

**POPULATION POLICY IN
BANGLADESH: A REVIEW OF
TEN PRIORITY AREAS**

Final Report

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FOREWORD

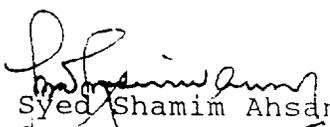
One of the most important factors contributing to the success of the Bangladesh FP-MCH Programme in recent years has been the strong and steadfast support provided at the policy level by all the governments of Bangladesh since independence. This support has given confidence to both the people and the officers of the Government, and has supported the development of a coherent and positive set of policies at the implementation level.

However, as times change policies must change as well. Indeed, the very success of policies at one stage in the development of a family planning program carries with it the need for changes in policy to support the program at the next stage. So it is in Bangladesh. If the nation is to attain the demographic goals which are so important to its survival, it must adapt its policies to attract much larger numbers of users through better service structures, stronger teamwork and cooperation both within Government and between Government and the NGOs, and ultimately through a higher quality of service to its clients.

This report represents an important contribution to policy development in Bangladesh. The Population Council and URC (Bangladesh) have been collaborating in this area since 1992, and the present report in draft form was instrumental in determining the long-term policy issues now being addressed by the National Steering Committee for Future Challenges in the FP-MCH Programme. Its detailed discussion of specific operational policies will, I hope, help us to make wiser policies in the future.

The fieldwork for this report was completed in September of 1993, and we have not been idle during the intervening time. Some important changes have recently taken place, such as the adoption of the National IEC Strategy and, most recently, the National Steering Committee structure and its Plan for Action. Nevertheless, the great majority of the information and analysis in this report remains valid, and its publication should enrich our dialogue on policy during the coming months.

I would therefore like to express my strong appreciation to URC (Bangladesh) and to The Population Council for preparing this report and for their subsequent efforts to put it to use.


Syed Shamim Ahsan :
Secretary
Ministry of Health and Family Welfare
People's Republic of Bangladesh
July, 1994

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This study was part of a larger effort, still ongoing, to systematically analyze, review, and discuss the policy climate for population policy in Bangladesh. The original impetus, along with considerable moral and intellectual support along the way, came from the mission of the United States Agency for International Development (USAID), particularly Mr. William Goldman, then Director, Office of Population and Health; Mr. David Piet, then Deputy Director (and now Director), OPH; and Mr. Sk. Ali Noor, Chief, Research, Evaluation, and Monitoring Unit, OPH. Within the Population Council we benefitted substantially from the insights of Dr. James F. Phillips, Bangladesh policy maven of long standing.

The study could not have been thinkable without the active support and contributions of the Ministry of Health and Family Welfare, Bangladesh, including officials in the Secretariat, the Directorates of Family Planning, Health Services, and NIPORT, and in the field; and of the Planning Commission. Without their collective memory, detailed understanding, and insight, any review such as this would have been futile, and we gratefully acknowledge their contributions both of valuable time and of candid cooperation.

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BACKGROUND

1. Introduction

The Bangladesh National Family Planning Program has achieved considerable success, despite unfavorable social and economic conditions. The program has been characterized by high levels of complexity and dynamism, with a wide range of activities involving many government organizations, non-government organizations, and donors.

The program has benefitted from a consistently high level of general policy support at the highest level of the Government. However, in order to sustain the success already achieved and strive for greater success in the future, it is necessary to undertake periodic reviews of policy from time to time. With this end in view, USAID/Dhaka asked its Office of Population and Health to develop "a policy implementation plan, including a discussion of management implications" in support its Family Planning and Health Services Project (FPHSP). The plan is to cover the policy environment related to the activities supported by the FPHSP, as summarized in the Logical Framework to that document, and should include a dialogue plan and management implications.

The Office of Population and Health, USAID/Dhaka, asked The Population Council, Dhaka, to provide the necessary assistance in developing this implementation plan. The Population Council, Dhaka, in turn, subcontracted URC(B) to undertake the "population policy review" component of the implementation plan. Thus, this report on "Population Policy Review" is the background study for the "Policy Dialogue and Implementation Plan for the USAID Family Planning and Health Services Project".

2. Objectives

The main objective of this study was to review selected population and family planning policy issues of the GOB. Per the terms of reference, URC(B) researchers undertook the following activities, for each of the identified priority areas, as appropriate:

- (a) locate and copy the relevant policy circulars or other policy documents;
- (b) interview knowledgeable GOB officials and field personnel regarding the history and rationale of these policies, the sources of support and opposition, and constraints to change; and

- (c) determine the degree of compliance with the policy through investigation and observation either centrally or in the field, as appropriate, and the reasons for compliance or non-compliance.

3. Methodology

In order to accomplish the objectives of the study, the steps followed by URC(B) included:

Step 1: Discussions with relevant persons in USAID and The Population Council, Dhaka, to identify the main policy areas to be reviewed. The ten priority policy areas identified for the present study are:

1. Relationships between non-medical and medical personnel in the FP wing
2. Status of FP staff funded under the Development Budget
3. Training
4. NGO/GOB division of labor and coordination
5. Urban health and FP
6. Pricing/cost recovery
7. Relationships between Health and FP
8. Accountability
9. Information for Program Management
10. Clinical contraception

Step 2: URC(B) in-house brainstorming sessions, and discussions with The Population Council, Dhaka, in order to formulate the major research questions and issues for each of the ten priority/policy areas identified in Step 1.

Step 3: URC(B) in-house activity aimed at identifying the major sources of information (GOB, NGO personnel, various documents and places where those documents are available, etc.) for each of the major research areas identified in Step 2.

Step 4: URC(B) activity related to collection and review of GOB Population Policy documents (circular, memos, etc.). Initially, it was thought that all

necessary documents would be available, and that available documents would be almost in line with the research issues identified in Step 2. However, indepth review of most documents (which, in most cases, are in Bangla) revealed that they do not provide straightforward answers to most research questions. Thus, it was necessary to read between the lines in order to infer the inner meanings of those documents. In analyzing the GOB documents, it was also found that there are issues/subjects on which repeated memos/circulars have been issued. Thus, the GOB documents (circulars, memos, etc.), in most cases, were used to substantiate the findings and conclusions generated in the subsequent steps. The relevant circulars/memos are presented in the text in the form of exhibits.

Step 5: URC(B) activity related to reviewing the MDU 5-volumes. The objective was to identify problems and solutions recommended by the MDU with those identified in Step 2. In this step, matching of the MDU findings with those identified in Step 4 was done.

Step 6: Extensive review of the existing literature (various studies undertaken by GOB, private research organizations, donors, and NGOs) related to the issues/problems and findings documented in the previous steps.

Step 7: (The most critical step): Synthesis of information gathered, findings and recommendations from previous steps.

Common Step: Discussions with relevant GOB and NGO personnel was a common step in this study, because there was a need for discussions with the relevant persons in each step.

1. RELATIONS BETWEEN NON-MEDICAL AND MEDICAL PERSONNEL IN THE FAMILY PLANNING WING

1.1. Introduction

The GOB policy related to population and family planning (FP), as laid down in its Fourth Plan, has emerged from the recognition of the population problem as the number one problem for the country, therefore requiring a multidimensional approach and total mobilization to make the FP program a success (GOB, 1990, p. XII-15). To bring about that success, congenial working relationships between the medical and non-medical personnel within the FP Wing should be ensured. The following are policy components laid down in the Fourth Plan document, which cannot be accomplished without having synchronized relationship between the medical and non-medical personnel within the FP Wing of the MOHFW (see GOB, 1990, pp. XI-5, XII-6, 7):

- a) integrated Health and FP at the community and PHC level;
- b) improved health and FP services in a package to the family with a view to increasing its welfare;
- c) strengthened MCH component of the FP program through provision of neonatal care, safe delivery, reduction of high-risk pregnancies, provision of tetanus toxoid to mothers;
- d) expanded and improved provision of clinical contraceptive methods, including IUDs, injectables, and male and female sterilization by ensuring adequate counseling, follow-up, and management support, as well as adequate medical care; and
- e) ensured 'quality of care' through augmenting effective screening for contraceptive choice, counseling, and follow-up of clients with respect to side-effects, dropouts, and method switching.

1.2. Structure of Placement of Medical and Non-medical Personnel

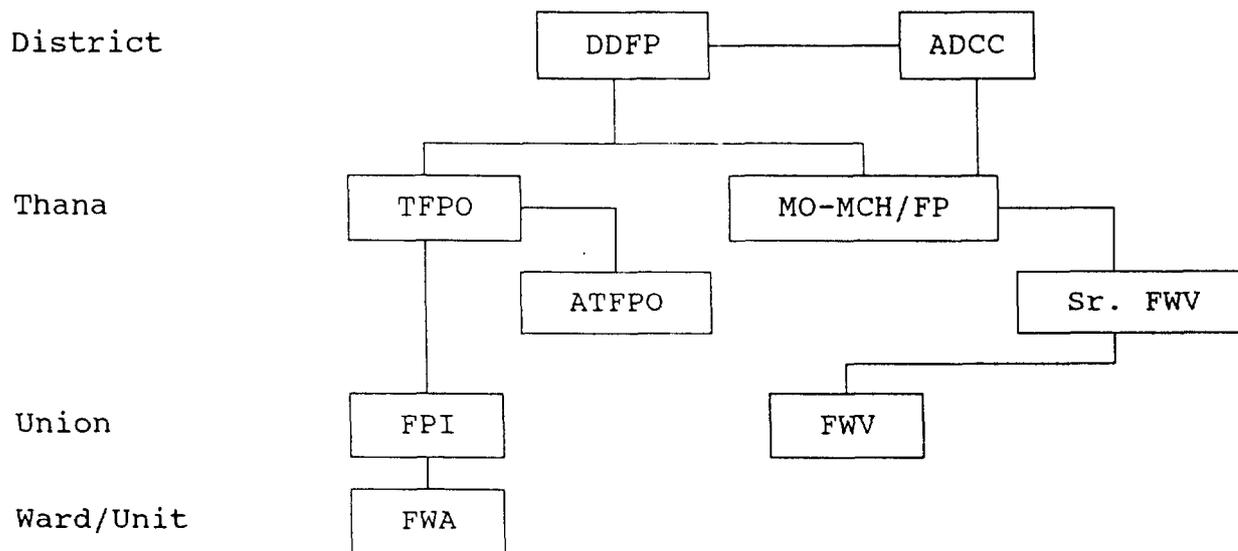
The FP-MCH Wing of the Ministry of Health and Family Welfare (MOHFW) is composed of medical and non-medical personnel. There are over 36,000 personnel in the GOB FP program, 77 percent of which are non-medical and 23 percent are medical/para-medical.¹

1. The number of staff in the Directorate of FP, as of 1993, is as follows:

MO (CC-MCH)	=	13
MO (MCH-FP)	=	421
Sr. FWV	=	450
FWV	=	4,623
MA	=	2,044
Pharmacist	=	801

The organizational structure, in terms of medical and non-medical personnel, is shown in Figure 1.1. (See list of abbreviations in front material.)

FIGURE 1.1: ORGANIZATIONAL STRUCTURE OF MEDICAL AND NON-MEDICAL PERSONNEL IN THE FP PROGRAM



The "medical officers" are the Medical Officer/Maternal and Child Health - Family Planning (MO/MCH-FP), the Senior Family Welfare Visitor (FWV), and the FWV; the "non-medical officers" are the Thana Family Planning Officer (TFPO), the Assistant Thana Family Planning Officer (ATFPO), the Family Planning Inspector (FPI), and the Family Welfare Assistant (FWA). It should be noted that while the MO-MCH reports to Assistant Director of Clinical Contraception (ADCC) on technical matters, s(he) reports to Deputy Director/Family Planning (DD/FP) for administrative reasons. The Senior FWV reports both for technical and administrative matters to the MO-MCH. Another relevant point to note is that neither the ADCC nor the Medical Officer of Clinical Contraception (MOCC) has a job description.

From the thana level down, there are parallel structures within the FP wing involving medical and non-medical personnel, who must cooperate if FP services are to be effectively delivered and administered. Recently, however, there has been some friction between medical and non-medical personnel on such issues as supervision, competition for promotion, encadrement, drawing and

FWA = 23,500

disbursing rights, etc. An understanding of the friction is discernible from Figure 1.1. The division of authority at the thana level between the TFPO and the MO-MCH is dysfunctional, not only in terms of the friction between medical and non-medical personnel, but also for the effective supervision of the program at the peripheral level. Their separate but parallel subordinate structures add to the problem.

Both medical and non-medical personnel are unhappy, for somewhat different reasons. Non-medical personnel consider themselves underpaid, and have little opportunity for career advancement. Also, for the most part, they are unencadred², and therefore, have little job security.

Physicians also have sources of discontent, and, unlike non-medical personnel, have other opportunities. Few doctors remain in their posts for a sufficiently long period of time. Some get themselves transferred to the Health Wing of the Ministry. Three major reasons for not continuing in the FP Wing are: (a) limited prospects of career development; (b) lack of motivation and willingness on the part of at least some to work under non-doctors of the FP Wing at the thana level, and (c) the ad hoc nature of appointment of the newly recruited doctors.

Discussions with field personnel (both medical and non-medical) indicate that in order to retain the MOs in the FP Wing as well as to create a sense of ownership among them for the program, their encadrement in the program as well as ensuring their upward career mobility are quite important. However, the non-medical personnel feel that those TFPOs who have not yet been encadred must be encadred before the newly-recruited MOs.

There are 401 regular posts of MO/MCH-FP; however, there are only 204 such doctors on post. Also, 303 ad hoc posts were created in 1991; 227 such doctors are working at present (Exhibit 1.1). Thus, there are 283 vacant MO/MCH posts. According to informed sources, there is no MO/MCH-FP in about 80 thanas. The large number of vacant MO-MCH posts may indicate lack of adequate interest in the administration (comprising non-medical personnel) to fill in the posts, thereby affecting program performance.

-
2. *Encadrement involves inclusion of personnel in the BCS (FP) Service, and transformation of the post from Class II to Class I.*

Exhibit 1.1: Creation of MO-MCH FP Posts

- Three hundred and three MO-MCHs have been appointed at the Thana level.
- This appointment is in addition to the already sanctioned 401 posts of MO (MCH-FP).

Source: DG, DFP, Memo: PP/S-U/J-1/91/95, Dated 8.5.91.

1.3. Issues/Areas of Friction Between Medical and Non-medical Personnel

The critical focus of tension between the medical and non-medical staff of the FP Directorate is between the TFPOs and the MO-MCH. In addition, there is lack of coordination between the paramedics and other union level staff (Huq and Koblinsky, 1988).

There are at least five major areas of friction between the medical and non-medical personnel of the FP Wing:

- (i) **Pay Scales and Status:** The MOs are Class I gazetted officers and have higher salary than the TFPOs, about 50 percent of whom (230) are Class II gazetted officers and not encadred. From discussions with field level personnel, it emerged that the starting salary of Circle Officers (now equivalent to TNOs) which was Tk. 325 per month, or Tk.25 less than that of the TFPOs in 1965, is now Tk.2,800 which is Taka 400 more than the starting salary of TFPOs. Also, most of the Circle Officers of 1965 have now reached the level of Deputy Secretaries, while most of the TFPOs have remained in the same position, even after more than 25 years of service. The frustration among the TFPOs due to the prevailing situation is quite understandable. Thus, the encadrement of those TFPOs who have not yet been encadred as well as that of the MOs should be high on the agenda. The encadrement should be based on the seniority criteria; however, among those with the same duration of service those who are Class I should get precedence over those who are Class II.
- (ii) **Drawing and Disbursing Authority:** At present, the TFPOs (not the MOs) are entrusted with the drawing and disbursing authority. As a result of this exclusive authority enjoyed by the TFPOs, in many cases, activities related to clinical contraception suffer. For example, the required funds for kerosine, soaps, etc. are not regularly made available to the MO/MCH-FPs. Consequently, the medical personnel feel frustrated and less inclined to do their work. It

should be noted that until 1978 both at the district and thana levels the medical personnel had drawing and disbursing authority over all clinic-related FP-MCH matters, while the non-medical personnel had drawing and disbursing authority over non-clinical matters. This continued at the thana level until 1982, when all drawing and disbursing authority was vested with the TFPOs (non-medical). This action generated frustration and disinterest in the work among the medical personnel. Perhaps to overcome this work, the Government issued an order in February 1991 (PAR-4/Misc.-4/91/118) entrusting the MO-MCHFPPs with the drawing and disbursing authority in those thana (upazilas) where the FPOs were not encadred; however, a subsequent order issued only two months later, i.e., in April 1991 (PKM/PKU-1/PPK-1/AOBA/91/213) cancelled the previous order, thereby further accelerating the frustration and disinterest among the medical personnel.

Issues related to drawing and disbursement have at least two major dimensions. The first relates to the absolute amount of money at the disposal of the program manager at the thana level ranging from Tk.5,000,000 to Tk.10,000,000. The second relates to a manager's authority, which itself depends on whether (s)he has the drawing and disbursing authority. For example, although the SFWV is under the administrative as well as technical control of the MO-MCHFP, in many cases the SFWV is more likely to listen to what the TFPO has to tell her, i.e., does not operate under the administrative control of the MO-MCHFP, thereby affecting performance of clinical contraception.

- (iii) **Career Advancement Opportunities:** Out of 534 doctors in the FP Wing, only six are encadred. Except those six, none of the other doctors can reach the level beyond the Assistant Director. In contrast, all encadred non-medical officers have career advancement opportunities upto the level of the Director General. This obviously is frustrating for the doctors employed in the program.
- (iv) **Sterilization Fees:** Some fees are paid to the doctors performing VSC and others connected with the operations; however, the TFPO and his staff do not get such fees, although sterilization is a Family Planning matter. Most doctors reportedly are willing to forego the meagre amount paid to them on account of this service. Thus, given the willingness of the doctors to forego the said amount, consideration might be given to the MOHFW withdrawing the doctor's fee related to VS, and use the money thus saved to improve quality of care in other areas.

- (v) **Office Room and Residential Accommodation:** The TFPOs generally get the worst rooms in the THCs, which hamper their public relation efforts. Also, unlike the doctors, the TFPO and his technical staff are not provided accommodation at the THCs. This was apparent during our field visits. Thus, office space and residential accommodation should be improved, to the extent possible, to facilitate better working environment.

2. STATUS OF FP STAFF FUNDED UNDER THE DEVELOPMENT BUDGET

2.1. Introduction

Despite the high priority of the FP program among development issues in Bangladesh, a considerable majority of the employees of the FP Wing are on the "development" rather than the "revenue" budget.³ This means not only that they have little job security, but also that they are not eligible for pensions when they retire. This causes considerable dissatisfaction among these employees, some of whom have, in fact, been employed by the program for decades. This has contributed to a recent, debilitating strike of program workers. The importance of these issues is recognized by the Government. For example, the Fourth Plan states that (see: GOB; 1990, pp. XII-6, 16):

- a) the status of FP field functionaries is important for a widespread expansion of the program; and
- b) total identification with, and 'ownership' of, the FP program of the field functionaries should be ensured.

Nevertheless, a decision to transfer all FP Wing employees to the Revenue Budget cannot be made without addressing several major issues in detail:

- a) To what extent, and how, is the effectiveness of the FP work force affected by lack of encadrement?
- b) What are the financial implications to the Government of bringing the temporary workers into permanent status? How affordable would this be?
- c) What are the long-term administrative implications of transferring staff to the revenue budget, if, e.g., the structure of the program changes?

