenough reminded us yesterday of the dangers of dogmatism; this is as true in family planning as it has been in diarrhea treatment (Greenough, 1993).

Market Research:

A lot of the work here could fall under the heading of Market Research. There is a whole trend in American management literature now arguing that the job of the top management is to "Listen to the Customers", and especially to the non-customers you want to reach.

One of the most useful functions of research is simply to open up an indirect channel of feedback from customers to managers.

I could cite many examples, including studies using both quantitative and qualitative research techniques, in our rural sites and now increasingly in the city slums. I want to mention especially the work of our colleague KMA Aziz, who cannot be with us this morning due to illness. He has for many years urged us by precept and example how to listen carefully to those we think are helping.

One of the most interesting results from the so-called Knowledge, Attitude, and Practice surveys in Matlab and the Extension project sites has been the great increase in contraceptive use by women still intend to have more children in the future (Koenig et al, 1992). This shows the importance of child spacing is understood and that the programs have succeeded in making reversible contraception widely available.

Another useful line of research is to look at how information and beliefs about health and family planning are diffused. There is some very interesting work along these lines going on in Matlab.

There is an active tradition here of looking carefully at who is using health and family planning services and who is being left out. These can help in what marketing managers would call "segmentation", giving clues on how programs need to be better designed and more precisely targeted. Two papers that will be given later today illustrate the possibilities here; one by Mafizur Rahman (Rahman, 1993) shows women are not being reached by the home visitation program of the family planning workers and one by Fazilatun Nessa (1993) shows the consequences of failure to reach adolescent married women in particular.

Supply-Side Program:

Market research can be carried on without much active collaboration with service providers; we just need to make sure we report the results to those who can use them. In "Supply-side" research the whole enterprise has to be more cooperative.

One type of study is designed to improve the diagnosis of problem, as a guide either to small-scale intervention or to large-scale reform. The subjects can be delimited either geographically, as in a report that Cristobal Tunon will present on investigations in Chittagong Division (Tunon, Maru, and Haaga, 1993) or by agency or level in the hierarchy, as in a paper on supervision that focusses on the Family Planning Inspectors (Ashraf, Maru, and Haaga, 1993).

Operations Research:

A much larger category of studies that can be potentially useful to the program is what we now call in family planning "Operations research". [This is conventional but a bit confusing because there is a field of applied statistics called operations research that has not been used much in these studies anywhere in the world.]

Many examples will be discussed at this conference or were presented a year ago. Some of the most important deal with our efforts to study how to make injectable contraceptives more widely available. The Caldwells have argued in a recent paper that the secret of success in Matlab was adding injectables to the repertory of contraceptives delivered in privacy to women in their homes (Caldwell and Caldwell, 1992). This may be understating the importance of other changes in the services, but they are no doubt right that in Matlab and elsewhere the injectables have proved to be a popular method. Our work has investigated many of the issues related to ensuring that such wider access can be done safely.

Satellite clinics represent an attempt to get family planning and limited health services out from fixed-site clinics on a regular basis without having to take them all the way to the client's homes. Several of our studies deal with satellite clinics; Amy Sullivan will present a paper that summarizes earlier work and reports some new data (Sullivan et al., 1993). Here, as in work reported previously on the effects of charging a small price for condoms, our work reverses the more usual sequence; the relevant policy decisions were made without much input from research; and the task of researchers was then to look at problems in getting the decisions implemented .

A study presented here by Tanjina Mirza (Mirza, Juncker and Mita, 1993) provides a further example: FWAs are supposed to be screening and referring pregnant women. She shows that this does not often happen, and indeed questions, as researchers should, whether it ought to happen as planned.

The test of success in this type of research is not whether the government did exactly what we recommended. They usually do not. Most governments do not. We can count it as a success if our work contributed to getting a problem recognized as important, and to getting some solution in place so that new problems can open up.

The reason studies like this are needed is that the family planning program is a complex, open system. It involves many different groups of people, spread out geographically, each with their own motivations and set of understanding, interacting in many ways. Our grasp of sociology and organizational behavior is not really good enough to give us confidence that any change we introduce will produce the results we expect. We do not know if something will work until we try it out. We are in the position of the

"empiricists" that Professor Greenough describes. If we think something will help the patient, we give her a small dose; if she seems to get better and does not die, we up the dose and give it to others. Operations research is the small dose in organizational therapy. It is unsatisfying to those with tidy minds, who may not even be willing to call this research, but our clinician colleagues recognize what we are doing.

