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LONG-TERM AND PERMANENT METHODS OF FAMILY PLANNING IN BANGLADESH

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ACRONYMS

ACQUIRE	Access, Quality, and Use in Reproductive Health Project
ADCC	Assistant Director, Clinical Contraception
ADFP	Assistant Director, Family Planning
ATFPO	Assistant Technical Family Planning Officers
BAVS	Bangladesh Association for Voluntary Sterilization
BCC	Behavior change communication
BDHS	Bangladesh Demographic and Health Survey
BRAC	Bangladesh Rural Advancement Committee
CC	Community clinic
CRHC	Comprehensive Reproductive Health Center
CPR	Contraceptive prevalence rate
DDFP	Deputy Director of Family Planning
DFID	Department for International Development (UK)
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DHS	Demographic and Health Survey
FPA	Family Planning Assistant
FPI	Family Planning Inspector
FPO	Family Planning Officer
FPCST	Family Planning Clinical Supervision Team
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
GH Tech	Global Health Technical Assistance Project
GOB	Government of Bangladesh
H&FWC	Health and Family Welfare Center
IFB	Islamic Foundation of Bangladesh
ITA	Imam Training Academy
IUD	Intrauterine device
LTPM	Long-term and permanent method of family planning
MCH	Maternal and child health
MCHTI	Maternal and Child Health Training Institute
MCWC	Maternal and Child Welfare Center
MFSTC	Mohammadpur Fertility Services and Training Center
MIS	Management information system
MLGRD	Ministry of Local Government and Rural Development
MOHFW	Ministry of Health and Family Welfare
NGO	Nongovernmental organization
NIPORT	National Institute of Population and Health Program
NSV	No-scalpel vasectomy
PHC	Primary health care
PHN	Office of Population, Health and Nutrition (USAID)
PM	Permanent methods of family planning
RH	Reproductive health
SACMO	Sub-Assistant Community Medical Officer
SMC	Social Marketing Company
TFR	Total fertility rate
UNFPA	United Nations Population Fund
UPHCP	Urban Primary Health Care Program
USAID	United States Agency for International Development
VSC	Voluntary surgical contraception
YM	Young Married program

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EXECUTIVE SUMMARY

The population of Bangladesh is currently estimated at over 158 million. In 2005, approximately 25 percent of the population was urban and 75 percent rural. Bangladesh is currently experiencing substantial urbanization, creating increasing demands for services within crowded and often disadvantaged areas where people live and work. By 2015, the population may reach or exceed 180 million, with the urban population projected to expand from around 38 million in 2005 to about 54 million and accounting for nearly a third of the national total (UN Statistical Data Base, 2007).

Long-term and permanent contraceptive methods (clinical methods that include hormonal implants, intrauterine devices, no-scalpel vasectomy (NSV), and tubal ligation) are critical to meeting the reproductive health (RH) and family planning (FP) needs of Bangladesh. These FP methods offer important additional choices for individuals, including:

- Spacing or limiting pregnancies
- Responding to changing reproductive lifecycle circumstances
- Providing more medical options
- Increasing alternatives suited to varying social, cultural, or religious considerations affecting individuals and couples

For the country and national program, long-term and permanent methods of FP (LTPMs) provide important tools to improve the health of mothers and children, provide cost-efficient and long-term service options, and increase options for balancing demographics with social service needs.

In Bangladesh, the provision of LTPMs was initiated by a few philanthropists from 1953 to 1959 as a clinic-based FP program in major cities. In the 1980s, LTPMs, particularly the permanent methods, were highly accepted and emphasized for couples who had completed their family size. By the end of the decade, the preferred methods had shifted to oral contraceptives and condoms, and the use of permanent methods plummeted. While the contraceptive prevalence rate (CPR) for all methods shows a dramatic increase from 7.7 percent in 1975 to 58.1 percent in 2004, the total fertility rate (TFR) hit a plateau in the mid-1980s and has only declined from 3.3 to 3.0 in 2004. This near stagnation in the reduction of the TFR is probably a result of the proportionate shift to short-term methods and a high discontinuation rate for most methods, including oral contraceptives, the most popular method. Significant weaknesses in service delivery and a stagnating demand for LTPMs only widens the gap between the demand for limiting family size (70 percent of women of reproductive age report a desire not to have any more pregnancies) and the actual use of permanent methods. Furthermore, implants and intrauterine devices (IUDs) are not often used by women who could benefit from their convenience and long-term protection against pregnancy.