³ Those recruited under the Revenue Budget have permanent jobs, and are entitled to such retirement benefits as provident fund, gratuity, and pensions. However, those recruited under the Development Budget are not entitled to such benefits, except provident fund.

2.2. GOB Field Functionaries' Job Status

A major factor that has considerable psychological impact on the morale, performance, and efficiency of about 35,000 field functionaries (Sr. FWV, FWV not in Thana HQ, EPI, MA, Pharmacist, and FWA) of the GOB FP-MCH program, is related to their status. Many among them have been working in the program for many years on

the Development Budget. This causes several problems such as:

- a) job insecurity;
- b) lack of pension on retirement;
- c) other direct benefit, e.g., gratuity, etc.;
- d) subjection to arbitrary discipline, for example, an FWA's salary may get withheld for non-achievement of targets, whereas an HA is seldom penalized, as was apparent from discussions in the field; and
- e) lack of the sense of being valued, since their counterparts in the Health Wing at the thana level and above are given permanent status. It should be mentioned here that an HA, on retirement, receives retirement benefits amounting to about Tk. 300,000, while the FWA does not receive any such benefits.

On the other hand, GOB has more latitude for management action, Possibility of structural changes.

Salaries of all officials at the central and thana levels are paid from the Revenue Budget, while the field functionaries get paid from the Development Budget. "The problem with regard to salary and allowance is not one of payment. It is the more fundamental question of the level of salaries and their comparability with the personnel of the Health Wing and other ministries, posted at similar field levels" (Chauls et al., 1984, p.56).

2.3. Effects on Morale and Performance

Beyond question, FP workers on the Development Budget are affected by their status. Discussions with district and thana level officials indicate that the FWAs are penalized by way of their salaries being withheld in case of their inability to achieve 40 percent CAR target. Discussions in the field also indicate that this is affecting the morale, and thereby the efficiency of the field functionaries. For example, some FWAs reportedly have left their jobs even for less paying, yet permanent, jobs elsewhere. Also, among those who are still on the job, this has a slow demoralizing effect, which may ultimately affect the program.

It is not as clear that performance is jeopardized. For example, the HAs, who are on the Revenue Budget, work less well than the FWAs, perhaps partly because they are out of reach of effective sanctions. In two ways, however, budget status has clearly affected performance. First, the recent strike had a strong negative affect on FP acceptance, and the underlying issues are not yet resolved. Second, the ability to recruit FWAs in some areas, particularly Chittagong Division, is undoubtedly weakened by the status of the position.

2.4. GOB's Capacity to Absorb the FP Field Functionaries in the Revenue Budget

One solution to the problem is gradual absorption of over 30,000 FP field functionaries in the Revenue Budget in a phased in manner over the next 4 to 5 years, beginning with the senior field functionaries, i.e., using seniority as the criteria. The issue is under consideration by the GOB, and the process was initiated a year ago (GOB, 1993b, p.39). An intake of, say 5,000 FWAs annually will entail an additional allocation of about Taka 200 million in the Revenue Budget.⁴ From the fifth year, Taka 900 million will have to be spent annually. To this must be added expenditures on other categories of FP field personnel in the Development Budget. Would the GOB be able to absorb the additional costs from within the Revenue Budget? Perhaps, it should, considering that population is the number one problem for the country, and therefore its field functionaries deserve consideration of being absorbed in the Revenue Budget. However, can the Government sustain such an expensive CBD type of service delivery program, predominantly dependent on the development budget: (88 percent compared to 12 percent from the revenue budget (GOB, 1989, p.49). The decision to absorb the FP-MCH field functionaries in the Revenue Budget will call for reallocation of resources within the Revenue Budget. This obviously will affect the intersectoral allocation of resources, and the extent to which this reallocation will affect the overall development process needs to be thoroughly assessed before taking any such decision. Nevertheless, recent substantial increases in government revenues suggest that, if the Government considered the matter of sufficient importance, the additional expenditures could be absorbed.

Another pertinent point relates to comparative efficiency of those in the Revenue compared with the Development Budget. For example, are the HAs, who are in the Revenue Budget, more efficient than the FWAs, who are in the Development Budget? Thus, before taking any major decision regarding absorption of

4. ⁴ *The amount of Tk.200 million is based on the following: (a) 80% of the FWAs are senior, (whose average monthly take home salary is Tk. 3000, and 20% of the FWAs are junior whose average monthly take home salary is Tk.2,200; and (b) the phased-in absorption will begin with the seniormost 5000 FWAs.*

the FP-MCH field functionaries in the Revenue Budget, it would be advisable to study the relative efficacy and efficiency of the workers in the two types of budgets.

2.5. Long-term Administrative Implications

About two-thirds of the FP employees on the Development Budget are FWAs, who have been the principal contributors to the success of the CBD system. However, there has been considerable discussion as to whether this aspect of the program is sustainable, whether it will continue to be needed in the future, etc. Putting these and other FP workers on the Revenue Budget would probably make it difficult to change the structure of the system, if at some future point it is agreed that change is needed.

Ideally, it would be best to have a range of options between Development Budget status with no security, pensions, etc., and Revenue Budget status with little possibility of change and great difficulties in imposing sanctions for poor performance. Flexibility might be desirable along the following lines:

- a) Providing Revenue Budget status to the FP workers who are now on the Development Budget, as discussed in Section 2.4. At present, the Government is considering a phased-in absorption of the FP field functionaries. Based on discussions with concerned officials, it appears that the Ministry of Health and Family Welfare (MOHFW) has sent an official request to the Ministry of Establishment for this purpose. The Ministry of Establishment is believed to have initiated the idea of an O&M study. Based on the findings of the study, the Ministry of Establishment will send the request for consideration of the Ministry of Finance. The Ministry of Finance will take appropriate decision, and refer the matter back to the Ministry of Health and Family Welfare for necessary action.
- b) A special arrangement providing pensions and related benefits such as gratuity, provident fund, etc. (as in the case of the staff in autonomous bodies) to Development Budget employees after a certain specified period of service, for the same purpose, without necessarily putting them fully on the Revenue Budget.
- c) Putting workers on the Revenue Budget, but allowing for easier means of termination if the program structure changes, or more practical sanctions for poor performance.

At present, the apparent limitation of options makes the present situation unsatisfactory and unfair, and transfer to the Revenue Budget expensive. Also, considering the long-term sustainability of the FP-MCH program, it would be quite pertinent to think in the long run in terms of gradually phasing out the present CBD

system, which employs field workers by the Government and the NGO programs, in favour of less expensive alternatives.

3. TRAINING

3.1. Introduction

In order to attain the population policy objectives of the Fourth Five Year Plan, the GOB emphasizes the need to improve training capacity and skill (see GOB, 1990, pp. xii-7,13-14), including:

- a) development of appropriate and realistic training modules for various field functionaries, provision of training including on-the-job training for outreach workers, and utilizing locally available expertise at thana and union levels;
- b) provision of training on effective screening for contraceptive choice, counselling and follow-up of clients with respect to side-effects, management of drop-outs, and method switching with a view to ensuring 'quality care';
- c) development of manpower potential by reorganizing all FP-MCH training institutes, namely, NIPORT, FWVTIs, RTCs;
- d) ensuring that NIPORT caters to the needs of program managers' training and retraining through curriculum development, training of middle level personnel, preparation of appropriate training methodology, evaluation of the training programs, provision of technical backstopping, and coordination of manpower development activities of NGOs; and
- e) ensuring the GOB-NGO collaboration and partnership in training.

3.2. Training Needs

There is no comprehensive⁵ training need assessment for the personnel involved in the FP-MCH program, both in the Government and the NGO sectors. However, based on discussions with concerned NIPORT officials, the estimated gross demand for training in the Government sector for the ongoing Fourth Plan period is 96,781 trainees.

There are deficiencies in the basic training received by the MCH-FP personnel, particularly with regard to MCH services.

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5. *Comprehensive training need assessment should include the total number of personnel by categories who need training in different subject areas, and a time frame.*

Refresher courses organized by the NIPORT system are neither frequent enough nor synchronized in time to meet the needs of the growing MCH-FP services and the individual needs of the trainees themselves. Estimates based on a recent national survey (Khuda et al., 1993, p.15) show that more than half of the FWAs (i.e., about 12,000) did not receive any refresher training, indicating the limited capacity of the existing FP-MCH training institutions. Also, none of the FPIs recruited since 1976 have received any refresher training. Local training, when provided by field managers, to introduce new instructions or circulars from headquarters, are generally provided by unplanned lectures with little attention given to basic training principles or to practical training (GOB, 1992, Vol.2, p.28).

Several studies and assessments have indicated areas where adequate training among the fieldworkers is lacking. For example, training on population policies and programs is inadequate, as indicated by the poor state of knowledge and understanding of the field-based health and FP personnel (Hossain, 1988, p.35). There is need for additional training on primary health care and health education (Khan et al., 1988, pp.271, 28; Mabud et al., 1988, p.14; Gupta, 1990, pp.5, 8, and 14; Rahman et al., 1991, p.14; Gupta, 1991, p.14; Kabir and Uddin, 1989, p.16). Also, there is room for improvement in client motivation and interpersonal communication skills (Green, 1991, p.52; Hussain, 1991, p.10; Mabud et al., 1989, p.14; Gupta, 1991, p.14; Mabud et al., 1986, p.23). Furthermore, there is considerable need for training in assessment of contraindications and management of side-effects (Green 1991, p.14; Mabud et al., 1988, pp.14 and 23); Gupta, 1990, p.8; Rahman et al., 1991, p.14). Finally, there is room for improvements in record-keeping, especially vital registration (Green, 1991, p.52; Rahman et al., 1991, p.12; Koblinsky et al., 1984, p.200, Ahmed et al., 1992, pp.24, 29).

Other training needs include: (a) supervision in general; (b) financial rules, accounting, the auditing system, and budgetary controls; (c) logistics and supply management; (d) effective communication; and (e) personnel management and managerial skills.

In depth interviews with concerned field personnel indicate the following areas of additional training needs among the DDs, ADs, DD/FPs, ADs (General), and TFPOs: population dynamics FP-related management, IEC, and quality of care. For the AD(CC), the additional areas of training include MCH-related issues; for the SFVV, supervision and quality of care; for the MA, general training on population dynamics and FP; for the FWV, interpersonal communication, supervision, and quality of care; for the FPI, supervision, record-keeping, and interpersonal communication; and for the FWA, interpersonal communication, general MCH, record-keeping, and quality of care. Also, there is a critical training backlog affecting the 303 doctors recruited in the program (AVSC, 1992, p. xv).

As a result of inadequate training among different categories of program personnel, especially the FWAs and the FWVs, the quality of service suffers. Consequently, the clients are not fully and adequately informed about the various contraindications, side-effects, etc., resulting in relatively high dropouts. Thus there is need for appropriate and realistic training modules for various field functionaries for on-the job training of outreach workers on a regular basis (GOB, undated, p.38).

Although the BAVS, with AVSC funding, provided training to 2,800 doctors on voluntary surgical contraception between 1970 and 1990, there is still a shortage of doctors who are trained in sterilization techniques. According to the circular presented in Exhibit 3.1, the newly-recruited 303 MO-MCHs are not trained in sterilization techniques; this is one reason for the decline in sterilizations.

Exhibit 3.1: Inadequate Training of the Medical Doctors is a Major Reason for the Decline in Sterilization.

- Withdrawal of referral fees.
- Lack of doctors trained in sterilization.
- Trained medical personnel return to the Health Wing, etc.

Source: Project Director (Clinical Services), DFP: Memo No. PPA/Sa-Sakha/255 Dated: 9.7.92

Thus, there is need to address deficiencies in practical training for clinical contraceptive methods. In Bangladesh, after more than 20 years of the FP program, there is no universal practical training of medical students and nurses in FP-MCH, including clinical methods. Also, there is no institutionalized system for in-service training for voluntary sterilization (Ahmed et al., 1992, p.54).

3.3. Training Capacity

There is no comprehensive study on training capacity and the degree of its utilization, either in Government or NGO sectors. In view of the lack of comprehensive studies on demand for and supply of training, it appears that training activities are being undertaken on a less systematic basis. There is evidence to suggest that while some personnel have received more than two or three refresher trainings, there are many who have not received any refresher training.

Recognizing the need for training, the Government began undertaking training programs for its fieldworkers beginning the mid-1970s. Over the years, both the content and duration of training programs have undergone several changes, reflecting the

need for longer duration as well as incorporation of various topics in the training curriculum. Despite improvements that have taken place both in the duration and content of the training programs, the need for additional training of fieldworkers still exists both among the Government and NGO fieldworkers (see, for example, Sohail, 1988, p.172; Kabir and Uddin, 1989, p.16; Mitra and Associates. University Research Corporation (Bangladesh), and East-West Population Institute, 1991, pp.143-47; Mabud et al., 1988, Table 12; Mabud et al., 1989, p.15; Khuda et al., 1992, p.27; Khan et al., 1988, p.287; Munro, 1990, p.9).

The first basic training curriculum was developed in early 1976. Training was imparted by 20 District Training Teams, each consisting of a Training Officer and an Assistant Trainer. The duration of training was four weeks, and a uniform curriculum, though not very detailed, was used. The overall responsibility of training was assigned to NIPORT from 1980. A detailed curriculum was developed in 1983, which included three weeks' institutional training and four weeks' field practice. The training curriculum was revised again in 1986. It was of eight weeks' duration, and more organized and institution-based.

Inadequate provision and capacity for training has been recognized as a major problem affecting the training programs (Khan et al., 1988, p.286; UNFPA, 1990a, p.231, UNFPA, 1990b, p.150; Hossain, 1988, p.35, Khuda et al., 1992, p.27; AVSC, 1992, p.23).

Realizing the need for training of various categories of its personnel, the MOHFW created the National Institute of Population Training in 1977, charged with the responsibility of providing the needed training. Subsequently, research was added to its functions, and it was renamed as National Institute of Population Research and Training (NIPORT) in 1980. The four major objectives of NIPORT are to: (a) impart training to program managers of health, FP, and multisectoral programs from the thana level and above, as well as the senior and mid-level personnel of the NGOs; (b) supervise the fieldworker and paramedic training conducted in the RTCs and FWVTIs; (c) conduct social science and population-related action research that is problem-oriented and program-focussed; and (d) monitor and coordinate with other institutions/organizations involved in action-oriented research and training in population and MCH.

NIPORT provides training directly as well as through the twenty Regional Training Centers (RTCs) and the twelve Family Welfare Visitor Training Institutes (FWVTIs). The RTCs were set up in 1977 with the objectives of: (a) imparting basic training to the newly-recruited FWAs to enable them to discharge their responsibilities efficiently; (b) providing refresher training to FWAs and HAs with a view to enhancing their knowledge and skill related to efficient discharge of their job responsibilities; (c) providing team training to FPis and AHIs; and (d) providing orientation training to fieldworkers of multisectoral programs on FP in collaboration with the training institutes of the multisectoral programs. The FWVTIs were set

up in 1977 with the objective of providing institutionalized training and retraining to FWVs to improve their knowledge and skill in carrying out their assigned job.

FWVTIs are located at 12 Greater District headquarters, and RTCs are located at 20 Thana headquarters, except one which is located at Noakhali. Among the institutes, FWVTI, Dhaka, is responsible for training the SFWVs only. Four RTCs (Dhamrai, Sitakunda, Mithapukur, and Monirampur) impart TOT (Training of Trainers) to FWVs, who in turn impart training to TBAs (Traditional Birth Attendants). The FWVTIs and the RTCs have been constructed with grants from USAID (Director General, FP, 1993, p.4).

NIPORT is mandated to provide task-oriented and practical training, based on needs assessment, implemented through modern teaching and learning methods, and carefully monitored by continuous evaluation. To achieve these training targets, strategies have been adopted to develop, upgrade, and implement curricula on a priority basis; provide all trainers with skills and knowledge (TOT), which are essential for effective teaching; develop master trainers and a core faculty in NIPORT through short-and long-term training in Bangladesh and abroad; conduct training-related research and evaluation to improve the quality of training curricula and methods; impart in-service courses, which are shorter in duration but more frequent than in the past; develop field training sites; emphasize communication and counselling skills in the curricula with the objective of providing comprehensive information and guidance to the clients; consolidate the role of the Mobile Training Teams; give priority to training on antenatal, natal, and postnatal care in the future; and train program officials in the ZOPP Method to strengthen program planning, implementation and monitoring (GOB, 1990a, Annex 5, p.6).

NIPORT's training plays a key role in the national health and FP program with the objective of ensuring that: (a) sufficient number of adequately trained personnel are available at all levels -- district and below; and (b) all categories of workers have the required skills to ensure better job performance (GOB, 1990b, p. 123).

The main training courses include: Management Development and Team Training for Civil Surgeons, Deputy Directors of FP-MCH, THFPOs, TFPOs and Medical Officers; Clinical Management for M.O.(CC); specialized course on training technology for faculty members of NIPORT, RTC and FWVTI; Office and Financial Management for Senior Officials; Basic and Refresher training for Senior FWVs, and TFPOs; Store Management for Store Keepers; Orientation in FP-MCH and PHC for those involved in multi-sectoral programs; workshops and seminars for national and district level program managers. In addition, NIPORT collaborated with BAVS in the training of 1,763 Medical Officers in sterilization against the target of 2,138. NIPORT/JSI implemented the logistic management training in two phases, involving 2,464 personnel against the target of 5,834 personnel (Das, 1992, p.11).

In-service training of doctors was started by NIPORT in 1992, with AVSC funding and technical assistance in 9 MCWCs, Mymensingh Model Clinic and Mohammadpur Fertility Service and Training Center. An ambitious program was undertaken to provide comprehensive training to 105 doctors and refresher training to 80 doctors. Only 29 physicians were trained in sterilization in 1991. MFSTC can be developed into a "Clinical nerve center", but the development of selected MCHWCs as sterilization training centers may not be easy, because: (a) there is only one Medical Officer, who already has a full plate of responsibilities; (b) considerable work would be needed to assure an adequate and reliable case load; and (c) it is not clear how the didactic component of the training could be managed for those sent to the MCWCs for training (AVSC, 1992, pp.40,41).

The BAVS no longer provides training to doctors on sterilization. Efforts are being made to fill the void, with NIPORT developing an in-service training program with AVSC assistance to create a long-term sterilization training capacity in existing government service sites around the country. Pre-service training in medical colleges remains a problematic area. During the 1970s, Model Clinics were constructed in 8 medical colleges; however, their services are underutilized. An evaluation of these model clinics found that there was lack of coordination and involvement with the Department of Obstetrics and Gynecology, little interest and attendance by students, low accountability of trainers, and low referrals to model clinics (Ahmed et al., 1992, p.38).

The existing training facilities of NIPORT, including 12 FWVTIs and 20 RTCs, are not adequately equipped to cope with the training needs of around 43,000 field functionaries (Health and FP personnel). Thus the duration of training had to be shortened to one week, which according to the administration was sufficient, but was considered inadequate by the trainers. There was an acute shortage of trainers in communication and motivation, an essential skill required for the fieldworkers (Hossain, 1988, pp. 35,40; Khuda et al., 1992).

Of the 20 positions of lecturer (PHC) in the RTCs, six were vacant in June 1989 and ten in December 1991. Of the 20 posts of Home Economists, six were vacant in December 1988. The situation has since improved, and only one post was vacant in December 1991. In the FWVTIs, the total number of vacancies in the training-related positions was thirty in December 1988, and twenty-one in December 1991. One post often lying vacant is Lecturer (Nursing and Midwifery); four posts were vacant in December 1988 and in December 1991. The post of Principal was vacant in five institutes again in December 1991. The posts of eleven Junior Trainers, approved in the PP, were not sanctioned till December 1991 (Das, 1992, p.29).