The trick with this kind of research is to see what it cumulates, that at the end of a lot of little studies we understand some big things, and communicate them. If we only study program changes we are already sure will work, then we have done nothing very useful.

Implementation:

There is a thin and permeable boundary between studying implementation issues and helping in implementation. A continual problem is knowing how, and when, to hand something over to the implementing agencies. We are a specialized organism, designed to do research and not to run programs, or even to do many things in many places at once. In the recent past we have handled this task in different ways with our government counterparts. One model that we should develop more strongly is to help in training of trainers and in producing training materials.

Research Synthesis and Policy Analysis:

Lastly we move to a larger scale, the task of synthesis and putting together results bearing on a set of related issues and recommending choices among policies. This has not been a major emphasis of our work. A notable contribution to policy analysis was the cost analysis produced under the direction of the late George Simmons (Simmons et al. 1990) which is still cited as the most up-to-date information on costs not only of Matlab but also of the national program. This is a piece of the puzzle, but not all of it. There have been some papers summarizing results bearing on a broad issue and making recommendations, for example, at the time of the planning of the Fourth Population and Health Project by the government and a consortium of donors.

It is important to note that this work does not have to be done by those who have done the studies that are being synthesized. There are advantages to division of labor.

III. PRIORITIES FOR THE OPERATIONS RESEARCH AGENDA

So that is the type of thing we have been doing. What should we be worrying about next?

In many ways new research leads on from what we have been doing; that is what the historian of science Thomas Kuhn called normal science. We find problems in our "laboratories", we know about

problems other people are working on; and we do what we can. But we also need to look up from our work to the big issues facing the national family planning program and check that we are devoting our energy and our sponsors' money to things likely to be useful.

The family planning program has reached 40, which I now realize to be middle age. The first-generation issues on which we worked -- getting a field staff of the right sort deployed, arranging supervision and a some sort of record-keeping and reporting system, adding reversible contraceptive methods to the sterilization program -- have been superseded, at least for much of the country.

The overarching task in the next decade is to continue the momentum toward higher rates of contraceptive prevalence. Based on prior international experience, a CPR above 70 percent will be required to achieve replacement-level fertility. And even when that fertility level is reached, the nations's population will still be growing for years to come. The legacy of past high levels of fertility is a large proportion of the population in the youngest age groups, yet to begin their own child-bearing years.

To increase CPR even from 40 percent to 50 percent by 1997 will require an increase in the number of contraceptive users from 10 million to 14.5 million couples (Kantner and Ali Noor, 1992). The more ambitious targets set by the government for the Fourth Plan would require even more rapid growth in the numbers of couples served by the program. The program has to do more just to stay in the same place.

Unmet demographic targets are not the only reason for redoubling efforts in the family planning program. On a personal, rather than national level, there is consistent evidence of an unmet demand for control over fertility. In recent national surveys, well over half the women (and where they are interviewed, well over half the men) express a desire not to have any more children. Many of those who do want more children want to delay having their next child. But the majority of those expressing these views are not using safe, effective, and appropriate methods of birth control.

A fifth of all contraceptive users rely on "traditional methods" including safe time, abstinence and withdrawal; many of these would likely prefer, and use more effectively, modern methods. Both limitation of family size and spacing of births produce desperately needed improvements in health for both women and their children. Morbidity and deaths related to pregnancy, abortion, and delivery are a real threat for most Bangladeshi women. Family planning is the most effective existing program to reduce the threat.

In most rural areas the family planning program has now passed the initial stages. Field workers are in place and have received some degree of training. Nearly all women know about modern contraceptives. Supplies of contraceptives to field workers and

clinics are frequently interrupted, but a nationwide network of warehouses, clinics, and private outlets does exist. In these circumstances, the program has probably already reached most of the "easy adopters", those whose motivation is so strong that they manage to obtain supplies or services despite the gaps and deficiencies in the program. To reach the higher levels of CPR and reduce the level of unmet need, though, will require increases in both adoption and continuation rates. And to achieve the full impact on population growth, health, and personal freedom, the higher levels of CPR will have to be accompanied by efforts to improve the "use-effectiveness" of contraception. Both goals require improvements in the quality of services, not just expansion of existing services.

The challenges for the family planning program in areas where it is now well established is to improve the quality of the full package of services, including counselling, side-effects management, and follow-up care, for a full range of methods.

Recent declines in the numbers of sterilizations performed and IUDs inserted have been linked to problems with the technical quality of services. Some of the couples relying on spacing methods would be good candidates for more effective methods if the latter were safely available.