The United States Agency for international Development's (USAID's) assistance for improving LTPM services in Bangladesh has largely been provided through the Access, Quality, and Use in Reproductive Health Project (ACQUIRE). The portion of the total LTPM services contributed by sites supported by ACQUIRE-supported sites is substantial, particularly for NSV, which has been one focus of ACQUIRE activities. LTPM activities are also supported indirectly through a number of other USAID-supported activities.

At the request of USAID, through the Global Health Technical Assistance Project (GH Tech), this report reviews the current status of and potential for strengthening support for LTPMs throughout the public, nongovernmental, and private sectors of Bangladesh.

The assessment team used a combination of quantitative and qualitative methods to examine trends and patterns related to LTPM use in Bangladesh. Information was drawn from the Demographic and Health Survey (DHS) and all available predecessor household surveys. The team visited public, private, and

nongovernmental organization (NGO) service delivery settings demonstrating low, medium, and high performance in urban and rural areas throughout Bangladesh. The team also paid particular attention to client-provided information, gender-related issues, reaching underserved populations such as youth (married or not married), community participation (including religious leaders), and urban versus rural access to LTPM services.

Summary of Critical Findings and Recommendations:

LTPMs, particularly permanent methods (PMs), are more frequently used or accessed by those with lower incomes and less education. USAID programs should ensure that service delivery sites and all associated information and counseling on LTPMs is provided in a way that is more accessible and acceptable to the illiterate and lower income populations.

Approximately 70 percent of all FP acceptors report using contraceptives to limit their family size. However, substantial numbers of these “limiters” are relying on oral contraceptives to realize their reproductive goals rather than using a more cost-efficient and permanent method, such as tubal ligation or NSV. USAID programming should emphasize the training of counselors and method providers on how to better inform FP candidates of their contraceptive choices and help potential acceptors select a method that more closely matches the individual’s needs (for example, to delay first pregnancy or limit or space further pregnancies).

The 12-month IUD discontinuation rate in Bangladesh was estimated to be 35.4 percent in 2004, not much lower than that of oral contraceptives (46.5 percent) and injectables (48.7 percent), showing that almost half of those using the most popular methods are discontinuing use within one year. There is a need to examine the IUD discontinuation study, which is in process, and expand its findings as possible way to minimize LTPM and other discontinuation rates.

Where a female service provider is not available, access to IUDs is substantially reduced due to prevailing concepts of modesty and culturally defined cross-gender sensitivities. This should be addressed by giving priority to supporting schemes to expand the number of skilled female service providers who are authorized and equipped to provide IUDs and by examining ways to reduce the stigma associated with men inserting IUDs to reduce this impact on service delivery.

Male awareness of IUDs and implants is noticeably lower than among women, and this may influence their popularity among women. The training of counselors and service providers should encourage the inclusion of men in informational sessions and in the process of making FP decisions.

In Bangladesh, there are unfilled and inadequate service-delivery positions within the public sector, due to a lack of policy to execute a recruitment and placement process based on the current needs of the population. This is perhaps the most urgent and critical problem in the delivery of FP services, particularly for LTPMs. Discussions with the Government of Bangladesh (GOB) and the donor community should emphasize this situation and assistance should be provided as requested to initiate a recruitment, placement, and training program that also increases the total number of these workers relative to the population served. Strengthening local training institutions can contribute to meeting the continuing training needs at the national and sub-national level. Training in all areas of LTPM provision should be decentralized so that districts have greater capacities to formulate and implement training plans for LTPM services.

Supervision, although strengthened in some areas where the ACQUIRE Project has worked, remains inadequate and insufficient to fully support the expansion of LTPM services. **It is recommended that USAID take immediate action to work with the GOB to rectify its staffing shortages and to implement a carefully organized and systematic training and supervision program.**

Current policies on client eligibility and service provision for PMs are unnecessarily restrictive and limit access. An active policy dialogue should be encouraged to modify the policies pertaining to client eligibility for LTPMs, particularly for PMs.

LTPM service delivery rests primarily within the public sector, and urban LTPM service coverage is more incomplete than in rural areas. New initiatives for LTPM service delivery in the private sector should be encouraged to make LTPMs more easily accessible to a broader spectrum of potential users, particularly in urban areas. Innovative financing schemes could encourage NGO and private sector involvement.