Table 3.1 shows the training capacity of the NIPORT system as a whole during the Fourth Plan period. It is, of course, possible to think of alternative estimates, when the basic variables of the system such as the number of training days per year or the trainee group's size is changed.

TABLE 3.1

TRAINING CAPACITY OF THE NIPORT SYSTEM

Institute	Training days per year	No. of training centers	No. of courses (concurrently)	No. of participants per course	Trainee training days per year	Trainee training days 1990-95
NIPORT HQ., Dhaka	250	1	3	20	15,000	75,000
RTCs	250	20	1	25	125,000	625,000
FWVTIs, all except Dhaka	250	11	3	20	165,000	825,000
FWVTI Dhaka	250	1	2	25	12,500	62,500
Total		33			317,500	1,587,500

Source: Schulz, 1991, p.13

Training targets of NIPORT for the Fourth Plan, presented in Table 3.2, are quite ambitious, since as in the past, it has been facing various problems, including trainer/faculty shortage. Although ambitious, the training target of 67,747 trainees represents only 70 percent of the estimated gross training need in the Government system. However, the training target has been revised downwards to 45,000 trainees, which is 46 percent of the estimated gross training need, because NIPORT has not been provided with the 156 additional personnel requested in the Fourth Plan. Thus, it is obvious that the NIPORT system is unable to cater to the training needs of even half of the gross estimated demand for training.

TABLE 3.2

NIPORT TRAINING TARGET: 1990-1995

Sl. No.	Institutes	No. of Trainees	No. of Trainee Training Days (TTDs)
01.a)	NIPORT Headquarters	9,144	92,608
b)	Through Upazila (thana) Health Complexes	8,000	48,000
c)	Logistic Management Training (LMT)	13,800	54,118
d)	GOB Doctors Training	900	5,400
	Sub-Total	31,844	2 00,126
02.a)	FWVTIs	5,503	7 88,652
b)	RTCs	30,400	4,82,400
	GRAND TOTAL	67,747	1,471,178

Source: NIPORT/GTZ, 1990, Document No.7, p.26

In-service training would be imparted to 5800 program managers and supervisors at NIPORT; 14,000 FWVs, Senior FWVs, teachers, and community leaders at FWVTIs; and 37,500 field workers of Health and FP at the RTCs (GOB, 1990a, Annex 5, p.5). However, NIPORT's capacity can be expanded by possible use of available local training capacity at the district level (GOB, 1992, Vol.2, p.15).

According to an evaluation report, NIPORT's training target for the Fourth Plan includes 61,964 personnel of different categories, involving 1,612,082 TTDs. Of them, 19,084 are to be trained at NIPORT headquarters, 36,650 at the RTCs, and 6,230 at the FWVTIs. The trainee-training-days are: 158,882, 571,200, and 882,000 respectively for the three different types of institutions (Das, 1992, p.11).

During July 1990 - December 1991, a total of 15,793 personnel were targeted to be trained. Of them, 12,748 (81%) were actually trained. The institution-wise achievements are: 78 percent for NIPORT, 83 percent for FWVTIs, and 74 percent for RTCs. The trainee-training days' (TTDs) achievements were 53 percent, 113 percent and 90 percent respectively for NIPORT headquarters, RTCs, and FWVTIs (Table 3.3).

TABLE 3.3

**ACHIEVEMENTS OF TRAINING TARGET OF NIPORT SYSTEM DURING
JULY 1990 - DECEMBER 1991**

Training Institute	Nos. of Trainees			Nos. of Trainee Training Days		
	Planned	Actual	%	Planned	Actual	%
NIPORT	3,220	2,499	77.6	28,892	15,325	53.0
RTCs	11,050	9,124	82.5	131,200	148,621	113.3
FWVTIs	1,523	1,125	73.8	262,668	235,815	89.8
Total	15,793	12,748	80.7	422,760	399,761	94.5

Source: Das, 1992, p.12.

NIPORT has a Mobile Training Team (MTT), which offers regular sessions in peripheral training institutes, and short-term in-service training to trainers and officials of the Health and FP program in collaboration with Bangladesh Rural Advancement Committee (BRAC), Center for Population Management (CPMR), Dhaka University, John Snow Incorporated (JSI), Pathfinder Fund, Radda Barnen, UNICEF, etc. (MOHFW, Vol.1, 1990, p.123).

The functioning of MTTs for training of trainers, especially on-the-job training and use of participatory training methods, lesson plans and audio-visual aids, is useful. The MTT members provide supportive supervision and problem-solving assistance to managers and trainers in peripheral institutions, as well as follow-up in Dhaka on problems that could not be dealt with locally. It was not, however, possible to assess the approach in terms of its effectiveness and peripheral trainers' perception (Das, 1992, p.21).

In the Fourth Plan, the training of 8,000 FP-MCH Inspectors (FPIs) is envisaged through the MTTs and eight Thana Health Complexes.

Eight Medical Assistants Training School (MATS) were set up in the late 1970s to offer a three-year course on PHC and basic medicine for high school graduates. The Medical Assistants (MAs) graduates from the MATs are supposed to provide basic medical care to the rural people. However, the MATS had been suffering from several deficiencies, including inappropriate curricula, inadequate teaching approaches, greater emphasis given to theoretical than practical work, inadequate utilization of equipment, etc. (Islam and Rahman, 1988). In 1986, the Government decided to close down

the MATS. However, there is now a rethinking to reorient and develop the MATS along the lines of RTIs (MOHFW, 1990 pp.67). Also, according to a news report published in a Bangla daily, a dialogue is going on between the Government and the Bangladesh Diploma Medical Association (BDMA) to reopen the medical diploma courses in the MATS (The Daily Sangbad, October 27, 1993). Given the policy of Health for All by 2000 and the extremely limited number of medically qualified personnel in rural areas, the decision to reopen the eight MATS appears to be justified.

In the non-government sector, some NGOs have been providing training, both clinical and non-clinical, to both their own personnel as well as those from other NGOs as well as the Government. Indeed, several NGOs have had their training programs operating successfully for quite some time. FPAB not only has its own regular training program, but also hires out its facilities to other NGOs and the GOB. BRAC provided refresher training to FWAs on MCH-based FP (Islam et al, 1990). The CWFP has a relatively strong training cell (Khan, 1991, p.5). Similarly, FPSTC has been offering training programs for several years, both for its own project staff as well as others from within the NGO community and the Government. Previously AVSC had provided technical and financial assistance to BAVS on clinical contraception training. However, since withdrawing its support to BAVS, AVSC has been working with the GOB, through NIPORT, to assist in the strengthening of the MOHFW's training capacity.

The foregoing discussion indicates the limited capacity within the existing MOHFW system to cope with the increasing demand for training (basic and refresher) of different categories of personnel. Also, this is somewhat true of the NGOs.

The institutional capacity for training of different categories of personnel, both in the public and private sectors, is inadequate, resulting in shortfalls in the number and quality of trained personnel. The shortfalls are exacerbated by bureaucratic red tape, faulty target planning in terms of capacity and associated factors, and lack of cooperation among the staffs of Health, Family Planning, and the Planning Commission. Key positions remain vacant, and there are difficulties in arranging logistics, gaps in training in terms of quality and selection of workers not according to needs, and the training curriculum relies too much on central design (Khuda et al., 1990,p.22; Choudhuri and Akhter, 1990, p.231).

However, it is quite likely that the Government, the NGOs, and the private sector enjoy comparative advantages in different selected areas of training. Thus, it should be appropriate to identify which of the actors has a comparative advantage in which areas of training. Based on this assessment, a national FP-MCH training program can be developed, and the different agencies can be assigned with training in areas of their comparative advantage.

3.4. Training MIS

A training MIS was set up in 1991 with GTZ support. Under the system, data related to the number of trainee days on each course at each institution are collected and sent to NIPORT to be entered onto a computer. However, the use of the data for improving training program performance is limited, since at present no information is obtained to assess the quality of training. Thus, there is a need to redesign the existing training MIS to collect information to assess the effects of training. Such a redesign of the training MIS is under consideration.

4. NGO/GOB DIVISION OF LABOR AND COORDINATION

4.1. Introduction

"Community participation through the NGOs" is one of the four "specific strategies" of the Fourth Plan (GOB, 1990, p.I-10). Recognizing the importance and contribution of the NGOs in national development, the Fourth Plan noted "services of the NGOs should be utilized in a more cost-effective and coordinated way" (GOB, 1990, p.1-13). Within this general framework, to accomplish the demographic goals of the Fourth Plan, the major components of GOB pertaining to the FP-MCH NGOs are as follows (see: GOB, 1990, XII-7, 14):

- a) in order to bring more dynamism and to generate additional demand for FP-MCH services voluntary and non-Government agencies would be encouraged to promote their supplementary and complementary role in implementation of the national FP-MCH program and to innovate cost-effective and nationally replicable models;
- b) NGOs should enhance professional expertise in planning for achieving demographic and contraceptive goals, and for ensuring effective accountability of all other concerned agencies and functionaries, including coordination and monitoring of multisectoral projects and NGO activities; and
- c) NGOs are encouraged to specialize in some specific areas of service delivery such as promotion of injectables, intensification of health education activities, delayed marriage movement, education on breast-feeding, nutrition and training/orientation of religious leaders, or some other innovative works, including income-generating activities for women.

Hence, NGOs are accorded a prominent place in the existing scheme of things. In practice, their roles include being a major community-based service provider, distributing perhaps a third of all non-clinical methods; taking innovative roles in training, IEC, research, and other support services; and, both in

individual and official capacities, contributing substantially to national policy debates and decisions.

Two types of issues regarding GOB-NGO coordination need to be addressed. First, at the larger policy issue, is the question of NGO roles in the long run. Should both the Government and the NGOs remain heavily involved in CBD activities, or should one or the other take over this responsibility? To what extent, and in what areas, should privatization of support services (e.g., training, IEC, logistics, etc.) take place, and in which activities should NGOs be involved? These issues will require a wider review of options and a complex political process, and are beyond the scope of this paper. The second type of issue relates to improving coordination between the Government and the NGOs in implementing roles currently agreed on. These issues will be dealt with in this review.

4.2. Nature of the GOB-NGO Partnership in FP-MCH Activities

The Prime Minister of Bangladesh, in her party's National Convention speech on 1.9.93, stated clearly the role of NGOs, among others, in the field of primary health care. At present, the GOB and NGOs are cooperating, collaborating, and coordinating their activities in several areas to avoid duplication and wastage of time, money, and energies. NGO involvement in FP and related activities occurs on a very large scale. NGOs distributed about 30 percent of condoms, injectables and pills during the last few years (Hug and Hug, 1990, p.3), and provided services to over 25 percent to all eligible couples (Islam and Rahman, 1992, p.85; Hashem et al., 1990, p.17). NGOs also provide assistance in such areas as EPI, nutrition, TBA training and other MCH activities, urban health, and community mobilization for health and FP. In addition, NGOs assist the Government in support services such as training, IEC, and research.

The primary mode of NGO involvement in service provision is to take responsibility for CBD field activities in defined geographic areas (both urban and rural), under the authority of the Government. In so doing, the NGOs are required to follow a similar model for house-to-house motivation and service, operating standards, record-keeping procedures, etc., to that of the Government's programme. This allows gaps to be filled in the system where the Government has difficulty in providing adequate service. At the same time, it results in complex problems in coordination, which will be discussed in Section 4.3 below.

An alternative service approach is for the NGOs to work directly with the MOHFW to successfully strengthen the GOB's service delivery system, e.g., assistance of organizations like BRAC (147 thanas) and CARE (96 thanas) in the Government's EPI program (ICDDR,B 1990, p.4; GOB, undated, p.17; Chowdhury, 1991, p.2; UNFPA, 1990a, pp. 262, 266). BRAC also has community-based growth monitoring, supplementary feeding, and TBA training programs, in addition to its assistance in the satellite clinic

program (GOB, Vol. 3; 1992, p.31). The Aga Khan Community Health Program (AKCHP) cooperates with the GOB in such activities as EPI, TBA trainings growth monitoring, distribution of Vitamin A capsules, etc. (AKCHP, 1988, p.33). Social mobilization by a number of NGOs has also contributed to making local institutions effective in mobilizing community support for small family norms and social legitimacy for contraceptive practice (GOB, 1990a, pp. 57, 58). A nationwide crystallization of social movements for small family norms has already begun, and this could be further strengthened and decentralized (GOB, 1990b, p.253).

NGOs contribute to the FP-MCH Programme in many other ways. Examples of other successful coordination between the Government and the NGOs include various other activities such as the development of long-term strategic planning and the development of the National FP-MCH IEC Strategy. Collaboration between the Government and the NGOs have been in the form of joint workshops and seminars, etc. For example, on the basis of the Union Level Report of the Expert Group, district-level workshops were held to determine coordination strategies between the Government and the NGO field functionaries. Besides, some NGOs -- e.g. FPAB -- rent out their training facilities to the government (Chowdhury, 1993, p.26). The FPSTC and Pathfinder International contribute to coordination efforts both among the NGOs themselves and between NGOs and the Government (Mitra and Associates, URC(B), East-West Center Population Institute, 1991, p.13).

The Social Marketing Company (SMC, erstwhile SMP) began its activities in 1974 to sell contraceptives at subsidized rates through private commercial outlets. Over the years, it has sold huge quantities of condoms, oral pills, and for a period, foaming tablets. Packaged oral rehydration salts were added to the product line in 1986, and safe delivery kits ("Sheba") in 1990. It has a distribution network, comprising 130,000 sale outlets, involving wholesalers (stockists), and retailers, including pharmacies, groceries, pan shops and rural medical practitioners. The SMC has played a significant role in the national FP program (Khuda et al., 1992, p. 128). In 1986 it accounted for 75 percent of all condoms sold and 25 percent of all oral pills sold (Shutt, 1991, p. 38). The SMC is represented in the NGOCC and several GOB committees, so that it can participate more effectively in the national FP program.

4.2.1. NGOs as Additional Sources of IEC and Training

NGOs also provide substantial support in Information, Education, and Communication (IEC) and in training. Regarding IEC, the NGOs focussed initially on urban IEC, but were asked by the GOB to extend their programs to rural areas (Shutt et al., 1991, p. 23). One of the strategies during the Fourth Plan in involving the NGOs is to supplement the GOB's efforts in the field of IEC (Hussain, 1991, p. 9, Khuda et al., 1992 a and b, and 1993), given that the NGOs have over time acquired strengths in designing and utilizing appropriate FP IEC materials in their catchment areas (GOB, 1990a, p.56).

The FP NGOs have undertaken various IEC activities from time to time to popularize the concept of small family norms. The UNESCO feels that opportunities should be created for combined GOB/NGO efforts (UNESCO, 1992, p.34).

The IEC interventions undertaken thus far related to surgical contraception include: (a) promotion of the method, (b) educative materials for the target population, and (c) educative materials for the service providers. The AVSC, has, among other IEC materials, produced the Voluntary Surgical Contraception (VSC) Trainer's Guide (Khuda et al., 1992, pp. 128-131). Also, AVSC helps provide training to GOB personnel.

The FPAB, with the introduction of the GOB's national FP program in 1960, redefined its role. It started to supplement and complement the national program efforts in undertaking promotional activities, and, among other things, produced a film on vasectomy. Pathfinder International has produced training materials, which NIPORT has used for the training of local level FP officials. Also, as a part of national decentralization of FP activities, Pathfinder International supports training of government officials including TFPOs, MOs, and trainers of FWVTIs.

Realizing the need to promote greater acceptance and use of more effective, long term clinical methods, some NGOs jointly developed a Quality Assurance Manual, which has subsequently been translated into Bangla to facilitate greater understanding of the manual among the field personnel (Khuda et al., 1992, p. 127). The GOB, in its FFYP 1990-95, had already stipulated that the NGOs will be encouraged to specialize in some specific areas of service delivery such as promotion of injectables" (p. xii-14).

However, despite the above efforts, there has been little effective coordination among the key IEC actors: among the NGOs, between the NGOs and the IEM Unit, and between public and private sectors (Khuda et al., 1992, p. 123).

Some NGOs train GOB personnel. The AVSC provides refresher and comprehensive training to GOB physicians, and training in MCH-FP to medical college interns. Also, the AVSC, at the request of the GOB, jointly undertook an assessment of clinical contraception services in Bangladesh. Pathfinder International provides training, training materials, technical assistance, etc. to GOB functionaries (Mitra and Associates, URC(B), East-West Center Population Institute, 1991, p.4,5).

4.2.2. Replication of NGOs' Innovative Service Delivery Interventions

Concerns regarding replication of NGO interventions have been raised by many. However, "because of the particular nature of management and resource allocation, most NGO efforts remain unreplicable" (UNFPA, 1990, p.270). Nevertheless, recent

experience has shown some success in transferring some elements of NGO programs with necessary adaptations. The Fourth Plan clearly states that the "NGOs would also be encouraged to evolve cost-effective and nationally replicable models of MCH-FP service delivery" (FFYP: 1990-95, p. xii-14).

An important potential mechanism for replication of NGO interventions is operations research. The most prominent mechanism for this is the MCH-FP Extension Project of ICDDR,B, whose basic purpose is to adapt successful innovations into a GOB-managed setting. This approach has had several successes. First, based on the ICDDR,B research findings showing strong correlation between fieldworker home visitation and contraceptive prevalence, the GOB decided to recruit 10,000 additional female fieldworkers (FWAs), bringing their total to 23,000 and considerably increasing the FWA/client ratio. Second, "client oriented record-keeping system designed to facilitate the female fieldworker activities helps to increase coverage through better planning and monitoring of the field activities" (Maru, 1991, pp. 7,8). This has contributed to the development of the FWA Register. Third, the joint GOB and Extension Project program on domiciliary injectable contraceptive delivery was begun (ICDDR,B, 1990, p.4). Fourth, a briefing paper was produced on mechanism for achieving effective coordination between the NGO and the MOHFW service delivery programs in rural Bangladesh (Huber et al., 1992, p.25). Fifth, a second generation FWA register was prepared in collaboration with the MIS Unit of the DFP (ICDDR,B, 1992, p.2). The ICDDR,B has also developed linkages with the MIS Unit as part of its improved policy linkages with the MOHFW program (Huber, et al., 1992, p.24).

The Government is appreciative of NGO efforts, and has also introduced some of the NGO innovations in its own program efforts. Notable among those are: (a) the Government's decision to decrease the worker-client ratio to 1:750 by hiring 10,000 additional FWAs; and (b) the Government's decision to print 40,000 copies of the Field Guide, after some modifications for its own fieldworkers (Khuda et al., 1992, p. 127). The NGOs' development of a record book and improved work plans and record-keeping mechanisms for fieldworkers have been positive contributions (Shutt et al., 1990, p.28). However, the NGO potentials insofar as development of cost-effective and nationally replicable models in different aspects of service delivery and demand creation activities are concerned have not been fully utilized. This is a crucial area for operations research and program development (MOHFP, undated, p.29).

However, situations where the Government has directly adapted service approaches developed by an NGO have been rare. Reasons for this include the following. First, many NGO approaches are not appropriate for Government replication, because NGOs can operate in ways that Government cannot. Second, while the general shape of NGO activities is well known to the Government, the right officials may not be sufficiently familiar with key details to understand how an approach might be adapted. Third, the Government does not have effective channels to process

information from outside MOHFW into formats useful for decision making. Fourth, the Government is often short of staff with the time and ability to draft the options papers, proposals, terms of reference, regulations, and policy circulars needed to turn an idea into a reality. In short, the management patterns and skill limitations which limit efficiency at the central level in other ways impedes replication of innovative NGO ideas, despite good intentions on both sides.