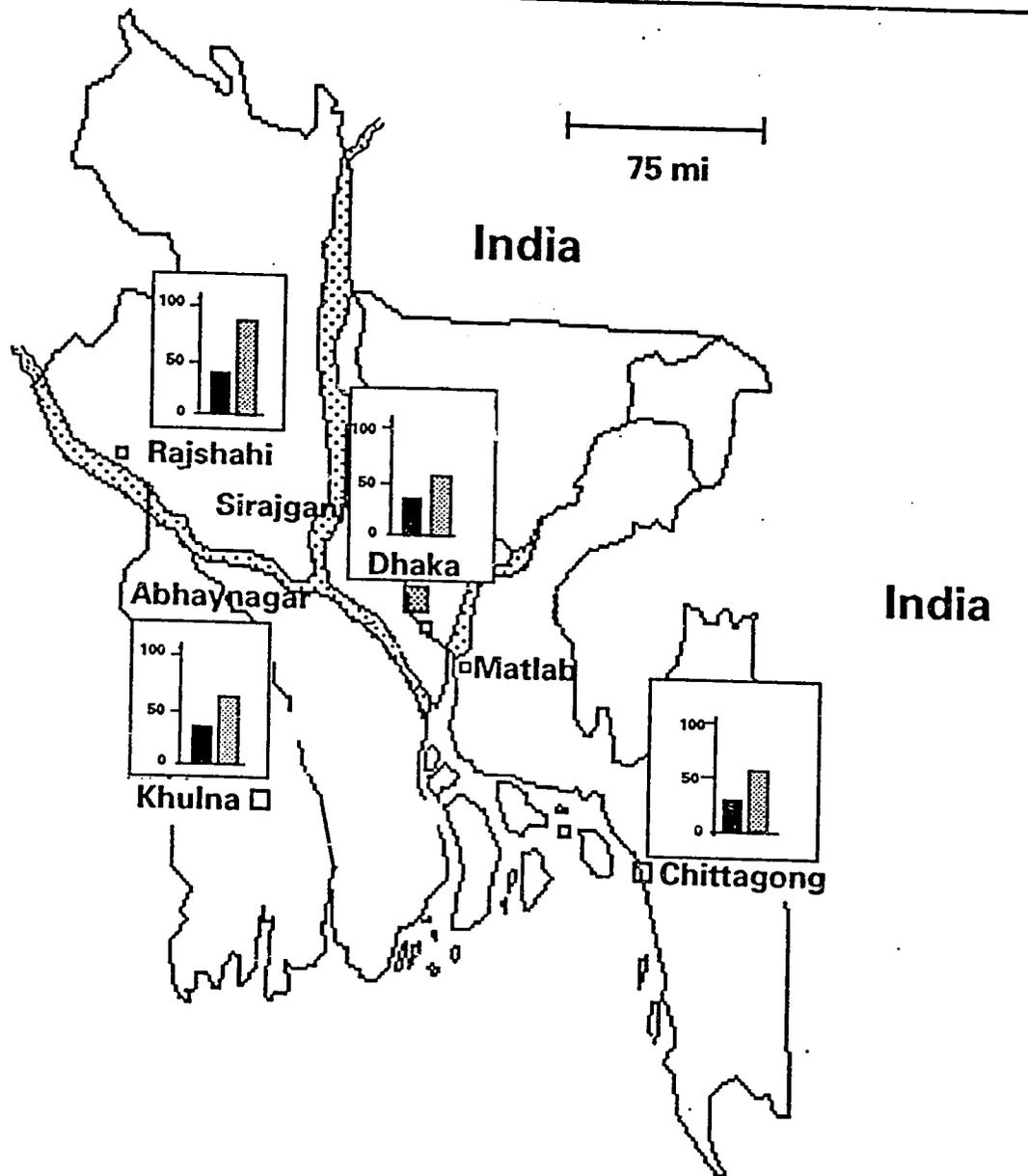
The types of research we should be doing to help in this task include continued market research, and studies of determinants of contraceptive method choice, method switching, how side-effects are perceived and handled, and how new methods are accepted.

To improve the quality of care, we need further work on how to measure and how to monitor quality -- most research data collection as well as program data reporting systems are set up to look at coverage and not to answer directly questions about whether couples' needs are being met, whether they really had the information they needed to choose, whether they received proper initial and follow-up care.