The government-controlled system of contraceptive procurement and importation has recently resulted in shortages and even outages in the supply of IUDs and implants. Options to open the importation of LTPM contraceptives and supplies to the NGO and private sectors should be promoted while continuing support to the GOB procurement system.

Considerable investment has been made in developing and implementing behavior change and communication messages in Bangladesh. In recent years, these interventions have had limited success in building widespread awareness about LTPMs. A significant opportunity exists to work with the GOB and other development partners to develop and implement a coordinated and integrated behavior change communication (BCC) campaign, including nationally recognized messages that:

- Focus on lifecycle needs (spacing versus limiting) and the use of LTPMs
- Dispel misconceptions about NSV among men and women
- Show NSV and tubal ligation as progressive, modern, and enjoyed by the rich as well as the poor
- Are comprehensible by the large illiterate population
- Focus on the large youth population entering a lifetime of family planning needs
- Use mass media such as TV, radio, and newspapers that are suited to the needs of adolescents
- Use public entertainment geared to youth, such as film and reading materials, to increase knowledge about LTPMs among youth
- Portray IUDs and implants in terms of their relative ease of use and appropriateness to certain clients and couples for spacing their pregnancies
- Use “satisfied customers,” “champions,” and branding as vehicles for spreading informed and positive messages about LTPM

The use of “educated individual-led information sharing” can be a useful client-based method of increasing demand for LTPM and other RH and FP services without relying on the formal service delivery system.

The Mission’s recent approach of primarily addressing LTPM service delivery needs through a single implementation mechanism has not been adequate in correcting many of the root problems plaguing service delivery. Furthermore, it did not integrate well with or take advantage of other FP-related interventions. An integrated approach—one that includes other FP efforts and used a variety of cooperating agencies with specific strengths in areas such as communications and demand creation, private sector service delivery and training, and other innovative interventions—might be more effective and cost-efficient.

Future programming in support of a broad spectrum of FP services should consider using specialized means or organizations supported through a local or USAID-sponsored procurement mechanism that specializes in the development and provision of BCC messages rather than relying on more generalized service delivery implementation mechanisms.

A review of USAID/Bangladesh’s strategic objectives found that a number of opportunities exist to achieve synergy among USAID’s overall development portfolio, but USAID is not taking full advantage of integrating cross-cutting issues that would strengthen development initiatives. LTPM activities should be coordinated and integrated with other USAID sector interventions, such as education and disaster relief.

I. INTRODUCTION

BACKGROUND

The total population of Bangladesh is currently estimated at over 158 million. In 2005, approximately 25 percent of the population was urban and 75 percent rural. Bangladesh is experiencing substantial urbanization, creating increasing demands for services within these crowded and often slum areas where people live and work. By 2015, the population may reach or exceed 180 million, with the urban population projected to expand from around 38 million in 2005 to about 54 million, accounting for nearly a third of the national total (UN Statistical Data Base, 2007).

In 1975, the GOB adopted a population policy that promotes voluntary FP service delivery to bring the population growth rate in line with the country's ability to support its people and to achieve improvements in maternal and child health (MCH). The first two decades of this program showed promising results, and Bangladesh became an example of a successful FP program with great promise for the future. FP services were introduced and extended nationwide through a system of service delivery points supported by a robust communications campaign that educated the population to the benefits of FP and where to obtain these services.

LTPMs are considered clinical methods and include hormonal implants, IUDs, and tubal ligation for women and NSVs for men. LTPMs are critical to meeting the RH and FP needs of Bangladesh. LTPMs offer additional choices to short-term methods, such as the pill and condom use, and are particularly important for individuals to space or limit their pregnancies, respond to changing reproductive lifecycle circumstances, accommodate medical needs, and increase alternatives suited to varying social, cultural, or religious considerations affecting individuals and couples. For the country and national program, LTPMs are an important and cost-effective intervention to improve the health of mothers and children, provide cost-efficient long-term service options, and increase options for balancing demographics with social service needs.