4.3. GOB Coordination Policy and Practice Regarding FP NGOs

4.3.1. Origin of the Policy

The Bangladesh Government places considerable importance on the involvement of the NGOs in its FP-MCH activities. The Second Five-Year Plan (SFYP) (p. xvi-6) states that the GOB would promote the role of NGOs in the population field, and make it complementary to GOB efforts. The Third Five-Year Plan (TFYP) (p. xii-7) went further, to argue that to enhance professional expertise and ensure accountability, the GOB would monitor and coordinate, among other agencies and functionaries, the NGO activities. Although the FP program started in Bangladesh through NGO efforts in the early fifties, the NGO FP programs did not gain momentum until the mid-1970s. Even then, until the mid-1980s, they were confined to urban areas, but since then the NGOs have been encouraged to work in rural areas as well. The expansion to the rural areas started with a Government request in 1986 to the NGOs, who were assigned specific rural locations of operation by the local government. Largely supported by USAID funding, rapid expansion of NGO activities in rural areas took place. As of 1990, out of 320 projects supported through the USAID-funded Cooperating Agencies (CAs), 178 were in rural areas. The demarcation of areas was designed to utilize scarce resources by expanding coverage and reducing duplication (Hashem et al., 1989, p.17).

4.3.2. Policies for Coordinating NGO Activities

In view of the size and scope of NGO activities, elaborate coordination mechanisms are necessary. The basic structure for coordination of NGO FP activities is shown in Exhibit 4.1.

Exhibit 4.1: Coordination of Activities of FP NGOs

- The DD/FPs will prepare a list (according to the attached format) of the NGOs working in the concerned districts, and will send the list to the Director, MIS Unit, by December, 1989.
- The NGOs will submit a monthly report, prepared according to the government designed format, to the TFPO.
- The DD/FP, TFPO, MO-MCH will regularly supervise the activities of NGOs under their jurisdiction, and will submit report to this effect to the DGFP.
- FP-MCH supplies will be kept in the Thana Stores and Project Offices for three months' use.
- After evaluating the progress of the projects, the TFPO will supply the FP-MCH supplies to the projects, according to their legitimate demand.
- The Project Directors of the NGOs will have to follow the supply manual issued by this Directorate.
- The TFPO will supply IUD and injectables.
- Those NGOs which have full time field workers and maintain the clinical programs, but do not get any materials or medicines from other sources, may be supplied with DDS kits, subject to the approval of the Director General.
- The TFPO will supply IEM materials to the NGOs operating in the area, depending on the population size.
- The representatives of the NGOs will be invited to participate in the monthly coordination meetings. They will submit the progress report of their projects to that meeting.

Source: DG DFP: Memo No.PPA/MP/88/8092, Dated 24.11.88

In view of the special status of Dhaka City, the GOB has written policy guidelines for enhancing coordinated FP-MCH activities of the GOB and NGOs in the city. The major components of the relevant GOB guidelines regarding coordination between the GOB and the NGOs are presented in Exhibit 4.2.

Exhibit 4.2: Coordination of GOB and NGO activities in Dhaka City.

Thana Family Planning Officer (TFPO):

The duties and responsibilities of the officers and fieldworkers working in Dhaka City are specified as follows:

- Although there are 12 thanas in Dhaka City, there are only two TFPOs in Tejgaon and Mirpur to coordinate FP activities. For the purpose of ensuring better coordination of activities of the NGOs and proper monitoring and evaluation of their activities, the concerned TFPOs will arrange coordination meetings with the NGOs during the first week of every month.
- After monitoring and evaluation of the activities of all the NGOs, the TFPOs will submit reports to the Deputy Director, FP, Dhaka, by the 10th of each month.
- He will ensure proper utilization of MSR, etc. by the NGOs related with clinical program.
- He will ensure regular and proper functioning of the fieldworkers of the Government and the NGOs in their respective catchment areas.
- He will ensure regular (monthly) follow-up of sterilization clients and the recipients of other methods from the Government and NGO clinics in accordance with the instructions laid down in the memorandum FPA/MP/88 dated 13/11/80 issued from this Directorate.

FP-MCH Inspector (FPI):

- Assuming each three wards as equivalent to one union in rural areas, the 75 wards of Dhaka City (in 1983) were divided into 25 units. And, accordingly, 25 FPIs are working in Dhaka City.
- A report, containing the monthly work progress of various NGOs, must be submitted to the concerned TFPO by the 10th of each month.
- Arrangements must be made to refer the IUD, injectables, and sterilization clients to the various recognized clinics by the field workers.
- With the help of NGO field workers, the group meetings and enlistment of couples must be made every year in the respective areas, especially in the slums.

Family Welfare Assistant (FWA)

- The FWA will have to work in close coordination/cooperation with the NGO fieldworkers in their respective areas.
- There are many clinic-based NGOs in the city. Each Family Welfare Assistant will refer sterilization cases, and potential IUD and injectable acceptors of her area to such clinics. For this purpose, the DD/FP will attach the FPIs and FWAs to various NGO clinics.
- The FWAs, with the help and cooperation of the NGO field workers, will have to complete the updated enlistment of couples within a specific time of each year.
- FP-MCH activities in the slum areas will have to be strengthened. The FWAs will have to maintain a special register for recording the names of the slums and their population.

Family Welfare Visitor (FWV)

- The FWV will have to arrange/organize satellite clinics with the help and cooperation of the GOB and the NGO fieldworkers.
- In order to make their services more dynamic, the FWVs working in the community centers of various wards will have to be attached to various NGOs under the directives/instructions of the Deputy Director.
- The FWV will follow-up and monitor the clinical programs, especially the MCH programs run by the various NGOs.
- The FWV will arrange home visits and group meetings with the mothers, with the help and assistance of the GOB and NGO field workers. This order will be effective from 1st December, 1988 in Dhaka City.

Source: DG, DFP, Memo No: PPA/MP/88/8092, Dated 24.11.88

The GOB has recently taken steps to streamline the project approval process for all NGO projects. Also, the GOB interest in establishing an NGO Implementation Assistance Team "to provide technical assistance to MOHFW 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" (Huber et al., 1990, pp.3 and 20).

However, there are also problems, misgivings, and confusion between the GOB and the NGOs. For example, the NGOs are not quite pleased with the GOB reporting requirements. Also, at times, the NGOs are said to be not submitting their monthly progress reports to the GOB, which, according to the GOB circulars, hamper the process of "planning for supplies". The NGOs have been reminded of the need to send their monthly progress reports through a series of circulars issued by the DFP. One such circular is presented in Exhibit 4.3.

Exhibit 4.3: Requirement for Monthly Progress Reports by the NGOs.

- Under the present system, the monthly progress reports of the branches of seven national level NGOs, except reports of the head offices of these seven NGOs and other voluntary organization, are supposed to be submitted to the MIS Unit of this Directorate through their respective upazila (thana) Fp offices.
- The demand for all FP-MCH methods and supplies required for the overall program is determined on the basis of the **monthly progress reports submitted to the MIS Unit.**
- Considering the amount of contraceptives being supplied presently throughout the country and the monthly progress reports of the GOB and the NGOs in this regard, a considerable amount of stock of contraceptives like condoms, oral pills, and injectables is supposed to be there at the field level. It is observed that though records like Form No.7 indicate a huge amount of stock of these methods, these are not found in reality. After indepth review of the problem, it has been **observed that though the NGOs operating throughout the country show utmost interest in receiving the supplies, they do not regularly submit their monthly progress reports.** Out of 406 voluntary organizations and their 1,300 service centers throughout the country, only 135 organizations submitted their progress reports in May 1988. In June 1988, the number of progress report was 333. With frequent reminders, this number rose to 350. In September 1988, approximately 400 voluntary organizations submitted their monthly progress reports. Among the organizations which did not submit their progress reports for several months together, it is not possible to determine/estimate their amount of supplies, stock and progress, because of lack of such reports.
- Under the above circumstances, it has been decided that **the NGOs, which did not submit their monthly progress reports since June 1988, will not be further supplied with any FP-MCH methods until they submit the stated progress reports.** The list of 73 organizations which failed to submit their progress reports is sent herewith. You are requested to report to this Directorate regarding the measures taken (to this effect) against the organizations falling within your district as mentioned in the list.

This order will come into force with immediate effect.

Source: DG, DFP, Memo No. DFP/LCM/89-88, Dated 9.7.88

4.3.3. The Process of Demarcation for NGOs in Rural Areas

The DGFP is responsible for planning, implementing, monitoring, and coordinating all FP-MCH services of the Government and the NGOs (Ashraf et al., 1991, p.57). The Government has made the NGOs responsible for specific catchment areas in urban and rural areas of the country. Exhibit 4.4 shows the relevant Government policy.

Exhibit 4.4: Demarcation of Areas of FP NGOs

- The concerned Thana FP-MCH Officer (TFPO) will equitably distribute the operational areas of both the government and NGO workers, and will seek approval of the concerned Deputy Director, FP-MCH, to this effect. In allocating operational areas, the worker-wise number of villages, mahallas (wards), and eligible couples will have to be mentioned clearly.
- In wards/units where new government workers have been recruited, the existing (already working) NGO workers of such wards/units will remain in their respective positions.
- If any enlisted organization/association intends to extend its operational area or implement a new CBD FP-MCH program, the concerned Deputy Director will review the new project proposal of the organization, and then, send it to the Director General, with recommendations for his approval.

Source: DG DFP: Memo No.PPA/MP/88/8092, Dated 24.11.88

"As FP-MCH is a transferred subject under the decentralized system of administration, it is pertinent that the upazila (thana) should be responsible for area assignment, contraceptive and logistics supplies, coordination, monitoring, and evaluation of performance of NGO projects within the jurisdiction of the upazila (thana) ..." (MOHFP, 1990, p.253). Also, according to the DFP circular presented in Exhibit 4.1, working areas would be demarcated among GOB and NGO workers, with the Thana FP Officer (TFPO) assigned to do the demarcation work and get it approved by the DD/FP.

A problem arises because the Government occasionally changes the catchment areas, thereby creating administrative, morale, and service problems for the NGOs (Alauddin, 1991, p.9). If, however, the NGOs were directed to work in high FWA vacancy areas (e.g., Chittagong Division as a whole), the likelihood of duplication of activities would have been less (ICDDR,B, 1990, p.2; Khuda et al., 1992, p.22).

The GOB created the Family Planning Council of Voluntary Organizations (FPCVO) and its secretariat, namely, the FP Services and Training Center (FPSTC) in 1978. In a meeting in August 1990, the FPCVO discussed issues related to area demarcation and solutions to the problem. The FPSTC has provided technical assistance to the Government, principally in its role as secretariat to the FPCVO, in reducing duplication in service areas and increasing field level coordination with local government function areas (FPHSP No.388-0071, 1992, p.40). More specifically, the FPSTC has adopted principles which include: (a) an area demarcation system for NGOs, and (b) withdrawing Government fieldworkers from NGO catchment areas. These

decisions of the FPCVO, among others, serve as the basic policy of the national FP program insofar as area demarcation and deployment of GOB fieldworkers are concerned (Mitra and Associates, URC(B), East-West Population Institute, 1991, p.13).

4.3.4. Problems of Area Demarcation in Rural Areas

The Government and the NGOs can maximize their common resources by demarcating areas to avoid service overlap (Maru et al., 1993, p.8). However, problems of demarcation of areas and duplication of work effort exist in the Bangladesh health and FP-MCH programs (UNFPA, 1990a, p.271, ICDDR,B, 1990, pp.1,2, Khuda et al., 1992, p.23). The working areas in the FP-MCH are not properly demarcated by the TFPOs, with the result that frequently one or more CAS support NGO projects in the same area as the Government (Ahmed, et al., 1992, p.83; Islam and Rahman, 1992, p.87). Also, in many areas NGO activities are not coordinated at the field level, and no formal coordination mechanism exists between the Government and the NGOs at the union level (GOB, 1991, pp. 6,9).

These problems are widespread (UNFPA, 1990a, p.228). Field discussions reveal that about 20 percent of the NGO catchment areas also have GOB fieldworkers in place. This duplication has resulted largely from the deployment of 10,000 additional FWAs in the late 1980s.

The extensive overlap between the Government and the NGO rural service delivery program has generated active exchanges within the NGO, Government and donor communities concerning how to achieve better coordination among these groups as well as how new NGO activity can be more effectively targeted toward low performance areas (Koenig and Whittaker, 1991, p.456, 457). It has been suggested that MOHFW, in collaboration with USAID and the NGOs, should consider reassigning NGOs wishing to continue CBD activities to those areas that are very poorly served by the GOB, instead of high-use, well-served areas (Huber et al., 1992, p.22).

4.3.5. Coordination at the Periphery between the NGOs and the Private Sector and the GOB Programs

The coordination of NGOs has been a concern of both the GOB and the NGOs themselves to avoid overlaps and to capitalize on their individual skills. In this respect, the GOB issued various circulars such as holding of coordination meetings with the NGOs, reporting of their monthly progress to the TFPOs, etc. (Exhibits 4.1 - 4.4 already referred to). While there are no major coordination problems at the central level, such problems exist at lower levels. Indeed, the problem becomes more acute as one goes down the level, and is most felt at the union level and below.

For example, it is alleged by the NGO workers that when they make client referrals to the clinics, such clients do not often receive due attention by the clinic staff.

A circular issued by the Secretary, MOHFW, dated 26.12.88 stated that GOB officials should not be involved in NGO committees, since they are responsible for supervision and evaluation of the NGOs.

The NGOs took steps toward better coordination among themselves in 1986 establishing an NGO Coordinating Committee (NGOCC), which has succeeded in fostering a coordinated approach in a number of areas, including updating and improving of training curricula, developing a plan for training NGO management, helping resolve issues related to area demarcation, etc. The coordination efforts include not only the USAID-sponsored NGOs but also other NGOs like ICDDR,B, BRAC, etc. (Shutt et al., 1991, p. 26). The NGOCC generally meets bimonthly, and is recognized by the FPCVO (FPHSP No.338-0071, 1992, p. 40).

4.4. GOB Policies related to customs duties and taxes affecting the NGO and the Private Sector

The NGOs do not have any provision to import FP supplies directly (Huq and Huq, 1990, p.3). They get their supplies from the Government warehouses. However, the FPAB gets part of its supplies from International Planned Parenthood Federation (IPPF).

Clearance of equipment, supplies, and other materials requires formal procedures by the ports (sea and air) and Customs authorities, and involves various documents, including: (a) Bill of lading/airways bill, (b) Invoice, (c) Package lists, (d) Certificate of insurance, (e) NOC (no objection certificate) from the Drug Administration for drugs and contraceptives (except condoms) and (f) NOC from the National Board of Revenue (Huq and Huq, 1990, p.19).

The clearance procedures are generally cumbersome and time-consuming and need to be simplified to improve program performance. For example, to meet an emergency, 5000 sets of MR kits were airlifted to Dhaka in October 1990 at a great financial cost. The release of the kits was delayed till April, 1991 -- a span of six months (Kamal, 1992, p.12). The public sector imports are generally cleared by the District Controller of Stores (DCOS), which charge 1-2 percent of the CIF value. The private clearance agents charge much less (0.3% of CIF value), and therefore, the GOB has allowed the appointment of private agents from 1985/86 on contractual basis. However, DFP imports other than contraceptives continue to be cleared by the DCOS. The UNFPA, which donates various types of vehicles and kits for the FP program, makes use of its own agents (Huq and Huq, 1990, p.3).

Contraceptives imported by the private sector (e.g., SMC) are exempt from taxes up to 1994. However, they have to pay value added taxes (VAT) for their local procurements, advertising, etc., which increases their operational costs. Discussions with the Finance Director and Marketing Director of SMC indicate that

there is a proposal with the MOHFW to foot the bill on behalf of SMC. What will be the modus operandi and the effects of such a move is not quite clear at the present time. It may be noted here that contraceptives brought in by International Planned Parenthood Federation (IPPF) as part of FPAB's supply are exempted from taxes.

5. URBAN HEALTH AND FP-MCH

5.1. Introduction

Although the Government has a structured health and FP service delivery system for its rural population, it does not have a comparable infrastructure for its urban population. The NGOs are the primary service providers for the urban population. Also, their coverage of the entire urban area is limited. The Government approach toward the urban health and FP program can be inferred from its policy approach related to the active involvement of the NGOs in the process of service delivery, IEC, and training. In this regard, the main policy statements contained in the Fourth Plan include measures to (see: GOB, 1990, pp. XII-6,7):

- a) promote and pursue population planning as an integral part of the total development process, and integrate population issues in all development programs;
- b) encourage the NGOs to promote their supplementary and complementary role in implementation of the national program; and
- c) enhance coordination and monitoring of multisectoral projects (LGRD, Ministry of Industries, etc.) and NGO activities.

According to the GOB policy, the primary responsibility of urban health and FP-MCH lies with the Ministry of Local Government, Rural Development, and Cooperatives (LGRD).

In Bangladesh, the urban health and FP program is vested with each of the 88 municipalities under the general direction of the Ministry of LGRD. Each municipality is required to plan and implement its own health services (CCC, 1991, pp. 3,10). According to discussions with the DD/FP, Dhaka, the Deputy Commissioner's Office has a section on local government, with an Assistant Director being in-charge. With the help of the DGFP personnel, the Deputy Commissioner's Office offers training programs on FP-MCH for union council chairmen and members, etc.

5.2. Status of the Program

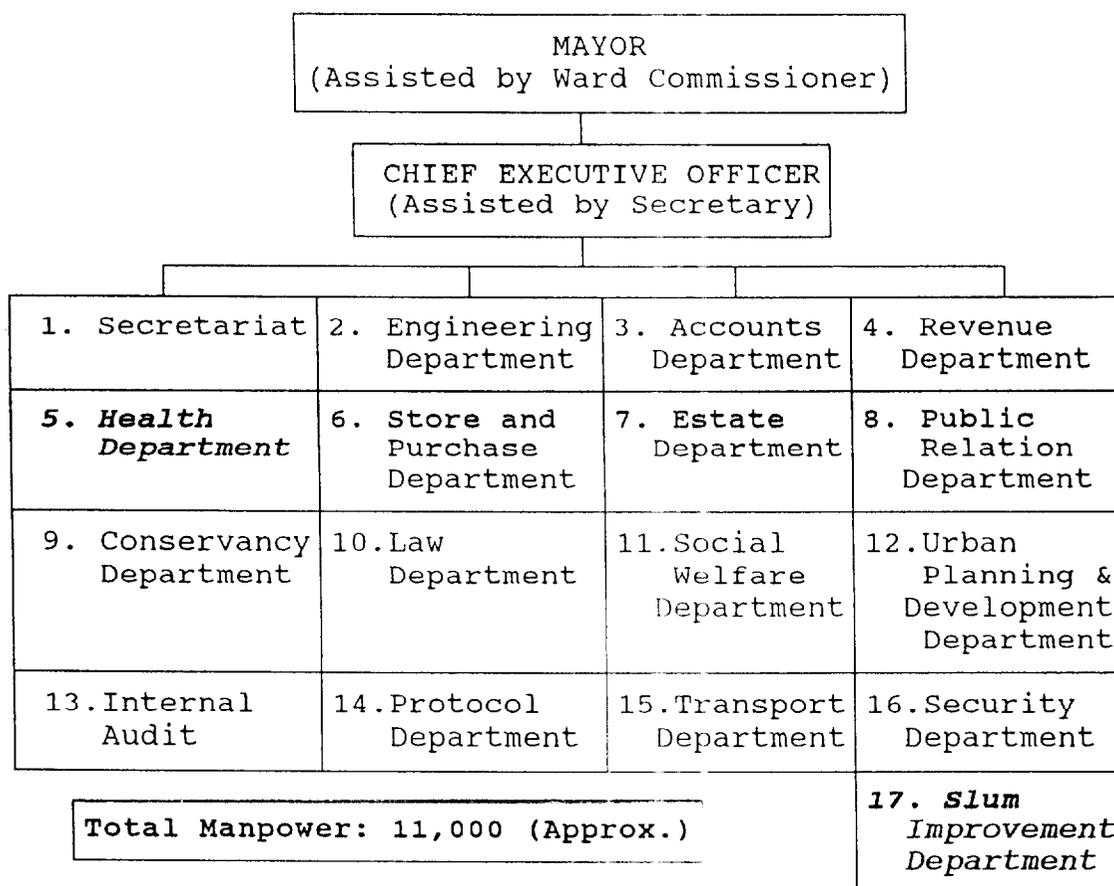
A conference-cum-workshop on the "Role of Municipalities in Population Control Activities" was held in September, 1984, and

suggested the need to earmark the areas of operation of NGOs and coordinate the activities of all agencies operating in the municipal areas. Furthermore, it stressed that without the endorsement of the municipalities no NGO should be eligible for support or funding by the government or any foreign agency. The workshop concluded that: (a) there was no need to make any changes or issue clarifications on the Poursava (Municipality) manual related to health and population control activities; (b) the authorities would constitute effective Municipal FP-MCH Committees, which would extend service facilities in the municipal areas to ensure community participation where necessary, earmarking the area of operation of the NGOs, and coordinating the activities of all agencies operating in the municipal areas; and (c) the chairman of the municipality would launch motivational campaigns.