Laggard Areas

In other parts of the country, such as the far northeast and the southeast in Chittagong Division, the family planning program has not reached this stage of maturity. CPR and service indicators lag behind the rest of the country (Figure 3). The policy and program changes that worked during the 1980s elsewhere in the country may need modification for the different social and physical environments of the current low-performing districts. The program needs to incorporate some flexibility to get established in the laggard areas. The recent AVSC report and the analysis of management issues by Tunon and his colleagues give us a fairly good diagnosis; the need now is to try some therapies.

Bangladesh



■ Contraceptive Prevalence Rate, 1991
(Source=CPS)

▨ 1-Year-Olds Fully Immunized, 1991
(Source=WHO)

I wouldn't include urban areas among the laggard areas, for contraceptive use and immunization are generally higher in urban than in rural areas. But urban slums are neglected areas for most service research. The Urban Health Extension Project will be working with counterparts from both NGOs and government to test alternate models of service delivery.

Management Improvement:

Parallel to this, work is needed on ways to build into the family planning system a concern for, and an ability to provide, services meeting good technical standards. We typically assume that this is simply an issue of hiring people and training them, but as researchers we know that skills deteriorate if not reinforced, and that people do not maintain the standards they learned if they are not motivated, and supervised.

Some of the problems now faced by the national family planning program are the result of rapid expansion. Logistics and other aspects of program management are greatly strained by the need to keep the large force of field workers supplied and supervised.

That brings us to the vital issue of management improvement. This is a matter for research, not just exhortation. There are ways to change the system so that you get better managers; there are ways to change the system so that the managers you have got can get the job done. We are one of several institutions working in this field, and our future research role has to be coordinated with others, including the Management Development Unit inside MOHFW, the Local Initiatives Project, and the Family Planning Logistics Management Program.

Integration of MCH and Family Planning:

With the exception of immunization, MCH services have not had a breakthrough in the last decade. Reproductive health services for women, in particular, have made little progress. Most babies are born at home, attended by relatively untrained persons, and there is no easy access to emergency care when something goes wrong with pregnancy or delivery. Though early abortions are legal and not proscribed by religion, large numbers of women suffer or die from incomplete, septic abortions (Rahman and Whittaker, 1992). Both health and family planning field workers and paramedics are meant to screen and refer high-risk pregnancies. But there are few good services to which high-risk or emergency cases can be referred. Basic questions about the feasibility, costs, and effectiveness of alternate arrangements for safe delivery services have to be answered. A mix of field trials and service research is needed.

There are good arguments for providing reproductive health services, and other components of MCH, along with family planning: convenience and acceptability to clients, convenience to field

workers, sharing facilities and other fixed costs. But as with all public services, there are also arguments in favor of division of labor. The proper balance of family planning services delivered by "other health" workers, and other health services delivered by family planning workers, needs to be worked out empirically.

Cost Analysis and Cost Containment:

The rapid expansion was achieved through an enormous effort and devotion of resources by government and international donors. Partly as a penalty of success, the program now must be much more concerned with both financial and institutional sustainability. Supply costs for the national program have grown far beyond projections made for the last plan period. Donor support on a large scale is likely for the foreseeable future, but an increasing share of resources for a continually expanding program will eventually come from local sources.

In the mid-1970s, there was no nationwide infrastructure, married women (and their husbands and older relatives) were unfamiliar with the idea of contraception, and women could not travel far on their own initiative to make contact with the health services. By now the situation has changed. Family planning is no longer deviant behavior: forty percent of eligible women use contraception, and most know someone who does even if they do not use contraception themselves. Contraception is a legitimate topic even for public discussion. Pills and condoms are available throughout the country in pharmacies or from government or NGO workers. Changes in women's jobs in many parts of the country have made women more mobile than they were even a few years ago.

The heavy reliance on house-to-house visits that was necessary when the program was in its infancy may no longer be suitable for the mature program. Delivering services by fieldworker visits to the home meets many of the privacy and transportation concerns of clients, but is not feasible for services requiring high levels of technical competence, close supervision, or bulky equipment. Even if current levels of aid can be kept up, the costs of alternate modes of service delivery must be estimated and considered in making decisions. The satellite clinic program represents one compromise between the two extremes of excessive reliance on home visits and exclusive reliance on under-used fixed-site clinics.