USAID's Mission in Bangladesh supports LTPMs under *SO 13, Program Component 1: Reduce Unintended Pregnancy and Improve Healthy Reproductive Behavior*, which states, "Consistent coordination with the GOB will ensure sufficient commodities for those who cannot afford them, with the private sector to provide for those who can. To complement efforts to reduce unintended pregnancy through short-term methods, support for long-term FP and expanded contraceptive choice will continue. USAID/Bangladesh programming will emphasize improved quality, access and availability of key family health services. With respect to adolescent RH, USAID/Bangladesh will collaborate with partners and implementers to produce and distribute information materials targeted at a burgeoning adolescent audience."

The U.S. Government's five-year plan includes programs to "increase the couple-years of protection to 9.5 million by 2010; reduce the contraceptive stock out rate at the warehouses to below 2 percent; and improve the sustainability of systems that promote access to quality RH, including FP services. USAID's contribution will expand access to high-quality voluntary FP services and information, and RH care by reducing unintended pregnancy and promoting healthy reproductive behaviors of men and women, reducing abortion, and reducing maternal and child mortality and morbidity."

USAID's assistance for improving LTPM services in Bangladesh has largely been provided through the ACQUIRE Project. The portion of the total LTPM services contributed by ACQUIRE-supported sites is substantial, particularly for NSV, which has been one focus of ACQUIRE activities. LTPM activities are also supported indirectly through a number of other USAID-supported activities.

PURPOSE AND MAIN FOCUS OF THE ASSESSMENT

This report focuses on LTPMs as an integral component of USAID's goal of supporting informed choice and access to a broad range of contraceptive methods. The challenge ahead is to build on lessons learned to identify constraints and opportunities to increase the adoption of LTPMs as a part

of a balanced and effective FP program that provides ongoing quality services to all sectors of the population.

The purpose of this report is to review the current status and effectiveness of LTPM service delivery throughout the public, nongovernmental, and private commercial sectors of Bangladesh and to assess the potential for strengthening support for these methods. Appendix A provides the complete scope of work for the assessment. Specific objectives include the following:

- Determine the overall progress and achievements in ACQUIRE activities and LTPM services.
- Document the effectiveness of ACQUIRE and other activities to increase access to services or facilities that offer an appropriate range of clinical FP methods.
- Determine the major constraints to achieving results and improvements in LTPM services.
- Determine the extent to which ACQUIRE and other activities have improved technical and managerial capacity to deliver LTPM services.
- Identify best practices and lessons learned from ACQUIRE that can inform future efforts to further improve LTPM services.

METHODOLOGY

USAID/Bangladesh requested assistance from GH Tech to prepare an assessment of the LTPM country program. GH Tech provided a team of four members with extensive international expertise—two development consultants from Bangladesh and two former USAID Population, Health, and Nutrition (PHN) Officers.

The assessment team used a combination of quantitative and qualitative methods and evaluation approaches, including a review of recent literature, an examination of available data sets, key informant interviews and field-based structured interview sessions with LTPM acceptors and potential acceptors, and facility observations. The team reviewed historical and recent studies and reports on Bangladesh's FP and RH program, including USAID-supported projects. Pertinent findings and lessons learned from these documents were noted. The team paid particular attention to the contribution of USAID-supported activities that address the following:

- Gender related issues
- Reaching underserved populations such as youth (married or unmarried) and certain urban groups
- Community participation (with religious leaders, peer groups and others)
- Urban versus rural access to LTPM services

Major Sources of Information

Key informants: Informants selected for interviews represent significant stakeholder organizations involved in RH, FP, and LTPMs and include the Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP); other public, NGO, and commercial sector administrators; and service providers and donor organizations (see Appendix B for a list of key informants). The clinical facilities and sites visited during the assessment are listed in Appendix C.

The team sought inputs from FP acceptors and potential acceptors in the context of field visits. Impromptu focus groups were held in clinic and community settings to gain a better understanding of the current knowledge, attitudes, and practices of FP methods to delay first pregnancies and limit or space further pregnancies, particularly through the use of LTPMs. The focus groups and individual interviews provided the team with firsthand testimonies from men and women who have or could have benefited from LTPMs, and gave the team a snapshot of individual needs and perceptions that could be compared with more comprehensive quantitative data available. These focus groups took place in clinic settings, in hotel lobbies, on the street, and at medical stores on an opportunistic basis during field visits.