The Dhaka Municipal Corporation Ordinance, 1983, was modified, and is now known as Dhaka City Corporation Ordinance, 1990. However, the modifications have been made mainly in The Penal Section. The organogram and the functions of the various departments remain essentially the same.

The Dhaka City Corporation (DCC) has 17 Departments, with approximately 11,000 employees (Figure 5.1). The Health Department

FIGURE 5.1: ORGANOGRAM OF DHAKA CITY CORPORATION



Source: Dhaka City Corporation, Dhaka

has Hospitals, Dispensaries, Maternity Centers, a Veterinary Hospital, a Food and Sanitary Section, and a Public Health Laboratory under its jurisdiction. Also, it has ten zonal offices in Dhaka, each headed by an Assistant Health Officer.

The Health Department deals with Public Health, Drainage, Articles of Food and Drink, Animals, etc. (GOB, 1983, pp. 66, 67). However, there is no mention of Family Planning as one of the functions of the Health department, although it is shown as one of the functions of the municipalities elsewhere in the country. The major public health-related activities include sanitation; registration of births, deaths, and marriages; drainage; collection, removal, and disposal of refuse; etc.

Based on discussions with the Secretary and the Chief Health Officer of the DCC it appears that the DCC is not involved in Family Planning in any major, systematic way. There is no staff or funds for FP service delivery program. However, the DCC has a Slum Improvement Department (SID), which implements the LGEB/UNICEF Slum Improvement Project (SIP) of the DCC, which started in 1990, in 13 slums of Dhaka City. Family Planning is one of the PHC activities of the SIP.

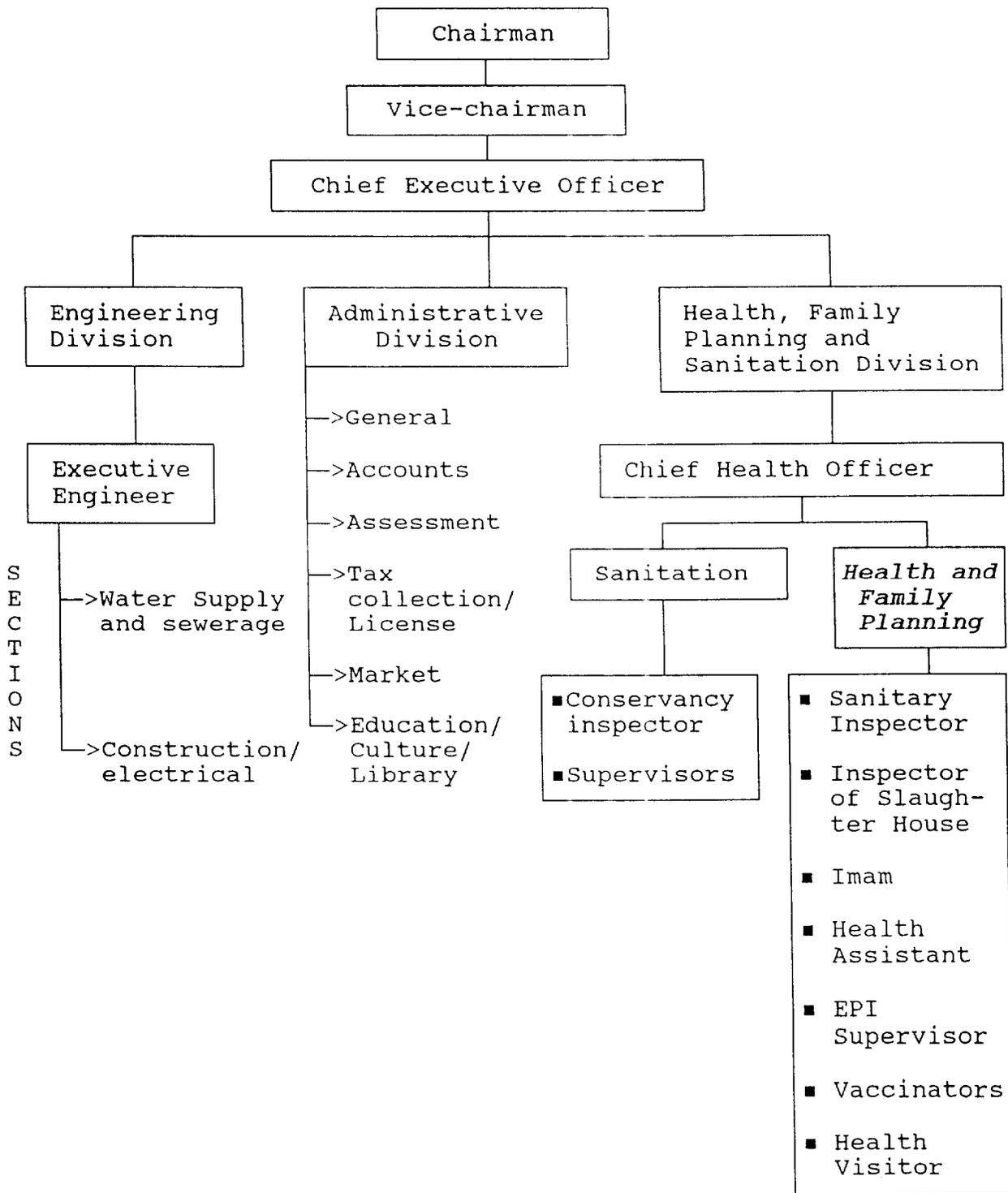
A Family Planning Service Week was inaugurated on November 8, 1993 by the Mayor of the DCC, indicating the willingness of the DCC to strengthen the efforts of the DFP and the NGOs in Dhaka City.

According to the most recent organizational structure of the municipalities (Figure 5.2), effective March 1992, the Health and Family Planning Division is one of the three divisions under the Chief Executive Officer of the Municipalities. Also, according to the GOB document entitled "Population Policy and the FP program" the major FP-related activities which should be implemented by the municipalities include formation of "population control committee⁶ (PCC), (DFP, June, 1989, pp. 8-11), which subsequently would:

- (a) plan the FP program for municipality areas in line with the National FP-MCH objectives and targets,
- (b) be responsible for coordination and supervision of the FP program within the municipality,

6. *The composition of the PCC includes the Chairman (Chairman of the Municipality ex-officio), and members - all ward commissioners and members, head of all NGOs, Civil Surgeon, DD/FP, Principal Women's College, Project Director of Model Clinic; Member Secretary - Chief Health Officer/Health Officer.*

FIGURE 5.2: ORGANIZATIONAL STRUCTURE OF MUNICIPALITY



Source: Kushtia Municipality.

- (c) extend cooperation to the NGOs working in the municipality or achieving their MCH-FP targets,
- (d) ensure regular supplies of FP commodities and extend assistance in the clinic-based FP activities,
- (e) meet at least once in a month in order to discuss FP-MCH related issues and consider the recommendations made by the ward level FP-MCH committees,
- (f) undertake monitoring activities in order to ensure regular home visits to the clients by the FP field workers,
- (g) undertake appropriate IEC activities,
- (h) maintain close contact with the DD/FP and TFPO in order to implement FP program in the municipality area, and
- (i) field visit at least five users each of sterilization, IUD, injection, oral pill, and condoms in each month, etc.

Thus, in the GOB official document the role of the municipalities in the FP-MCH activities has been made clear. However, based on visits to some municipalities the following became evident:

- (a) in many cases, no "Population Control Committee" (PCC) has been formed;
- (b) even if the PCC has been formed, in most cases, no meetings were held during the last one year;
- (c) most of the chairmen of the PCC (i.e., Chairmen of Municipalities) do not even know the DD/FP;
- (d) there is no staff in the municipality (under the Health and FP Division) responsible exclusively for FP activities; and
- (e) the role of the municipality in overseeing the municipal FP-MCH program is either non-existent or at best limited in the present context.

According to the DD/FP, Dhaka, Dhaka City is divided into two zones, namely, Tejgaon and Mirpur, and each zone is headed by a TFPO. All the wards of Dhaka urban areas (75) have been demarcated among the different NGOs, except wards 60 and 61 and a few others where the NGOs are not very active due to their own internal problems (wards 6,7,8,9). However, in each of the wards, there is also an FWA with a clearly-demarcated area. The demarcation has been made by Deputy Director, FP, on the basis of recommendations made by the TFPO, before final approval by the DG/FP. There does not seem to be any overlap at present, since

both the FWAs and the NGO workers know their exact area of operation and the number of eligible couples under their jurisdiction.

The NGOs continue to serve the urban areas of the country, although, per the Government request of 1986, they have also started operating in rural areas of the country. From the DG/FP Circular of 24.11.88 and another undated circular, it appears that the NGOs are doing clinical as well as CBD FP activities in Dhaka City.

There are three main providers of contraceptive supplies and services in Dhaka City, namely, the MOHFW, the SMC, and several NGOs. Most of the NGOs operate community-based services. It was believed that the coverage of couples in Dhaka City was uneven, and that there were geographical disparities in FP services provided and in the CPR (Miah and Bernhart, 1988, p.1). Furthermore, it appears that the urban areas have been neglected in terms of Government service provision (Salway et al., 1993, p.1 and p.43).

Similar to the rest of the country, the "cafeteria approach" is followed in providing FP services in Dhaka City. The two Medical Colleges of the city where sterilizations are performed, Government Outdoor Dispensaries, Mother and Child Welfare Center Clinics at the City Corporation Ward Commissioners' Offices, are all under the jurisdiction of the Dhaka District FP Office, while the Azimpur Maternity Center and the Mohammadpur Fertility Service Training Center operate directly under the DFP. Also, 16 or 17 CBD NGOs operate in the city areas, with some among them providing IUD services. In addition, there are 40-50 NGOs which provide clinical services plus contraceptive distribution but no outside motivational activity.

The Deputy Director holds monthly coordination meetings with the NGOs. Also, the DD, TFPOs, and representatives of NGOs attend the District Family Planning Committee meetings chaired by the Deputy Commissioner, Dhaka. The TFPOs can call meetings if and when required. The national NGOs deal directly with the DFP. However, there does not appear to be any problem in the field between the Government and the NGO workers.

The FWAs (as also the NGO workers) make their reports to the FPI, each of whom are in charge of three city wards. The FPIs, in turn, report to the Thana Family Planning Officers, who then report to the Deputy Directors. The consolidated figures are, then, sent to the MIS Unit of the Directorate.

Among the four (now five) administrative divisions of the country, Chittagong Division has the lowest CPR. In Chittagong City, almost all the community-based FP-MCH programs were carried out by the NGOs. However, uneven levels of service delivery exist, with duplication in some areas and little or no coverage in others. Other problems relate to huge variations in worker-client ratios in different areas, competition between the GOB and the NGO workers regarding referral cases of

sterilization, inadequate contraceptive and drug supply, unstandardized record-keeping and reporting, inadequate coordination between NGOs and GOB, and concentration of static FP facilities in some areas. Accordingly, a conference was held in January 1986 in Chittagong to discuss the problems of the FP NGOs. The main objective was to develop a plan to reallocate areas among the NGOs to deal with the problems. As an outcome of the conference, an area reallocation plan was developed and put into practice by a majority of the NGOs. Consequently, **overlap was reduced, service gaps filled, and coverage increased.** However, some overlaps with GOB workers continued and the Coordination Committee could not be operationalized, thereby leaving the program without a mechanism to resolve inter-NGO conflicts and confusions, etc. (Miah et al., 1988, p.1).

There continue to be rural-urban differences in contraceptive use which cannot be wholly explained by differentials in socioeconomic conditions. It is likely that the higher use rate in urban areas is a function of an environment which is more conducive to FP acceptance as well as accessibility and availability of FP methods (Waliullah and Mabud, 1982, p.431).

A disturbing feature of the FP program in urban areas is that contraceptive use has by and large plateaued in urban areas, at around 48 percent (Khuda, 1993, p.1). Priority action areas to deal with plateauing of the CPR in urban areas includes working closely with the Ministry of LGRD, as well as strengthening of the NGO efforts and those of the private sector.

Slum areas of Dhaka City are considered part of the wards where they are located. These are covered by the usual CBD programs operating in those wards as well as by satellite clinic program. Also, the Dhaka District FP Office provides assistance to the LGEB/UNICEF/Slum Improvement Project (SIP), if and when such assistance is sought. Furthermore, the Urban Health Extension Project (UHEP), previously the Urban Volunteer Program (UVP) of the ICDDR,B has been working in the slums of Dhaka City since the early 1980s. The Project operates through volunteers (slum mothers who are involved in health and FP-MCH education), and provides basic service provision to their local communities. Until recently, FP was a relatively small component of the volunteers' work; however, FP is now being increasingly encouraged. Project staff, including volunteers, have received basic training in the area of FP-MCH, and are expected to make referrals for FP-MCH services.

Awareness and exposure to EPI messages is almost universal in urban areas. However, it is lower in the slums than in the middle and the lower middle classes. Acceptance is highest among the middle class, intermediate among the lower middle class, and lowest among the slum dwellers. Some recommendations aimed at improving the situation include targeting of messages toward lower middle class and slum dwellers, more extensive use of health and FP workers after training them to disseminate information regarding timing and doses of immunization,

orientation to diffuse misconceptions and fears of immunization, etc. (Khan et al., 1990, pp.x,xv).

5.3. Urban Family Planning Policy Issues

In order to develop an effective policy dialogue on urban family planning, it is probably necessary first to do a substantial inventory of existing policies, structures, and realities, which was not possible in the time available for this report. Ultimately, some issues which should be addressed in such a dialogue are as follows:

1. Is there a need for a restructured urban family planning program? The present system is not elegant; success, not elegance, should be the criterion.
 - (a) Is a structural change needed to improve program performance, and would it in fact do so?
 - (b) Is the present system, mainly directly donor-funded, sustainable?
2. What should be, in the long run, the roles of the public and private sectors in urban family planning coverage? What intermediate institutions will be needed to get to that point?
3. What should be the relationship between health and family planning within service delivery institutions in urban areas?
4. What should be the attitude of service providers in the public sector toward slum dwellers living in illegally occupied land?
5. What should be the structural relationships among MOHFW, LGRD, and the municipalities?

To establish the basis for a dialogue on these matters, we recommend a status review on urban family planning in Bangladesh.

6. PRICING/COST RECOVERY

6.1. Introduction

Toward achieving the goal of sustainability in its FP-MCH program, the Government decided to introduce some cost recovery measures. Also, such a policy was introduced in view of possible declines in donor funding, and to minimize wastage in the distribution of FP supplies. As a first step, the Government decided to introduce charging for condoms nationwide, effective July 1, 1990 (see Exhibit 6.1). The intention was "to eventually become self-reliant and reduce some of the wastage associated

with free distribution of contraceptives" (Khuda et al., 1991).

Another intervention, designed to charge for both oral pills and condoms, was implemented in one union of a thana in the country where charging for condoms began in July 1990 and oral pills in September 1990.

Exhibit 6.1: GOB decision on Pricing of Condoms

In order to stop free distribution of condoms from the GOB service facilities and also to enhance the FP users' responsibility toward the family planning program, the GOB has decided to introduce pricing for condoms to be implemented by the FWAs.

- Cost will be recovered from the users @Tk.1/dozen of condoms.
- Prices of condoms will be displayed on notice boards in FWCs, satellite clinics, and users' houses.
- This policy will be effective from July 1, 1990.

Source: MOHFW, Memo No: Kom/JNP/Price-40/90/327 Dated: 30.6.90

However, contraceptive pricing is not a new concept in Bangladesh, since during the 1960s and the early 1970s condoms were sold at a token price by depot holders and part-time agents on a commission basis. In 1972 the FPAB introduced nominal charges for all types of contraceptives. However, in a majority of cases, the sale proceeds were not received by the authorities. Also, the accounting system for condom sales was not cost-effective. Moreover, many poor condom users could not pay for the condoms. Also, it was assumed that free supply of condoms would increase the number of condom users. Thus, the pricing was withdrawn.

There is no uniform policy for charging price for condoms (Alauddin, 1991, p.3; Islam et al., 1991, p.9.). Effective November 1990, at the suggestion of URC, condom pricing was reduced from Tk.1.0 to Tk.0.50 per dozen. While the GOB started charging the reduced price, the NGO workers continued charging at the previous rate, i.e., Tk.1.00/dozen. Therefore it becomes difficult for the NGO workers to face various questions raised by the clients regarding the price of condoms. In addition to charging for condoms, several NGOs started charging for oral pills. When this drew the attention of the Government, a circular (Exhibit 6.2) was sent out prohibiting this. However, another circular was sent out later (Exhibit 6.3), allowing the NGOs to realize charges on their FP-related services.

Exhibit 6.2: GOB Decision prohibiting pricing of oral contraceptives.

The Government had decided to sell condoms to the users at a nominal price instead of continuing to distribute them freely.

However, it is being observed that some NGOs, including subprojects of FPSTC, are charging price from the oral contraceptive users in the name of service charge. Charging of price of oral contraceptives is against the directives of the Government, and is therefore, illegal.

Source: DG, DFP/Memo No.PPA/Sa-SP/91//394

Dated 17.8.92

Exhibit 6.3: Charging of service charges for FP by the NGOs

I would like to draw your attention toward the circular dated 17 August, 1992 signed by me. In that circular, the NGOs were instructed not to charge service charges on FP-MCH methods, except condoms.

In this regard, I have had a meeting with the representatives of cooperating agencies (FPSTC, Asia Foundation, Pathfinder International, FPAB and AVSC) on September 8, 1992.

In that meeting, the representatives of the cooperating agencies mentioned that in order to achieve long-term sustainability, the NGOs supported by those cooperating agencies have introduced nominal service charges on FP-MCH methods, but those are also distributed free among those who were unable to pay for the service charges. They have given me assurance that the organizations/associations supported by them are regularly maintaining separate accounts, and that the amount collected through realization of service charges are **not being spent without their permission/approval**. The representatives informed me further that they will provide me with a list of NGOs supported by them, which have already introduced service charges in their respective catchment areas.