The crucial area of uncertainty is the effect of any change in service delivery on contraceptive use. The demand for contraceptives may still be very sensitive to "price" (the price paid by women in terms of embarrassment, violations of social norms, and inconvenience and travel time, as well as money prices). If so, then radical changes that require rural women to travel more, make their own purchases, and generally take more initiative, could undo many of the gains of the last decade. These are not issues that can be resolved by consulting policy makers'

preferences or by asking women hypothetical questions. Tests are needed in a variety of real field conditions to answer fundamental questions about the future of the program.

There are numerous proposals for alternate roles for the FWAs besides simple house visitation: bringing family planning to EPI spots, or extending their work through use of volunteers, or through communication with groups. It may prove that the most cost-effective mix of FWA and FWV services in one area is unsuitable for parts of the country where the program is still not well established.

Changes have to be tested in the field, to see what works for Bangladeshi women, and what the implications are for training, supply, and supervision.

Conclusion

I have used a taxonomy of research with six categories, but I was struck yesterday morning by Professor Greenhough's use of two categories. He distinguished between "curiosity-driven research" and "need-driven research" and showed how advances in the development of ORS came from a continual interplay between the two. One lesson I take from that is that is valuable to have a mixture, at one institution, of different types of research. We should have some need-driven research, on fairly well defined topics, tied to issues already on the agenda of the implementing agencies. But we, as an institution and as individuals, also need to keep our eyes on the horizon, to stay open to possibilities, and to follow our noses where they lead. If we try only to be immediately useful to our funders and our counterparts, then it is certain that we won't be much use to them.

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**THE SIGNIFICANCE OF NEWLY MARRIED COUPLES IN
BANGLADESH FAMILY PLANNING PROGRAM**

Second Annual Scientific Conference of ICDDR,B
January 17, 1993

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According to the Bangladesh Demographic Survey and Vital Registration System, 1.14 million couples get married every year in Bangladesh. In terms of crude rates, 11 marriages per 1000 population are solemnized every year (Statistical Year Book of Bangladesh, 1991). These couples need to be oriented to the means of family planning so that they are enabled to exercise control over their own reproduction.

It is held by many in Bangladesh, as in many other societies, that newly married couples are not likely to accept and practice family planning until they have their first child. Conventional wisdom tells us that there is strong familial and social pressure on the young bride to prove her fecundibility as soon as possible after her marriage and thereby gain greater acceptance as a member of her husband's family. Such wisdom not only prevails in Bangladesh but in many cultures as well (UNFPA 1990).

The same social pressure is reflected in the attitudes of family planning and health service providers. Family planning service providers traditionally have focussed their efforts on older, high-parity women. They have tended to disregard young, and low-parity couples, especially newlyweds, as a target group in the belief that they will not accept and use family planning until they have their first child.

Young, low-parity couples are a critical target group for family planning in Bangladesh (Alauddin and VanLandingham, 1989), yet they are underserved. According to the 1991 Contraceptive Prevalence Survey in Bangladesh, only one out of every five couples aged less than 20 received a visit from family planning field workers (mitra, et al. 1992). Of the underserved, newlyweds couples are the least served group, if they are served at all with family planning education and services, in all cultural contexts. Further evidence of low level of services offered is that at least 5 percent of the Family Welfare Assistants did not suggest any method of family planning to young couples (newlywed couples included) because they perceive that it was not appropriate or important to offer services to them (Mabud, et al 1988). Bangladesh has one of the highest incidence of early marriage in the world and early marriage is almost universally accompanied by early childbearing. Although the age at marriage is increasing, albeit slowly, one study reported that 73 percent women were

married and living with their husbands by age 15. Consequently, adolescent fertility rates in Bangladesh are higher than in many other countries as is evidenced by the fact that more than one-fifth of adolescents had given births by age 15, and two-thirds by age 18 (Safe Motherhood in South Asia, 1990).

The adolescent women are at high risk for maternal mortality and morbidity. The children that they bear are also at high risk. The maternal mortality rate for those women who are below 20 is 8.6 per 1000 live births, which is much higher than the already very high maternal mortality rate, 5.7 per 1000 live births for all women, in Bangladesh (Alauddin, 1986). Also, data from four Thanas of Jessore and Sirajgonj district provide evidence that younger mothers experience more foetal loss, neonatal and infant deaths (Fazilatun Nessa, 1993).

Contrary to traditional notions, recent striking changes in couples attitudes about the desired number of children signal that Bangladeshi young couples are highly receptive to the concept of the small family. Younger women desire even smaller family size, 2.5 children compared to 2.9 children which is the average for all women. Desire for achieving small family among young couples is again reflected in their actual behaviour. Encouragingly, contraceptive use among young women who are less than 20 is on the increasing trend - the rate of contraceptive use doubled between 1985 and 1991.