Major questions:

Asked of individuals during focus groups (acceptors and potential acceptors):

- What do you know about FP and what methods do you know?
- What are your FP needs (to delay, space, or limit pregnancies)?
- What FP methods are you using? Why or why not?
- What do you know about LTPMs? Where did you learn about LTPMs?
- What does this message mean (after viewing LTPM related materials)?
- What are your concerns about using LTPMs?
- Do you know where and how to get more information on them?
- Do you know where to get services?

Asked of service delivery providers:

- What helps or hinders your ability to get your work done?
- Do you feel that you are adequately trained, supervised, equipped?
- Do you get the promotions and acknowledgement you desire?
- Is your service delivery point adequate? If not, how would you change it?
- What would improve the provision of FP services, in particular LTPMs?

Asked of administrative-level informants:

- What are the factors that contribute to the sustainability of LTPM services?
- What are the conditions that have affected the provision of LTPM services?
- How has the FP program changed in general in the past ten years, and how has this affected each of the LTPMs?
- Has coordination between the various stakeholders in the public, NGO, and private sectors, as well as the donor community, helped or hindered the program? How?
- Has coordination between the various activities supported by USAID helped or hindered the program? How?

Documents reviewed and data sets used: The Bangladesh National Family Planning Program, spanning over the past three decades, is probably one of the most examined and well-documented FP programs in the world. The team used a variety of data sets to examine trends and patterns related to LTPM use in Bangladesh. Information was drawn from all DHS and predecessor household surveys.¹ Service delivery statistics from the DGFP's national management information system (MIS) for FP services were examined along with data from the ACQUIRE Project MIS. The combination of these data sources provided both a retrospective and nearly current service-provision point of reference for LTPMs. In combination, these data sets provided the team a comparison between population and clinic-based information to get a more complete picture of the situation. Key documents reviewed are listed in Appendix D. A companion CD is supplied with this report to provide the reader with a broader list of resources (as available in electronic version) on FP and LTPM provision in Bangladesh.

Site visits: The team designed a site visit schedule to include facilities in four different districts and different levels and types of health facilities. The selection of districts to visit also took into account the relative performance history for LTPM service delivery. Service delivery statistics were used to identify districts with a pattern of low, medium, and high totals of FP acceptors generally and LTPM procedures specifically. The team selected and visited Jessore (high performing area), Tangail (medium performance), Moulivibazar "M'Bazar" (a very low performance area with the lowest

¹ The 2007 preliminary DHS data was unfortunately not available during field visits and information collection and synthesis, so is not included in this report.

contraceptive prevalence rate (CPR) and highest total fertility rate (TFR) in Bangladesh), and Dhaka city (an urban area with pockets of low performance).

KEY INDICATORS AND TRENDS IN CONTRACEPTIVE USE

Brief highlights of the introduction of LTPM in Bangladesh²

1953-59	Clinic-based FP programs in major cities are initiated by a few philanthropists.
1960s	Three clinic-based FP methods are available: IUDs and voluntary surgical contraception (VSC), as well as male and female sterilization. ³ Vasectomy is the first choice of the majority of acceptors.
1969	A total of 389,500 vasectomies are performed, a record high to date. Tubal ligations are only performed during Cesarean-sections with client consent.
1970-75	Clinic-based program momentum slows due to political unrest. Tubal ligation begins to be promoted as a permanent FP method, not necessarily performed concurrent to receiving a Cesarean-section. 1,822 VSC ⁴ performed, 43,190 IUDs inserted, with a CPR of 7.7 and a TFR ⁵ of 6.3.
1976-79	A broader range of methods is available through the public sector, although sterilization continues to be most popular for women (349,000 VSCs performed and 200,356 IUDs inserted).
1980s	Decade begins with an emphasis on VSC for couples who have completed their family size, and by the end of the decade, the emphasis is on oral contraceptives and condoms. Two new methods, found only in clinic settings, are introduced. Of these, the injectable hormone for women gains nationwide acceptance, though only offered on a limited basis. Minilap-tubectomy is introduced to minimize tubal ligation-related morbidity and mortality (though it does not become a popular long-term method in later years).
1984	Clinical methods (VSC and IUDs) are widely available. NSV is introduced. Payments for providers, referrers, and clients associated with these methods helps increase the numbers of acceptors.
1985	VSC begins to decline while IUD performance increases (491,599 VSCs performed and 403,000 IUDs inserted).
1986	Both VSC and IUDs begin a declining trend (267,543 VSCs and 367,668 IUDs inserted).
1988	DGFP and DGHS are integrated within the Ministry of Health (MOH). Referral fees are withdrawn in October 1988. Serving new acceptors is still rewarded; however, the careful follow-up of services is not (196,015 VSCs performed and 379,128 IUDs inserted).
1990/2001	VSC services plummet, the lowest rate since 1978-1979. Average per year from 1995-96 to 2000-2001: 143,729 VSCs performed, 169,657 IUDs inserted, and 49,307 implants inserted. In 1999-2000, the CPR was 53.8 and TFR, 3.3.
2002-06	Disintegration of DGFP and DGHS occurs. Stock-out of implants in 2005-2006. 437,998 VSCs performed, 843,464 IUDs inserted, 315,299 implants inserted. In 2003-04, the CPR was 58.1 and TFR, 3.0.