In the light of the discussion with the cooperating agencies, I have realized that, for the sake of attaining long-term sustainability of the FP-MCH program, introduction of service charges on FP-MCH methods is a creative and potential initiative. I have given consent to continuing the initiative undertaken by them in this regard. You are requested to submit a list of the NGOs charging service charges to this Directorate.

Source: DG/DFP: PPA/Sa/SKha/50/4

Dated: 30.9.92

6.2. Effects of Contraceptive Pricing

The demand for contraceptives is relatively inelastic, and some instances where price is very low, the demand curve for contraceptives is even backward bending. Evidence from Sri Lanka, Jamaica, Columbia, Thailand has shown that increased prices generally have no effect on demand. If contraceptive prices are too high for low-income households, price reduction will have a positive impact on utilization. However, free services do not appear to be necessary and moderate charges may even have a beneficial effect on demand because of consumer perception that a products' value is reflected in its price (Lewis, 1986, p.134).

Experience in many countries shows that pricing does not necessarily reduce contraceptive prevalence. Indeed, contraceptive prevalence could even rise, if clients believe that they obtain better product or service value by paying a price. However, in Bangladesh, the rural households may have little disposable cash and women may have little authority to make independent decisions about spending money (Khuda et al., 1991, p.i). That there is a sizeable clientele population who cannot afford to pay for condoms means that both the GOB and NGO workers have to sell a sizeable proportion of condoms on credit. The credit becomes bad debt, and hence, many fieldworkers refuse to provide such clients with fresh supplies on credit (Khuda et al., as cited in Khuda and Barkat, 1991, p.10; Alauddin, 1991, p.3; Nessa et al., p.5). However, it is also argued that it is not necessarily true that the poor cannot afford to pay for the contraceptives. In fact, "the main problem lies with the attitude of the clients rather than their economic capability" as they feel that it is the responsibility of the NGO or GOB to provide the contraceptives free to them (Chowdhury and Huq, 1991, p. 7).

Evidence from a study conducted on behalf of the MOHFW shows that condom usage declined as a result of pricing (Khuda et al., 1991). Also, evidence from the ICDDR,B MCH-FP Extension Project Area shows that the number of new condom acceptors was reduced by 50 percent (Nessa et al., 1991, p.3). At the suggestion of URC(B), the price of condoms was decreased by half in November, 1990; yet the number of new acceptors did not increase (Khuda et al., 1991). Also, service statistics and surveys show that after the introduction of pricing in July 1990, the number of condoms distributed declined moderately nationwide (Khuda et al., 1991, p.19).

Charging for oral pills was only introduced, per the GOB order, in Lebutala union in Monohordi Thana of Narsingdi District. Unlike the effect on pricing of condoms, there was no evidence of any large and sustained drop in the number of pills distributed after pricing was introduced. On the basis of contraceptive histories given during the follow-up survey, "there is no evidence that the pricing intervention had an adverse

affect on pill continuation rates" (Khuda et al., 1991, pp. 23,30).

The major field-level problem that was identified was that a substantial minority of the condom and oral pill users were unable to buy the contraceptives on cash, and hence the fieldworkers had to supply such users with condoms and pills on credit. The ultimate result was that in most cases such credit sales turned into bad debt (Khuda et al., 1991; Nessa, et al., 1991). Based on our recent discussions with the relevant field personnel, it was obvious that the situation has not changed. However, a proportion of the clients buy SMC oral pills and condoms at subsidized prices,⁷ indicating that they are willing to pay something for convenience and quality. Nevertheless, convenience and quality would not be the overriding factors among the poor and the very poor.

Evidence from the NGOs shows that there were initial dropouts and switches to other methods. The dropout rate varied between 10 and 20 percent; however, condom sales have gradually reached almost the pre-pricing level. Anecdotal evidence suggests that 10 percent of clients would still be unable to pay for condoms and oral pills (Shaheed, 1991, p.3; Chowdhury and Huq, 1991, p.7). Also, there is evidence of reduction in wastage (Islam et al., 1991, pp.7-9).

6.3. Extent of Cost Recovery

Estimates of revenue generation, based on evidence from an operations research project undertaken by URC(B) on behalf of the MOHFW, to assess the effects of contraceptive pricing on contraceptive prevalence, etc., indicate that each fieldworker, on average, collected about Tk.75 from condom sales over a 10-month period and Tk.195 from pills over a nine-month period. Extrapolated nationwide, the revenue generation would be roughly Tk.10.7 million; however, approximately one-fifth of this is bad debt borne by the fieldworkers. The estimated amount covers less than 3 percent of the FWA salaries (Khuda et al., 1992, pp.v,45).

Pricing may appear to be the simplest strategy for cost recovery; however, the greatest hurdles are imposed by an "entirely free distribution system that had been in existence for about three decades, making the clientele population used to the concept of free supplies, thus unwilling to pay for supplies, and the inability to pay for supplies due to extreme poverty (Khuda and Barkat, 1991, p.8). Nevertheless, an Expert Group for Field

7. According to the 1991 CPS data, about 14 percent of the oral pill users use SMC brands and more than two-fifths of the condom users use SMC brands (Mitra et al., 1993, p.72).

Action Plan has recommended measures for cost recovery through service charges for clinical programs and pricing of oral contraceptives in order to raise the level of quality of care and services (MOHFW, 1993, p.21).

The NGOs have been selling contraceptives and realizing some revenue. For example, Tk.700,000 is realized annually from contraceptive sales by the FPAB (Chowdhury, 1993, p.25). The PI earned Tk.758,298 in one month (June, 1991) from contraceptive sales and clinical services from its 15 projects (Islam et al., 1991, p.5.). These figures seem high, because of the number of projects taken together under a single umbrella. However, the amounts realized from individual projects, e.g., the FPAB's Rakhaine Tribes Projects, are quite low (Helali et al., 1993, pp.56, 57).

Another method of cost recovery introduced by the various NGOs relates to charging of fees for various services rendered, including initial registration fees and smaller fees for subsequent visits. The FPAB, Pathfinder International, FPSTC, TAF, CWFP, etc. all charge service fees from the clients (Mitra and Associates, URC(B), East-West Center Population Institute, 1991, pp. 11,12; Shaheed, 1991, p.3; Islam et al., 1991, p.1; Chowdhury and Haque, 1991, p.3). However, the charges vary from one organization to another.

Evidence with cost recovery shows that: (a) clients are willing to pay, especially when assured that the sale proceeds are not "pocketed" by the fieldworkers; (b) when paying, clients are less willing to accept supplies they do not need, resulting in reduced wastage; and (c) absolute adherence to charging for all couples may discriminate against those who cannot afford the fees, resulting in dropouts (Mitra and Associates, URC(B), East-West Center Population Institute, 1991, p. 12). Couples living in the slums would also be prepared to pay for services, but only if assured of quality care; however, if services are at first offered free, it is difficult later to ask people to pay for the services offered (Salway et al., eds., 1993, p.45).

6.4. GOB Policy Affecting the Private Sector

SMC has been selling condoms and oral pills for about two decades, and has generated a considerable amount of revenue in the process. Also, it decided to raise its price to determine the impact of increased price on sales. The effect was that their sales initially declined, but since have gradually picked up (Islam et al., 1991, p.11). It is not known whether SMC customers shifted to other sources or stopped using any method, due to price hikes of SMC contraceptives (Shutt et al., 1991, p.45). SMC recovers around 21 percent of its total program costs, and plans to increase its cost recovery to 43 percent by 1997 (FPHSP No. 388-0071; 1992, P.43).

Donor agencies, including USAID, have been urging greater financial sustainability. However, this objective cannot either

be achieved from income from sales alone (Shamsuddin, 1991, p.3), nor would addition of more lucrative product lines be a more promising contribution toward cost recovery, in the resource-poor environment of Bangladesh (Shutt et al., 1991, p.45).

As has been stated elsewhere in the study, there is tax exemption on the imports of contraceptives up to 1994. Operational costs, however, have increased due to the imposition of VAT.

6.5. GOB Policy Related to Reimbursement of Contraceptive Sale Proceeds

A hazy area of GOB policy is the absence of any directive regarding the use of contraceptive sale proceeds. Serious consideration should, therefore, be given to issuing instructions regarding utilization of contraceptive sale proceeds by the concerned authority.

Although a MOHFW circular dated August 27, 1990 authorizes the TFPO of an experimental thana, Monohordi, to spend the revenue generated from the sale proceeds of the condom and pills on a specified set of items, this revenue has not been spent, and lies unspent in a bank account as "no initiative was taken at the lower levels to improve program performance by purchasing items they believed were essential to their activities" (Khuda et al., 1991, p. 44). Here as in other circumstances, a circular or government order issued to implement a certain GOB decision may remain unimplemented. The reasons for non-implementation of such orders are largely related to lack of initiative on the part of the concerned personnel. Nevertheless, according to the NGOs, lack of a GOB circular/guideline authorizing use of sale proceeds on specified items is clearly affecting their program activities. NGOs feel that there is an urgent need for such an order to be issued, so that they can use the sale proceeds to buy essential drugs, etc. Furthermore, it has been argued by both the GOB and the NGO personnel interviewed that the sale proceeds should be kept in interest-bearing accounts rather than the existing system of keeping the deposits in the current account.

7. RELATIONSHIP BETWEEN HEALTH AND FP

7.1. Introduction

One of the major health-related objectives of the Fourth Plan is "to reach improved health and family planning services in a package to the family with a view to increasing its welfare" (GOB, 1990, p. XI-5). The Fourth Plan while advocating an integrated FP-MCH program stated that "during past plan periods, government attached priority to the improvement of the health status of women. But due to segregated efforts and lack of delineation of clear-cut responsibilities of Health and FP sectors toward maternal health care, the desired objectives could not be achieved" (GOB, 1990, p.XI-12). The policy

components concerning the relationships between Health and FP, according to the Fourth Plan, are (see: GOB, 1990, pp. XI-5,7,8,13; XII-11,12):

- (a) the FP-MCH program will be an integrated function of health and FP at the community and PHC level;
- (b) integrated PHC services will be delivered at the community level by paraprofessionals with active participation and involvement of community leaders;
- (c) health and FP services will be integrated/rationalized at the thana level and below to provide comprehensive services of requisite quality for mothers and children, and MCH and FP services will be delivered in a package and form the main thrust;
- (d) all out efforts will be made to sustain and effectively maintain the national capability for delivery of EPI services to the target population through integrated services of health and family planning workers;
- (e) domiciliary services will be provided through the field workers of the Health and Family Planning Directorates;
- (f) the potential of outreach workers of health should be fully utilized in family planning service delivery;
- (g) attempts will be made to bring together the Health Education Bureau of Health Directorate and the IEM unit of FP Directorate under a unified structure to develop and disseminate health and FP messages, according to the needs of specific motivational programs of the sectors; and
- (h) with a view to strengthening of the MCH component of the FP program, emphasis will be given to provision of appropriate ante-natal care, including safe delivery at home through TBAs, reduction of high-risk pregnancies and provision of TT to mothers, and integrated efforts toward EPI, ORS, Vitamin-A capsule distribution, and other PHC services.

7.2. Past Attempts at Integration

The separation of the family planning program from the health services dates from the Pakistan period. In 1965 the Family Planning Board was set up as a parastatal body, with female paramedics providing IUDs, village midwives motivating women, and male organizers promoting male methods. After Independence, most of the staff and officials of the Pakistan program were encadred. The female paramedics and female outreach workers, with male supervisors and officers, were kept as an independent family planning "wing" within the Ministry of Health and Population Control (later MOHFW). Except for about two years during the

mid-1970s when it was merged with Health, the FP wing has always been working independently (GOB, 1989, p.iii). Several attempts have been made in the last two decades to bring about structural integration (that is, combining the cadres of field workers, and unifying the supervisory chain at different levels) or functional integration (that is, using workers and other resources from both wings to deliver certain PHC services in collaboration). In essence, functional integration implies: (a) separate functional units for health and FP at the top level; and (b) integration of "functions" of health and FP personnel at the field level (coordinating and complementing each other).

Recognizing the importance of at least functional integration, the successive Five Year Plans emphasized the need for integration of health and FP service delivery system (GOB, 1985 and 1990). The Secretary, MOHFW said "the Government's intention is not to integrate the basic organizational structure of both population control and health wings but only to provide required administrative links that will permit FP-MCH and primary health care services to be delivered at the grass-root level" (as cited in Chauls et al., 1984, p.30).

In 1980, the government decided to implement very thorough-going integration. Several administrative measures were taken at the national, district, thana, and union levels. The Health and Population Control Divisions were renamed as "Wings" and brought under the control of one Secretary at the national level. At the district level, the District FP Officer was renamed Deputy Director, FP, and was given joint responsibility with the Civil Surgeon of the Health Wing in the matter of health and FP-MCH. At the thana level, the Thana Health Officer continued to be the drawing and disbursing authority over funds managed by the Population Control Wing, and would also be responsible for the day-to-day responsibilities of FP activities. At the union level, the Family Welfare Centers were renamed Health and Family Welfare Centers (HFWC), to be headed by a Medical Assistant. At the ward level, the job descriptions of workers in the health and FP wings were revised to reflect a more integrated approach toward service delivery (UNFPA, 1984, p.6).

These measures could not be implemented in their entirety. The family planning program was virtually shut down for several years in the mid-1980s because of opposition to some measures. As a fallback, the GOB decided in favor of functional integration which would provide "the required administrative links to FP-MCH delivery, and primary health care services in a coordinated and complementary manner at the thana level and below" (GOB, 1987, p.15). To implement functional integration, the job descriptions of all personnel at the thana level and below were rewritten and put into effect. As a result the health workers have been assigned FP tasks, and FP workers have been assigned PHC functions.

In early 1983, a Ministry directive established the FP and health workers as a 'team', both members of which were jointly responsible for a series of MCH/FP/PHC tasks. However, the

experiment, as actually implemented at village level, was brief (Chauls et al., 1984, p.12; Rafiquzzaman, 1989, p.iii). "Where official management of the program is relatively inflexible, centrally controlled supervisory system is again vitiated by continuous changes brought about in the control mechanism at the thana level through integration and disintegration of functions of Health and FP personnel at regular intervals, while district and other higher functions of Health and FP-MCH personnel remain separated. All these contribute to the confusion at the field level and result in dislocation in the official field performance" (Waliullah and Mabud, 1982, p. 249).

According to circular No. pp/S-6/1/74/213 dated September 7, 1983, while the THFPO was given the overall charge of the program, he was to be assisted by the TFPO in the implementation of the FP program at the thana level. In order to remove certain ambiguities regarding the position of the THFPO as the chief administrator of the integrated program another circular No. PC/SHA/CORD-1/1985/55, dated June 25, 1985 was issued by the then Secretary of the Ministry to the effect that the THFPO would continue to remain the head of the program at the thana level and would also continue to write the Annual Confidential Report (ACR) of the TFPO. However, difficulties in administration, lack of coordination between health and FP workers, lack of motivational work by health workers at the field level, and differences of opinion between the high officials of the two directorates resulted in limited integration.

About half of the officers reported that integration caused problems in running the administration, with the most commonly stated problem being lack of cooperation between the workers of the two departments (Kabir et al., 1986, pp.2,3). One of the major reasons for failure of functional integration, according to the Directorate of FP-MCH, was the absence of clear job descriptions in the field (Hossain, 1988, p.36). In 1988, the major complaint of the TFPOs was removed by a circular making the TFPO, instead of the THFPO, chief of the FP program at the thana level (circular No. Sha-8/1C-3/85/126(460) dated 10.2.88).

7.3. Current Problems

Why is integration needed? The reasons usually put forward can be grouped under four headings: (1) the FP wing needs medical support and technical supervision for clinical services, and relies on the health wing for deputation of medical officers; (2) The two wings share some common facilities (notably space at the Thana Health Complexes); (3) The field workers (FWAs and HAs) have overlapping functions -- the Health wing has few female field workers or paramedics and many MCH functions require female providers; (4) Linking FP and MCH can make things easier for clients and improve the credibility and sense of achievement for the FP workers.

These do not all necessarily require very much integration. Clear delineation of roles, and provision of adequate training,

supplies and supervision to the workers meant to carry out each role, could reduce the need for coordination.

7.3.1. Delineation of roles

MCH responsibilities are awkwardly split between the two wings in the current system. EPI is a shared responsibility at the field level. FWAs are supposed to help motivate women and conduct EPI sessions in their work units. Antenatal, delivery, and postnatal care are divided among the wings: FWAs are supposed to screen for high-risk pregnancies and refer all women to FWVs, but if further care is needed, FWVs refer women to the Thana Health Complex. FWVs provide much routine treatment for women and under-five children, and MAs provide much treatment for children and men, but serious cases have to be referred to health wing facilities and personnel. Although MCH and FP services are formally integrated under the FP Wing of the MOHFW, a few components of MCH services are delivered through vertical programs of the Ministry's Health Wing. For example, immunization services are provided under the national EPI program, and ORS packets and information under a National Oral Rehydration Program. While the EPI and NORP share some facilities with the FP Wing, these programs maintain separate staff (Nag, 1992, p.6). This is despite the GOB's intent that "Health and FP services will be integrated/rationalized at the thana level and below to provide comprehensive services of requisite quality to mothers and children".

Dual administration was reported by the Health and FP officers as the main problem in surveys in the mid-1980s. They suggested that there should either be a total integration or total disintegration. (Hossain and Khan, 1988, p.13; Chauls et al., 1984, p.34). Shortages of field staff and noncooperation between the health and FP staff were identified as other problems in the field (Ahmed and Ali, 1987, p.76; Rahman and Siddique, 1985, p.81).

The personnel of the two wings view the problem of integration differently. The health personnel interviewed in a 1988 study thought that "the problem originates at the conceptual stage and persists all the way through." On the other hand, the FP functionaries do not question the concept of integration, but considered that "specific operationalization of this concept through the existing functional integration strategy is ill-conceived" (Hossain, 1988, p.13). Furthermore, the health personnel do not consider FP as part of their job, and FP workers do not consider health part of their job (Ahmed et al., 1992, p. 45).

The 1991 Task Force on Population Policy suggested that the job responsibilities of the FP and health fieldworkers, with similar educational levels and training, be made similar. This would minimize cost and reduce worker population density. There might be no need to recruit additional workers, if all these personnel could be brought under one common authority, though HAs and FWAs

cannot substitute for each other in all functions, especially since most HAS are men. Another suggestion was to link the chains of command and provide joint supervision (Khuda et al., 1991, p.12).

7.3.2. Problems in Implementation

According to the GOB policy, the THFPO and TFPO are supposed to jointly decide as to which outreach centers (EPI) and satellite clinics are to be integrated, besides the integrated EPI-Satellite Clinic every Monday. Satellite clinics are to be held jointly with EPI spots. However, it can be inferred from a joint circular of the Directors General of Family Planning and Health that there is a lack of such an integration (Exhibit 7.1). Also, another circular noted "the relationship between EPI and FP should be further strengthened" (Exhibit 7.2). A recent situation analysis study of selected satellite clinics in Rajshahi and Khulna divisions found that satellite clinics were not coordinated with EPI spots in 34 out of the 64 sample unions studied (Khuda et al., 1993, p.28). To coordinate the clinics with outreach sites requires good communication and cooperation between the TFPO and the THFPO, and this is often lacking.