Given such evidence of lower fertility preferences and increasing trend in contraceptive use among young women, the newlywed couples, many of whom beyond doubt are receptive to small family norm, deserves special attention for family planning education and services. But no serious attempts have been made to explore and develop a service delivery approach for meeting the needs of this important target group and experience shared and documented.

While continuing to make contraceptive services available for older, higher-parity couples, beginning January 1992, 29 NGO family planning projects, with funding and technical assistance from Pathfinder International, started to develop a service delivery approach to pay focussed attention to newlywed couples. This begins with registering newly married couples by family planning workers. Fieldworkers visit each household every 4-6 weeks. Each marriage held within the assigned geographic area of a fieldworker is registered within 4-6 weeks during her routine daily visits.

Registration of the newlywed couples provides the family planning fieldworker an opportunity to introduce herself to the couple and to establish relationship with the bride's family and thus set the stage for offering services subsequently. Establishing such a relationship is very important in Bangladesh.

The fieldworkers provide supplies of contraceptives to the newlywed couples who want to use them. Should the couples become pregnant, the family planning workers advise them on pregnancy care, and safe delivery. When the baby is born, family planning workers encourage the mother to breastfeed, arrange immunization for the newborn and provide appropriate contraceptive services and supplies for spacing for the next pregnancy.

Besides receiving education and counselling at their individual houses, the newlywed couples are also invited to family planning and MCH orientation meetings in some projects. In these meetings in most cases wives come, but in a few cases husbands accompany wives. In some cases mothers-or sister-in-law have accompanied the new bride to meetings at the local family planning office. Such meetings are even held in conservative areas like Noakhali and Sreemangal.

The purposes of such meetings are to orient the newlywed couples about population problems of the country, explain to them the need for keeping a family size small, tell them what kinds of MCH and family planning services are available should they wish to delay pregnancy, and introduce service providers from whom they can obtain such services at their doorstep. On the average 8 to 10 wives attend such meetings with enthusiasm.

During the last 12 months, from January to December 1992, 15,347 newlywed couples have been registered in 40 project sites, mostly rural, and they have been served with family planning and MCH services. Of the couples registered and served with family planning education, 30 percent are using family planning methods. Thirteen percent of the newlywed couples have become pregnant and three percent have already given birth. About half of the newly weds, 48 percent use condoms, and the remaining 52 percent take oral pills. Assuming that nearly one-third of the newlywed couples would not have used family planning, undoubtedly the pregnancy rate for the newlywed couples would have been significantly higher than the present rate.

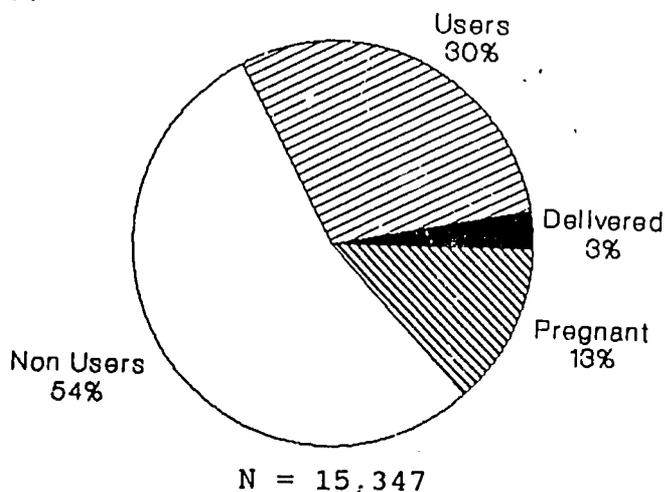


Figure 1: Newlywed Couples by Contraceptive Use, Pregnancy, Delivery Status of PF-supported NGO Projects, Jan-Dec, 1992.

From the newlywed couples' perspective, it becomes imperative for a number of reasons that they be treated, unlike in the past, as a critical group for family planning and MCH services. First, their sheer size: 1.14 million newlywed couples added each year to the pool of eligible population for family planning services, is an important consideration. Second, they are receptive to family planning services, as last year's experience demonstrates. Third, their pregnancy rate, as expected, is very high. Fourth, they are one of the highest risk group for maternal mortality and morbidity. Most of all, they are willing to serve the demographic interest of the country by responding to the country's need for small families. Their desired family size is close to the 2-child family which is the goal of the national family planning program.