Exhibit 7.1: Coordination among Satellite Clinics and EPI outreach Centers.

A directive was sent from the FP Directorate through a memorandum No.PPA/MCH/528 dated 6.5.91 for experimental integration of an outreach with a satellite clinic. At the 14th meeting of the National Steering Committee held on 22.8.91, a decision was reached for taking further effective measures in this regard.

In view of the above, it is directed on behalf of the Directors General of Health and FP that from now on a satellite clinic and its nearest outreach center will be unified. They will not be organized separately. Through these joint centers of EPI outreach and satellite clinic, services of both categories will continue to be delivered, per previous instruction. The upazila (thana) health and FP-MCH Officer and the Upazila (Thana) FP Officer will decide with the cooperation of their subordinate officials/staff as to **which outreach centers and satellite clinics are to be unified/integrated.** If necessary, a satellite clinic may be integrated with an outreach center for facilitating service delivery.

You are, therefore, requested to prepare upazila (thana)-wise list of unified/integrated centers, per format supplied earlier, and send jointly-signed copies of the same to the Director, MCH Services and the Director, EPI latest by 15.9.92.

This directive is given in public interest, and will be effective immediately.

Source: DG, Health and DGFP: Memo No. FPD/MCH/2E-4/80-110
Dated 29.08.91

Exhibit 7.2: Further Strengthening of the EPI and FP Coordination

The officers and employees of the FP Directorate are working hand-in-hand with the employees of Directorate of Health to properly implement the EPI program. With due efforts of all officers and employees of the Ministry, considerable progress was achieved in attaining the EPI targets. Thus, with a view to achieving the targets in each district and upazila (thana) in 1991 and to ensure immunization of all the newly-born babies, the relationships between the EPI and FP should be further strengthened.

Source: DGFP Memo No. PPA/MCH/HE-4/83(528) Dated 06.05.91

Coordination Committee meetings are supposed to be held at the district, thana, municipality, union, and village levels, as well as institutions and participation by the relevant officials.

According to a DFP circular (Exhibit 7.3), it is evident that these meetings are not held regularly. This was corroborated by most field functionaries interviewed in this study. The MOHFW Memo. No. PC-1/019/84/205 dated 15.4.85 directs the setting up of District MCH Coordination Committee with the Civil Surgeon as the Chairman, DD/FP as Vice-Chairman, and MO-CC as Member-Secretary. Each DD is expected to have coordination meetings with all TFPOs, MO-MCHs, MO-CCs, MO-Cs on the 6th or 7th of every month. However, such meetings are not held regularly; and even when held, the minutes of the meetings are hardly ever sent to higher authorities. Furthermore, there is a lack of feedback and lack of necessary

Exhibit 7.3: Holding of District and Thana Level Coordination Committee (MCH) meetings.

It is being observed that regular meetings of the District and Thana Level Coordination Committee are not being held regularly at the district and thana levels; and in some cases, though meetings are held, the minutes of the meeting are not being sent regularly.

Therefore, all Civil Surgeons and the Deputy Directors are hereby requested to hold meetings of the Coordination Committees (MCH) and to send the reports of the meetings regularly.

Source: DG/DFP: Memo No. PPA/M-88/60

Dated: 20.6.88

Exhibit 7.4: Holding of MCH Coordination Committee meetings and lack of feedback.

It is being observed that the Coordination Committee (MCH) meetings at the district and thana levels are not being held in accordance with the rules laid down in the memorandum No. FP/1/011/84/205 dated 15/4/1985. In many cases, necessary measures are not being taken in the District Coordination Committee Meetings, after proper review of the minutes of the Upazila (thana) Coordination Committee meetings. Therefore, you are requested to ensure holding of regular coordination committee meetings in the upazilas (thanas) under your district, according to the guidelines of the above notification.

Source: Director (MCH-Services), DFP: Memo No. PPA/MCH/253(128) Dated 20.6.88

follow-up actions to the decisions taken at such meetings (Exhibit 7.4). This irregular holding of coordination meetings and lack of follow-up actions clearly indicates lack of functional integration at the district level and below (Director MCH circular, dated 20.6.88).

7.3.3. Status Issues

Another impediment to integration relates to the "inequality in status" between the personnel of the two directorates. Several cadres of workers in FP have lower seniority, job security, benefits, and career development opportunities than their counterparts in the Health sector. This is largely because such FP personnel are in the "development budget", while their counterpart health personnel are in the "revenue budget". The FP personnel have suffered a setback in rank and status at the thana level, and found the chain of command severely impaired at the district level. This is affecting the performance of FP officials (Ahmed et al., 1992, p.45; Hossain, 1988, p.13). This was also apparent from the discussions in the field.

A study conducted in 1984 found that about two-fifths of the FP officers were not in favor of integration; however, over three-fifths of the THFPOs and over half of the MO-MCHs suggested total integration from top to bottom. In another study conducted in 1987, only 26 percent of the health and 60 percent of the FP personnel at the district and thana levels were not in favor of integration while 59 percent of health and only 16 percent of FP personnel were for total integration (Ahmed and Ali, 1987, pp. 60, 61, 75). Thus the proportion in favor of integration is higher in the health than FP. According to the FP personnel we interviewed, health wing personnel are in favor of greater integration because they expect to control the integrated program.

There is confusion and conflict of jurisdiction between the THFPO and the MO-MCH over administration, maintenance, and utilization of the six beds earmarked for FP at the THCs. According to the field functionaries interviewed, two opposite views emerged. While the FP personnel complain that, in actual practice, they do not get the beds earmarked for them, the health personnel argue that in most cases they do provide the six beds to the FP personnel when asked for.

At the union level, the FWCs extend their services through satellite clinics at the ward level twice a week. The FWC staff supervision comes from the MO-MCH, thus creating duplication in supervision (Khuda et al., 1990, p.21).

8. ACCOUNTABILITY

8.1. Introduction

One of the main sources of inefficiency in the FP and health programs is that workers and officers are not aware of what they are supposed to do, or if they are aware, they are not doing the quantity or quality of work expected of them. Money and supplies are often diverted and not available for their intended uses. These problems are part of the sustainability issue: one of the most effective ways to mobilize more resources for the FP program

would be to make sure that the resources (both human and material) already being paid for are actually used for the program. To do this will require a greater effort to ensure that managers at every level are held accountable for the use of resources entrusted to them.

There are virtually no data on which to base an estimate of the size of the problem of resource "leakage". However, the magnitude of the problem is not small, and it exacerbates many of the other problems facing the program.

Greater managerial accountability is crucial for attempts to implement any of the reforms to improve quality and coverage of the FP system. For example, the quality of IUD services suffers because the FWVs do not receive the money that they are supposed to get to reimburse them for kerosene purchases, and therefore, do not use the autoclave to sterilize instruments. Satellite clinics are not held, in part because FWVs are not getting Tk.100 meant to cover their expenses for transport, ayah, and supplies. In focus group sessions to test FWAs' reactions to a new program for home delivery of injectable contraceptives, many expressed an unwillingness to take on a new assignment when they were not receiving their full salary, since TFPOs were routinely withholding some. The reward and punishment system does not work when, as is all too common, it is misused as an income generating project for officers. The system for transfer of FWVs and officers cannot be used to assign the right person to the right job if it is being misused as an income-generating project for those with the authority to make transfers. THCs and FWCs cannot function properly if they are continually running out of antibiotics and office supplies due to diversion, which is one of the underlying problems of the supply system. Facilities remain underused, and the system of referrals does not work as intended, in part because community members and first-level providers know that clients will be charged exorbitant sums for many emergency and obstetric services at the hospitals.

Issues related to accountability can be perceived broadly in terms of those which are controllable and those which are not. Among the controllable issues, there are those which fall within the direct purview of the MOHFW and Directorate of Family Planning (e.g., those related to supervision, logistics and supplies, etc.), and those which are prone to changes by the actions of the Government through broader reforms in the civil service system. Among the non-controllable issues, the major components are cultural (e.g., inertia, dependency, etc.), and political (local political structure, etc.). It should be stressed that in order to bring about accountability in the FP-MCH program, those issues which are controllable and directly within the purview of the MOHFW should be high on the agenda. However, appropriate reforms in the civil service system deserve careful consideration to further improve the situation.

8.2. Past Attempts to Ensure Accountability

There has been a reluctance to deal with such issues, in part because they are part of a larger problem of accountability in the public services. Many of the solutions must be found and implemented, not just at the level of the FP program of the MOHFW, but throughout the Government system. Another reason for the lack of discussion could be that many of those involved with the FP sector feel that little can be done about these problems. It is true that so-called "corruption" is unlikely to be eliminated, in this or any other country, in the near future. However, there could well be measures that could be undertaken within the FP-MCH sector to reduce leakage and improve efficiency, well short of attaining perfection. As with any other policy reforms, these need to be discussed, researched, tested on a pilot scale, evaluated to see if their benefits outweigh their costs, and then implemented.

There are several means through which some accountability is ensured. Every level of manager is supposed to make frequent field visits, and to report, or issue "show cause" letters about, any violations of rules. There is also a system for independent checks by the FPCST teams, which were originally introduced to monitor conditions for sterilizations but which now make reports about other clinical methods as well. On a wider scale, the Establishment Ministry is supposed to prevent irregularities in recruitment and other personnel actions, and the Anti-Corruption Agency investigates allegations. Officers have on occasion been disciplined or allowed to retire because of corruption charges.

8.3. Current Problems

Some major issues in the area of accountability relate to: (a) authority and responsibility in the FP organizational structure, (b) lack of performance appraisal, (c) inadequate system of rewards and punishment, (d) misreporting of user statistics, (e) problems concerning leakages in the system, and (f) misallocation of supplies and equipment.

There is a system of reward and punishment; however, it is neither foolproof nor efficiently implemented. Hence, there is scope for misuse of powers. "Disciplinary action in the form of reward and punishment focussing on field supervision are seldom initiated and followed through" (GOB, 1993, p.30). Also, it emerged from the discussions with the field personnel that there is no system of tangible rewards for good performance or punishment for bad performance, except that the salary of FWAs could be withheld for a few days/weeks, until the CAR target is met.

Several Government circulars have been issued regarding reward and punishment, lack of supervision, problems related to logistics and supplies, lack of follow-up of pre- and ante-natal clients, non-compliance of weekly time schedules, lack of accountability of the MOs (MCH-FP) regarding sterilization,

non-compliance of technical norms regarding use of autoclaves, etc. The contents of some relevant GOB circulars have been presented in Exhibits 8.1 - 8.5.

In general, a "lack of a fair and operational set of personnel policies" has been identified as affecting accountability of the system (Hossain, 1988, p.39). Lack of responsibility and accountability is due to lack of clarity in job descriptions, and confusion in direct line supervision throughout the field level health and family welfare system (Ahmed et al., 1992, p.47). Toward this end, the MDU revised the job descriptions for different categories of personnel. Similarly, following approval of DGFP, the organogram and specification of duties and responsibilities of different categories of personnel have been printed and distributed (GOB, Vol.2, 1992, pp. 25-26).

There are cases of Civil Surgeons, THFPOs and others being transferred and their orders overturned, when they took to task their inefficient or errant lower level staff, who seem to wield a considerable degree of influence in the system (BRAC, 1991, p.48). In such an event, accountability affects the morale and performance of sincere officials. Indeed, this is a major reason why personnel management has not been effective (GOB, 1992, Vol.2, p.15).

Supervisory guidelines are often not followed, and feedback and follow-up of supervisory action are often lacking. Overall, the supervision of the FWAs by the FPIs and others is unsatisfactory. The thana level officers do not generally reside at the thana headquarters, which hampers supervision (GOB, 1991, p.8). Many MAs and FWVs do not reside at the quarters earmarked for them at the FWCs. According to DGFP circulars (dated 22.06.88 and 04.06.91), they are to be punished; however, this is hardly implemented. The field level functionaries agree with the contention that supervision is the weakest link in the program. They, however, suggest that there should be a "top - down" thrust on supervision. In this connection, they also emphasized the need for training on supervision and monitoring techniques.

Diversion of materials and money is alleged to be a problem in the program. There is a drain of valuable items like paracetamol and antibiotics from the THCs and the FWCs, which can make the satellite clinics dysfunctional. Also, non-reimbursement of Tk.100 per satellite clinic session has been affecting the performance of satellite clinics (Khuda et al., 1993, p.21). In addition, there have been reports of shortages of contraceptives, medical supplies for surgical contraception, spare parts for autoclaves, etc.

(Ahmed et al., 1992, p.48; Khuda et al., 1990, p.33; Corbett et al., 1986, pp. 38-41). These issues should receive top priority by the policy-makers and program managers, if the present situation is to be improved.

Exhibit 8.1: Special Efforts on Strengthening of FP Program

■ From the reports of clinical supervision teams, it has been observed that in many cases the standard of clinical service, with respect to sterilization, IUD and injectable services, has been below the specified level.

■ Some of the main reasons for the poor performance relate to lack of efficient management in implementing the programs; lack of initiatives at the district and thana levels to remove the problems in achieving targets through formulation of local level plans; lack of measures to ensure that the male and female field functionaries are accountable for their duties and responsibilities; lack of proper inspection and supervision; complications and side-effects reported by the users of clinical contraceptives because of inadequate quality of care; under-utilization of thana and union level health centers; mismanagement in the FP logistics and supplies; lack of follow-up measures for FP-MCH clients; and lack of organized IEC activities.

■ To ensure better monitoring and supervision, the following field visit schedules should be followed: Deputy Director 12 days (with reasonable number of night haltagas); TFPO 14 days; Medical Officer (CC) 8 days; Medical Officer (MCH) 8 days; Assistant TFPO 16 days; Senior Family Welfare Visitor 15 days; and FPI 18 days.

■ The statistics supplied by the MIS Unit regarding deficiencies in achieving the thana-wise target shall have to be reviewed; and based on such statistics, the programs/courses of action shall be formulated in the monthly coordination meetings.

■ Due to lack of proper management, the standard and amount of service in many of the maternity centers is below the expected level. The Deputy Director and the Medical Officer (CC) shall regularly visit the maternity centers.

■ The Deputy Director will visit 10 union Health and Family Welfare Centers in each month, and the Upazila (thana) FP Officer will visit all the centers in his/her area each month. Each Assistant FP Officer will visit all the Health and Family Welfare Centers in his/her area twice a month, and the Senior Family Welfare Visitor will pay visits to each of the Family Welfare Centers once a month.

■ Each FP-MCH Inspector will regularly sit in the Union Family Welfare Center in his/her area; and after recording his/her presence, he/she will go out for inspection. He/she will keep all the official documents in this center.

■ Measures will have to be taken immediately to ensure that the Medical Assistant and the Family Welfare Visitor stay at their specific official residence all the time.

■ Instances related to shortage of equipment or absence of measures to repair the equipment for long will have to be brought to the notice of the concerned Deputy Director.

Source: DG, DFP; Memo No. PP/MP/88/5069, Dated: 22.6.88

Exhibit 8.2: Weekly Routine of Activities and Time Schedule of FWCs.

■ It has been observed that the time schedule for keeping the FWC open is not being followed properly in many places. After visiting different centers, it has been observed that many centers do not prepare their weekly routine of activities. As a result, the people in those areas cannot avail of the services offered by the centers.

■ Under the above circumstances, all concerned are hereby directed to follow the following time schedule in the Health and FP Centers of the Unions:

Time Schedule

Saturday 8:30 AM to 2:00 PM (checking patients and supplying medicines)

through

Thursday 3:00 PM to 4:00 (official work of the clinics).

Source: DG, DFP: Memo No. FP/S-U/C-2/82/1334, Dated: 21.12.88

Exhibit 8.3: Non-compliance of Clinical Norms for Sterilization

During their field visits, the FPCST team found that sterilization operations were being performed in many instances with the instruments autoclaved some days ago or at least 24 hours before the operation, which is against all medical norms.

Source: DG, DFP; Memo No. PPA/Sa-Sakha/15, Dated: 10.4.91

Exhibit 8.4: Irregularities in the Supply System

From the reports of various departmental inspection teams, it is being observed that the FP supplies, medicines, and equipment sent to warehouses do not reach the Thana FP Offices and the Family Welfare Centers in time. As a result, the program activities suffer.

Source: Additional Director (Drugs and stores), Central Warehouse, Dhaka Memo No: PP/Ka. Panna/90/184(20), Dated: 19.2.90.

Exhibit 8.5: Screening of Sterilization Clients

Sterilization-related complications are cropping up, because the essential examinations/check-ups are not generally conducted by the operating surgeon.

Source: Director (MCH-Services), DFP, Memo No. PP/S-U/S-11/88129(64), Dated: 29.11.88.

9. INFORMATION FOR PROGRAM MANAGEMENT

9.1. Introduction

The major policy components of the Fourth Plan concerning the various dimensions of the "information systems" of the FP program are (see: GOB, 1990, pp. XII-7, 17):

- (a) the existing MIS systems will be strengthened by introducing Field Workers' Record Keeping System (FWRS), so as to facilitate assessment of program performance at the field level;
- (b) efforts will be made to strengthen District Offices in the existing data collection, methodology, analysis, and storage of data, as well as timely dissemination through a process of computerization;
- (c) future research will be conducted on the action and operational aspects aimed at the improvement of program management and implementation. Research efforts will also be directed in such areas as use-effectiveness and cost-effectiveness of different FP methods and interventions;
- (d) efforts will be made to fill-in the knowledge gaps of the policy makers and program planners to make useful changes in policy strategy and program;
- (e) proper emphasis will be given for undertaking operations and action oriented research;
- (f) appropriate mechanisms will be evolved for coordination and dissemination of action-oriented research findings among program managers to provide feedback in implementation and management of the program at the field level; and

- (g) to strengthen the process of local level program planning and formulation of strategy, local population data-bases will be formed.

9.2. Target Setting

The overall national targets, by method mix, are determined in the Five Year Plans developed by the Planning Commission in consultation with the MOHFW. The MIS Unit of the Directorate of Family Planning, then, assumes the responsibility of apportioning the overall target set by the Planning Commission to the districts. The districts then apportion targets among the thanas; and in turn the thanas apportion the target among the unions, based on the eligible population and past experience. Field level discussions indicate that the process is top-down, and interpreted by some as imposition of targets without adequate consideration given to local conditions in which the fieldworkers operate.

9.3. Problems of Information Flow: Top-down and Bottom-up

The MIS system is responsible for regular collection of output data to assist in the planning process. The bottom-up flow of information is shown in Figure 9.1. Also, the MIS system provides the program managers with data in a form that permit diagnosis of field-level problems, and evaluation of performance of individual workers and areas. There is, however, irregular and improper submission of reports and returns, and data quality is poor (GOB, 1993, p.35). "The FWA is not properly trained to fill-in Form 4, which constitutes the basis of the entire reporting system" (Huq and Huq, 1991, p.57). Provision of training to the FWAs regarding filling-in of the various columns should be provided by the MIS Unit, so as to improve the quality of data (GOB, 1992, p.35).

The Directorate of FP issued several circulars regarding the supply of inaccurate lists of the number of satellite clinics organized at the union levels (Exhibit 9.1); reminders on accurate information flows from the grassroots in order to plan supply of DDS kits, etc. (Exhibits 9.2, 9.3, 9.4), and incomplete progress reports supplied by the NGOs (Exhibit 9.5).

FIGURE 9.1: FLOW OF FP INFORMATION

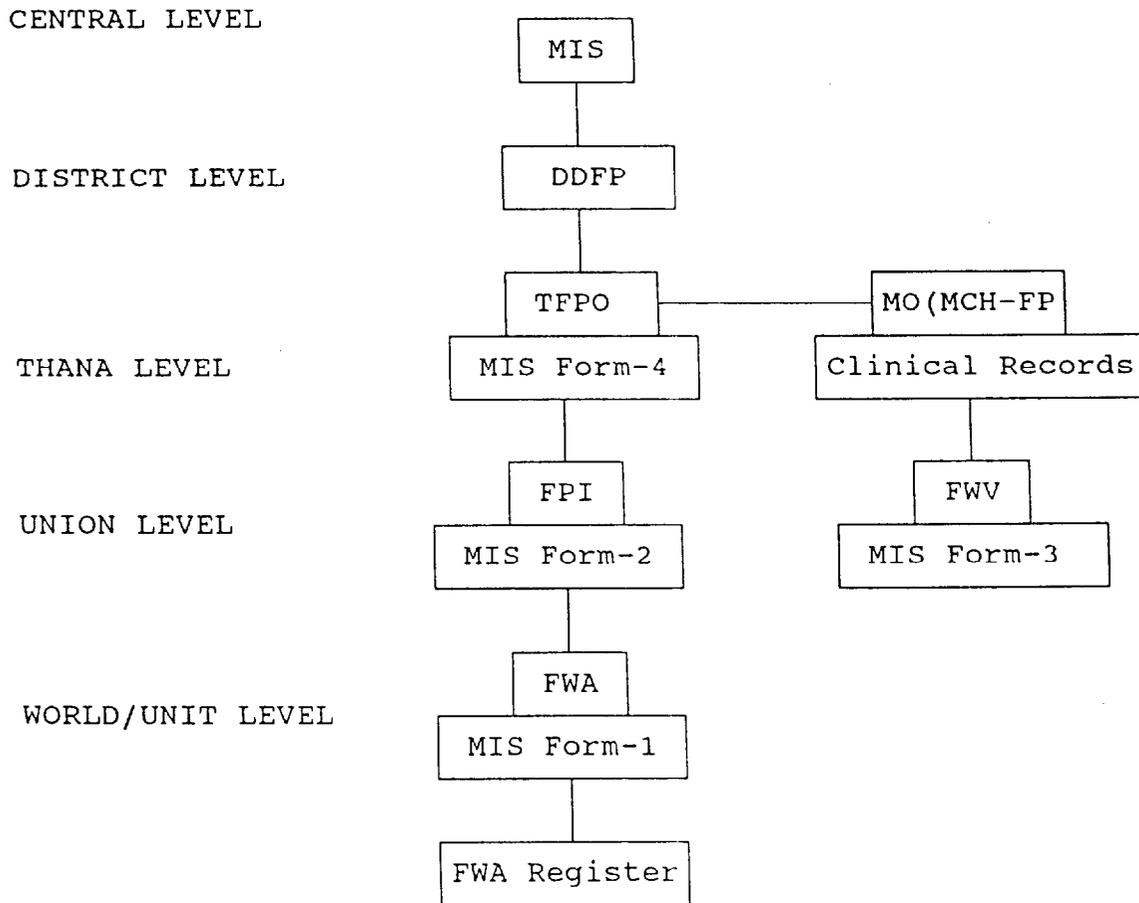


Exhibit 9.1: Furnishing of Accurate List of Satellite Clinics held

It is hereby informed that reports containing wrong information regarding satellite clinic have been received from 57 thanas out of the total of 460 thanas in the country.

- All columns of the format as stated in the source are not being properly filled in.
- The names of the eight houses/places in which the clinics are organized are not being shown separately.
- If there are exceptions in organizing clinics as directed, the reasons for those are not mentioned in the comments column of the format.

There are some mistakes in the list sent from the thana; as a result, it is not being possible to send the required amount of DDS kits and transport allowance to the satellite clinics. With a view to running the satellite clinic program properly and to smoothen the system of transport allowance payment, you are requested to send the corrected list to the undersigned by 15/12/92. The format sent previously is again attached herewith.

Source: Director (MCH-Services), DFP: Memo No. PPA/MCH/2-S/P-3/2779, Dated: 19.11.92

Exhibit 9.2: Information necessary to plan Supply of DDS Kits for Satellite Clinics.

With reference to the subject and source mentioned above, you are requested to distribute/supply the DDS Kit for satellite clinics, according to the attached list. This distribution/supply has been made only in accordance with the list of satellite clinics organized, according to the format shown in Memo No. 2117 dated 23-6-92. Subsequent measures for supply of kits will be taken, if the lists of properly organized satellite clinics (in accordance with the rules) are received later.

Source: Director (MCH-Services), DFP: Memo No. PPA/MCH/2-S/P-3/2336, Dated 26.10.92.

Exhibit 9.3: Reminder regarding the number and places of Satellite Clinics held in the District.

For proper distribution of DDS Kits it is necessary to know the exact number of satellite clinics being really organized presently in the unions.

Therefore, you are requested to send us information regarding the number and places of clinics being organized at various upazilas (thana) under your district and the amount of kits needed in those centers. Otherwise, it will not be possible to distribute kits.

Source: Director (MCH-Services), DFP: Memo No. PPA/MCH/M-10/89/1878, Dated: 16.2.92.

Exhibit 9.4: Non-submission of Reports on Satellite Clinics by the DD/FPS.

Through Memo. No.3 mentioned above, you have been requested to submit a list of the satellite clinics (prepared according to the following format), organized by the Family Welfare Visitors of the unions where they have been working.

However, till now no reports have been received from you. You are again requested to send the list of satellite clinics, according to the following format on an emergency basis:

Sl. No.	Name of Upazila (thana)	Name of Union	Name of FWV	Name of satellite clinic	Name of Ward	Comments
1	2	3	4	5	6	7

Source: Director (MCH-Services), DFP, Memo No. PPA/MCH/4/2-S/88/502, Dated: 2.9.89.

Exhibit 9.5: Incomplete Monthly Progress Reports of FP NGOs

The complete and accurate information regarding the delivery of FP-MCH services not only helps in assessing the progress in relation to the target but also helps in determining future target. Also, this is necessary for procurement of FP supplies, medicines, and other materials, according to the pre-determined target. However, it has been observed that the information received by the MIS Unit of the FP Directorate from upazila (thana) in this regard is largely incomplete.

This problem is more acute, especially with respect to the information regarding the progress of the NGOs. One of the reasons for this is that the performance-related information of those NGOs which are located at upazila (thana) level and which receive their required supplies directly from their central offices at Dhaka, are not required and are not reflected in the monthly progress report of the concerned upazila (thana) FP Offices, eventually sent to the MIS Unit.

Therefore it is hereby directed that information regarding distribution of FP supplies by such NGOs will have to be incorporated in the upazila (thana) monthly progress reports, sent to the MIS Unit of the Directorate.

Source: DG, DFP: Memo No. PPA/UOS/89/10174, Dated: 13.9.89

9.4. Feedback and Utilization of Data for Planning and Decision-making

The feedback provided by the MIS Unit to the district managers allows them to compare only their own CAR with the rest of the country. There is no further analysis of thana level data, and no other indicators are generated. The feedback in the present format does not indicate areas that need further investigation or supervision by the district and thana managers (Ashraf et al., 1991, pp. 162, 165). Also, until recently no effort was made to obtain program input data, which could be related to program output. Although data on only one input variable, namely, the number of fieldworkers in place, are being obtained, it is likely that data on some additional key input variables will subsequently be collected. Another encouraging sign is the recent decision to integrate the LMIS with the MIS.

Information available through MIS or LMIS is not systematically and regularly analyzed and acted upon. Also, since there is lack of monitoring, the available information is sometimes not used. Furthermore, in the absence of such use of information, LMIS or MIS become merely suppliers of information and compilers of information for various reports (Huq and Huq, 1991, p.62). Thus, to be effective, the feedback and data utilization systems need to be strengthened, so that the information can be used both to review performance at different levels and for future planning.

Exhibit 9.6: Irregular Meetings of the FP Coordination Committee

■ There is Government instruction to form Coordination Committees at the district, upazila (thana), municipality, union, and village level and institutions. These committee meetings are not held regularly. These committee meetings should be arranged by making regular contact with Deputy Commissioners, upazila (thana) Chairman, Municipality Chairmen, and Union Council Chairmen. The Deputy Director may participate as guest at the upazila (thana) Council and Municipal Coordination meetings, as well as the upazila (thana) FP Officer or Assistant FP Officer at the union council meetings.

■ In the village, municipality and institutions, family planning committees have been formed in a small number of places. If this committee has not yet been formed as per Government instruction, it should be done immediately.

Source: DG, DFP: Memo No. PP/M/88/5069, Dated: 22.6.88

9.5. Coordination and Utilization of Information

9.5.1. Routine Information within MOHFW

While the MIS is the single most important source of routine information within MOHFW, it is by no means the only one. Separate information systems exist in more or less structured form for logistics, training, administration, and finance. The Logistics MIS has been overhauled recently, and now puts out readable and timely reports. The Training MIS is currently under revision. The ability of the system to get accurate administrative information such as postings and vacancies is limited. This report was unable to review the financial information system.

Each of these information system is managed by a different unit, and no unit has responsibility for coordinating this information or for ensuring that it adds up to an appropriate body of information. For example, the system has no good way of getting detailed data on program inputs to relate to outputs, or to see how a particular thana is functioning in all aspects together (e.g., logistics, training, personnel, and CAR).

9.5.2. Routine Information from Outside MOHFW

There are several sources of routine information collected from outside MOHFW which are, or perhaps should be, fed into the system. The NGOs are required to provide service statistics in standard format to the Government, a process which works fairly

well but with some problems described in Section 4.3 of this report. The SMC operates within a different type of structure, and therefore, cannot use the same reporting format, but routine information on their sales is available to MOHFW. The NGOs and the SMC also contribute to the LMIS monthly reports. Information on the training contribution of the NGOs to the public sector is available to NIPORT. There would not seem to be a need for routine, detailed administrative information from the NGOs or the SMC to be provided to the Government.

9.5.3. Research Information

Coordination of research is vested in the National Steering Committee for Population Research (NASCOPOR). Research plans and activities from within the Government (e.g., NIPORT, PDEU, and BIRPERHT, etc.) are reviewed and approved by this Committee, which serves effectively as a way to require periodic research planning by these agencies and to reduce duplication and overlap in activities.

NASCOPOR has two major limitations, however, which limit its effectiveness. First, it operates almost exclusively within the public sector, whereas a good deal of important family planning research is carried out by NGOs, universities, and private agencies. Second, NASCOPOR has no paid secretariat, and NIPORT cannot devote sufficient resources to this task. Hence NASCOPOR cannot effectively identify gaps in research which need to be filled, or help in keeping the various research organizations informed about what they each are doing.

NASCOPOR is also not an effective body for communicating research findings to the Government. NIPORT provides an important service through its periodic annotated bibliographies of population and family planning research, but this may not be timely for some decisions, and may not be directly usable by managers. Research findings are disseminated through reports which reach Ministry desks, but may not be read. An increasingly important forum for dissemination of research findings is through dissemination seminars; however, this is not always time-efficient for managers, and much research does not get out effectively in this form.

In sum, the process of getting research to MOHFW so that it might be utilized is a spotty process. Because of the interest of some managers and the diligence of some researchers, many findings do come to the attention of policy makers, but many others do not. No agency in MOHFW has either the responsibility or the resources to manage this task.

9.5.4. Information Utilization

Once information is available, whether from research or from routine sources such as an MIS, its utilization depends in part on how it is stored, accessed, and processed. No one, especially

senior managers, has time to read all relevant information; it must be absorbed and processed, one topic at a time, for use in management and decision making. This requires assignment of staff time at a fairly high level of expertise.

This presently happens in various ways. NIPORT is in the process of developing an Information Network which is already a substantial collection and should ultimately be an important and accessible repository of existing information. The LMIS (but not other information systems) regularly lists actions to be taken as a result of its findings. The MCH-FP Extension Project has a history of preparing briefing papers, intended to extract key information for management use. Dissemination seminars may have useful recommendations or discussion sessions, depending on the inclination and policy understanding of the researchers.

These mechanisms do not necessarily focus information at the time it is needed, or gather together all relevant information. There is little capability in MOHFW to produce, on short notice, a report for management use which brings together relevant information on an assigned topic and presents plausible options for discussion. There are two primary obstacles to a manager who attempts to request such a report. First, the task of collecting the information needed is still difficult, although the Information Network should ultimately meet this need. Second, there is a dearth of personnel within MOHFW with the combination of substantive expertise on any given topic and the particular skill needed to review and summarize data for such a report.

10. CLINICAL CONTRACEPTION

10.1. Introduction

The Fourth Plan emphasizes the need "to continue the 'cafeteria approach' in matters of contraceptive distribution with unhindered access to quality service at a nominal cost or free of cost" (GOB, 1990, p. XII-6). The major policy elements of the Fourth Plan directly or indirectly related to the clinical contraception are (see: GOB, 1990, pp. XII-6-7):

- (a) expand coverage through domiciliary and clinical services;
- (b) improve quality of services and follow-up care for increasing acceptability as well as continuation rates of contraceptive practices;
- (c) in order to ensure 'quality care', it is necessary to augment effective screening for contraceptive choice, counselling and follow-up of clients with respect to side effects, management of drop-outs, and method switching;

The Fourth Plan states that, (a) with adequate counselling, follow-up and management support, considerable expansion of IUD program would be feasible, (b) with proper management satellite clinics near to the doorsteps of the rural people will open the door for wider use of contraceptive services, and (c) with the recently-introduced technology of no-scalpel vasectomy, considerable expansion of male sterilization is within the realm of possibility (see: GOB, 1990, p. XII-8).

10.2. Decline in Voluntary Sterilization and IUD Performance

Voluntary sterilization has been a prominent component of the national FP program since the mid-1960s. Beginning in the mid-1970s, annual voluntary sterilization performance continuously increased, reaching its peak in 1983/84. Since then, however, there has been a declining trend. By 1990/91, the number of sterilizations performed had dropped to 165,300, the lowest figure since 1978/79. Similarly for IUDs the number of insertions has declined considerably in recent years from the mid-1980s (Ahmed et al., 1992).

While the Government follows a cafeteria approach, thereby enabling informed choice among the eligible population, it nevertheless views the decline in voluntary sterilization and IUD performance with considerable concern, as clearly reflected in the Five-Year Plan documents.

10.3. Causes for Decline in Sterilization and IUDs

While various factors may have contributed to the decline in voluntary sterilization and IUDs, it would be appropriate to identify the four critical ones.⁸

(a) Strengthening of the CBD System

The last decade witnessed strengthening of the CBD system by both the Government and the NGOs through recruitment and deployment of 23,500 FWAs, plus several thousand NGO fieldworkers. The CBD system has been augmented by the establishment of the satellite clinic system. Thus, accessibility to and availability of the supply methods, especially oral pills and injectables, have increased, enabling greater choice among the users as well as potential users. These changes in program strategy have tended to make inroads on the uptake of sterilization and the IUD. Thus, while the increased accessibility to and availability of such contraceptive methods as oral pills and injectables should continue, there is, nevertheless, a need to make available good quality voluntary sterilization and IUD services.

8. For detailed discussion, see Ahmed et al., 1992.

(b) Deficient Supply of Services

A number of factors are believed to account for deficient supply of services. These include: (i) inadequate training capacity, as reflected in a sizeable number of personnel at different levels who have not received refresher training, inability to provide timely training to the 303 doctors recruited in May 1991, and the theoretical nature of training, all indicating the need to institutionalize enlarged and improved training capacity in clinical contraception; (ii) insufficient training and inexperience of many doctors, which make field workers reluctant to bring clients to them for clinical methods; (iii) lack of ownership and commitment to FP among many doctors on deputation from the Directorate of Health; and (iv) lack of adequate equipment and supplies such as autoclaves, kerosine, essential drugs, etc. in many service sites.

(c) Erosion in the Medical Quality of Sterilization and IUD Services

There is evidence suggesting that the infection rate among the sterilization and IUD clients has gone up due to inadequate training and supervision, resulting in an increase in the number of sterilization deaths. This therefore makes the method less attractive among the clientele population, and more difficult for motivation by the fieldworkers. This was also confirmed by discussions with relevant field staff.

(d) Imbalance in the Reward Structure between Clinical and Non-Clinical Methods

In the 1980s, the program was overbalanced because there were substantial rewards for both providers and clients to accept sterilization, while there was little incentive to promote temporary methods such as pills. In recent years, the incentives to promote sterilization have largely disappeared -- in fact, there are now some disincentives -- whereas the near-universal implementation of CBD, with emphasis on fieldworker performance and the CAR, has resulted in rewards for motivating pill and condom acceptors, with little incentive to promote clinical methods. This imbalance would appear to be particularly amenable to changes in policy. Some aspects of policy which relate to this imbalance are the following:

- i. Incentives for Clients,
- ii. Incentives for Providers,
- iii. Acceptor method targets,
- iv. Referrals (include medical and non-medical), and
- v. MIS management.

The imbalance in the reward system interacts with deficiencies in the structure of clinical services; if those services are not readily available and of acceptable quality, the factors favoring non-clinical methods are enhanced, and vice versa. Improving the availability and quality of clinical services is largely an issue of implementation; a policy dialogue on clinical methods should focus largely on possible modifications in the reward structure.

10.4 Policy Considerations

a. Incentives for Clients

The most valuable incentive for clients to adopt clinical methods is probably high-quality care; but this is primarily a matter of implementing existing policies, not of policy. An important existing incentive is the payment of Tk. 175 per sterilization acceptor (male or female), which has remained stationary since 1983. Given inflation, this means that the payment has lost about half of its real value (AVSC, 1992). These payments have been controversial, and USAID, considering them incentive payments rather than compensation, withdrew support for the payments in 1987. An important study (Cleland and Mauldin, 1991) judged that the payments "may be a contributing factor to the decision to become sterilized in a large majority of cases, but a dominant motive for only a very small minority." That study was carried out in 1987, and has not been updated.

On the other hand, introduction of CBD has provided a major incentive -- doorstep delivery -- for pills and condoms, which, in a context of limited female mobility, is of major importance. In contrast, IUDs and injectables are (in theory) available at the FWC, and sterilization at the THC or District Hospital.

b. Incentives for Providers

Doctors are given a fee of Tk.20 per sterilization acceptor (female or male), and support staff receive a fee of Tk. 15 per tubectomy and Tk.12 per vasectomy. A referral fee of Tk.45 was discontinued in 1988 due to abuse in the form of misinformation and sometimes coercion. There is no conveyance allowance for accompanying acceptors to the clinical site, although this is an important expenditure of time and money, especially for female sterilization. Hence for fieldworkers, there is no financial incentive, and some disincentive, for referral.

FWAs are judged primarily on the basis of their reported CAR. Targets by method have been discontinued, and FWAs seem to have little sense that older, higher-parity women need more long-term methods, and are not judged or supervised, to any great extent, on achieving appropriate method mix. In this circumstance, an acceptor of pills or condoms is a more immediate success than an uncertain referral; this appears to be a significant deterrent to referral for clinical methods.

Along the same line, referrals generally go from non-medical FP personnel (FWAs) to medical FP personnel or to health wing personnel, and the strains between these groups provide further disincentive for referral. For NGO fieldworkers, referring to Government clinics may simply represent an extra hassle, with uncertain compensating reward even in acceptor statistics.

In all these ways, the existence of the CBD system encourages the methods provided by that system, to the detriment of clinical methods. It is important that, in addition to improving the quality and availability of clinical methods, a balance of incentives and disincentives be reached for both clients and providers that encourages an appropriate method mix for clients.

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