In the national family planning program, a system of registration of eligible couples by the Family Welfare Assistants (FWAs) is already in place. The family planning program management needs to acknowledge the significance of newlywed couples, require FWAs to register newlywed couples with a priority attached to them and take on the responsibility of providing services to them. In addition, service providers need to challenge themselves to correct their skepticism that newlywed couples are not receptive to the idea of family planning. The evidence of contraceptive use among the newlywed couples disprove such skepticism. Managers and service providers in the family planning program need a rigorous reorientation. Program staff's conviction about the significance of offering services to newlywed couples, and commitment and motivation of service providers to empower newly married women and men to exercise control over their own reproduction are the most important steps towards success of contraception among newlywed couples. The family planning services, however, must be linked with relevant future needs of newlywed couples, such as prenatal care, immunization for themselves and their infants, and other aspects of child care, which are needed and much sought after long-term contributors to family wellbeing.

Counseling, care and services to be provided to newlywed couples must be of high quality; they must have best possible positive experience of contraception and contraceptive care. Any negative experience by the newlywed couples as first time users of family planning services is likely to affect contraceptive practice for the rest of their reproductive life.

There is conclusive evidence that demand for family planning exists among newlywed couples. The implementors of the national planning program, both governmental, non-governmental and private sector, need to commit themselves to serve newly married couples (in addition to others, of course) from the very beginning of their marital life to help them achieve a small family of no more than two children. The greatest dividend for the demographic transition, and consequently, for a healthy and prosperous Bangladesh for our next generation, lies in how successfully the

family planning program can turn the large number of newlywed couples into committed family planners from the very beginning of their conjugal life.

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**POPULATION AND FAMILY PLANNING: POLICY AND PROGRAM
CHALLENGES FOR THE 1990'S**

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Discussion: William Goldman, USAID

The central challenge for the National Population Program in the 1990's will be to maintain and continue the substantial success of the 1970's and 80's. The last twenty years have seen remarkable progress, with a six-fold increase in contraceptive use rates and a decline in fertility from 7.5 to 4.5 births per family. These gains are more remarkable given the socio-economic setting in Bangladesh. The success of the program is well recognized world wide. It casts serious doubt on the traditional demographic transition theory that espouses that fertility declines are not possible in the absence of considerable social and economic improvements.

The national program model is based on the premise that there is substantial unmet demand for family planning services which can be satisfied by increasing availability of a broad range of high quality contraceptive services. It is also based on the premise that providing services will generate additional demand among women who traditionally would not have used contraception. The National Family Planning Program now consists of a comprehensive service delivery system including 23,000 FP/MCH fieldworkers and 4000 clinics of the Ministry of Health and Family Welfare, the Social Marketing Company with 130,000 outlets in shops and pharmacies, and 265 NGO sites with 9000 community workers and 173 clinics. The service sites, which are supported by a large administrative infrastructure with training, communications, research, logistics, and monitoring components, can be found throughout the country.

Thus, given that (1) a large program structure is in place and (2) the program and its policies have clearly had a major impact, it seems logical that the current approach should be maintained and strengthened in the 1990's. However, there are three major challenges confronting the program that should receive increasing emphasis in the 1990's. These are: (1) future demographic impact, (2) efficiency and effectiveness, and (3) costs and sustainability.

While the program has had a significant demographic impact, population growth is still high (around 2.3% per year). Even if the program maintains its success, future population projections still present a staggering challenge. For example, Bangladesh, which is already the world's most densely populated country, will have a population of 235 million by 2030. This figure could be much higher if the program fails to meet its ambitious targets. Dhaka currently has the second highest population growth rate in the world for a large city. It has grown ten-fold in the last 30

years and could again increase 10 times in next 40 or 50 years to an unimaginable 60 million. Furthermore, experience in other countries has shown that when the contraceptive prevalence rate reaches 40% to 50% levels, which is the situation in Bangladesh today, future gains are more difficult. There tends to be a plateauing effect. The long term demographic projections provide a persuasive argument that the 1990's is no time to let down but rather a time to strengthen efforts.

The second major challenge for the 90's is improving efficiency. A close look at program performance data provides direction for focusing resources on program and policy weaknesses. The following are nine examples of key concerns that should be addressed in the 1990's:

- (1) The program is increasingly dependent on oral contraceptives. Currently more than one out of every three contraceptive users are using OCs. Furthermore, their use is rapidly increasing. However OCs have a low continuation rate and low use-effectiveness. There is a need to improve the quality of service delivery and strengthen information, education and motivation.
- (2) The relative use of IUD and sterilization has declined substantially since 1985 such that many high parity, older women are using inappropriate, less effective, non-clinical methods of contraception. However, the injectable, while appearing to be extremely popular, is not yet readily available. Extra efforts are needed to improve the quality and availability of IUD and voluntary sterilization and to accelerate the expansion of the popular injectable program.
- (3) Traditional contraception continues to be high, contributing about 20% of all use. A greater emphasis on converting users of traditional methods to modern methods could have a substantial demographic impact through improved use-effectiveness.
- (4) Couples under age twenty five years use contraceptives at a rate only about 1/2 of that of couples between the ages of 25 and 45 years. Again, this could be an area for greater research and program focus, especially for communications and motivational activities.
- (5) Men, who make up less than 10% of all contraceptive users, play a large role in family planning and fertility related decisions. Special communications programs should be designed to motivate greater male acceptance of family planning.
- (6) Contraceptive stocks-outs at service points are still much too common, sometimes reaching 30% nationwide. There should be a

focussed effort of BDG, donors, and NGOs to measurably reduce this unacceptable high level.

- (7) Fieldworkers visit less than 40% of their clients and commonly omit visits to higher priority non-users, young women, and more remote houses. This coverage problem could become much worse in the future given the rapid increase in the number of eligible couples. The BDG and NGOs should reconsider their approach to household visitation, taking into account the findings from the Local Initiative Projects, Trisal, FP/MCH Extension Project and other ongoing activities.
- (8) Chittagong Division has a contraceptive use rate of only 2/3 that of the rest of the country. There need to be extra efforts to reduce the difference and more applied research regarding the reasons for this substantial difference which has not been reduced over time.
- (9) Contraceptive use in urban areas appears to be levelling off. The urban CPR has increased by less than 4% points since 1986. This finding has important implications for the program as it could indicate a peak rate (around 50%) which could be difficult to exceed given current conditions. This topic should be a priority for further analysis and urban family planning and health research.

The third major challenge for the 1990s is costs and sustainability. The current program is expensive and cost effectiveness could be improved. Furthermore, the program costs have escalated substantially and will most likely continue to increase rapidly, especially given the number of ever increasing new eligible couples. To meet program goals the number of current users of contraception will have to double in the next ten years. This would require adding more than 10 million new users while maintaining those currently using.

Furthermore, the program is heavily dependent on funding from donors, which provide more than 70% of total program costs. The government of Bangladesh provides almost all the rest. Beneficiaries contribute less than 3% of the total program expenses.

Prospects for long term sustainability are even more worrisome given that only about 10% of the BDG's budget for family planning comes from their revenue budget. Union and ward level family planning workers' salaries are paid from the development budget. Clearly, the issues of costs and sustainability can not be ignored in the 1990's. Key challenges in this area include:

- (1) Improvement of the cost-effectiveness of the BDG FP/MCH service delivery system. The existing successful system has had a vertical household focus. Cost-effectiveness should be

improved as the redesigned Satellite Clinic program and integrated EPI outreach sites are expanded and improved. The challenge will be to move towards a more cost effective, integrated, community based approach to service delivery while improving upon and maintaining the gains made in family planning. This could be done by careful well monitored phasing first in those areas where family planning is more institutionalized.

- (2) A more efficient definition of the roles of the commercial sector, social marketing company, the NGOs, and the BDG in family planning service delivery. This should be based on a thorough analysis of the relative strengths, weaknesses, and effectiveness of each of these groups in providing the various family planning services.
- (3) A reduction of dependency on donor funding by cutting program costs, generating revenue, increasing BDG revenue budget funding for family planning, and improving cost-effectiveness. Various approaches should be piloted and reviewed before changing policy and initiating national implementation.

To meet the challenge of the 1990s, the BDG will have to make difficult policy designs. These include decisions regarding the roles of the various fieldworkers, decentralization of authority, the allocation of the revenue budget, the roles of the BDG, NGOs and the SMC in service provision, contraceptive logistics, fee-for service and pricing policies, audience segmentation of motivational messages, and the introduction of new contraceptive methods. The key policy decisions will have a major program impact.

In summary, the challenge for the 1990's is to keep the momentum of success by redoubling efforts, improving efficiencies and effectiveness while simultaneously beginning to improve the program's cost-effectiveness and potential for long term sustainability.