Since the mid-1970s, CPR for all methods has shown a dramatic increase, from 7.7 in 1975 to 58.1 in 2004 (figure 1). The rise in LTPM use kept pace with the increase of all method use for about ten

² Thanks to the Director General of Family Planning for assistance in creating this timeline.

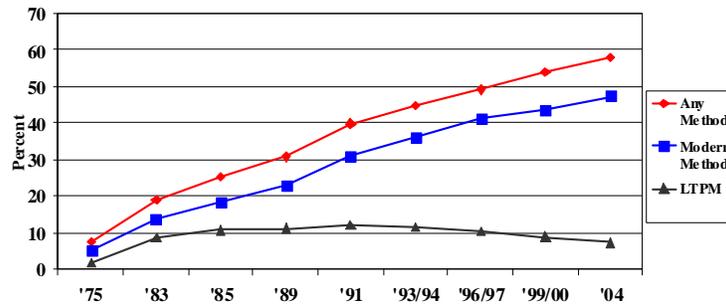
³ The term used in the DHS is “sterilization.” Also, depending on when NSV was introduced, the term “male sterilization,” when used in early survey years, may not be referring to NSV, but an earlier method instead.

⁴ VSC refers to male and female permanent methods of contraception.

⁵ TFR refers to the average number of children a woman has in her reproductive lifetime.

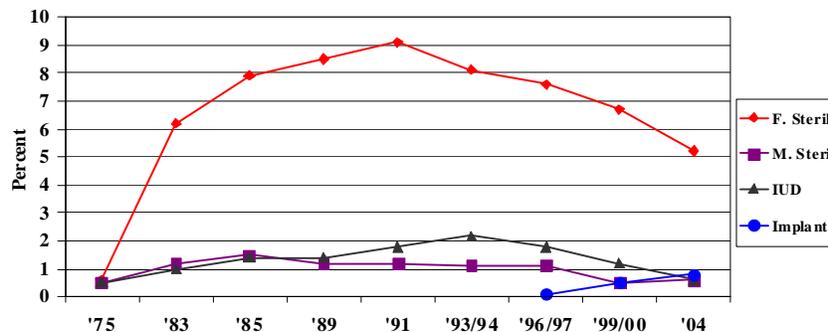
years, while slowing its momentum until it reached its peak in 1991. Declines in LTPM prevalence have occurred throughout the 1990s, and this downward trend increased by the end of the decade.

Figure 1
Contraceptive Prevalence Trends in Bangladesh
 (Source: BFS 1975, CPS 1983, CPS 1985, BFS 1989, CPS 1991, BDHS 1993/94, BDHS 1996/97, BDHS 1999/00, BDHS 2004)



One reason for the rapid growth in total CPR in Bangladesh during the 1970s and 1980s was the increase in female sterilization (tubal ligation) services and a rise in user acceptance of that method (figure 2). Tubal ligation constituted the majority of all LTPM services and still does, although it has not maintained the same level of popularity in comparison to other FP methods in recent years. In 1991, tubal ligation represented 43 percent of all use of modern methods in the country. However, from the early 1990s, the prevalence of tubal ligation as a contraceptive method began declining steadily. In 2004, tubal ligation constituted only 11 percent of current modern method use, a 75 percent drop from 20 years earlier.

Figure 2
Trends in Use of LTPMs in Bangladesh by Method and Year
 (Source: BFS 1975, CPS 1983, CPS 1985, BFS 1989, CPS 1991, BDHS 1993/94, BDHS 1996/97, BDHS 1999/00, BDHS 2004)

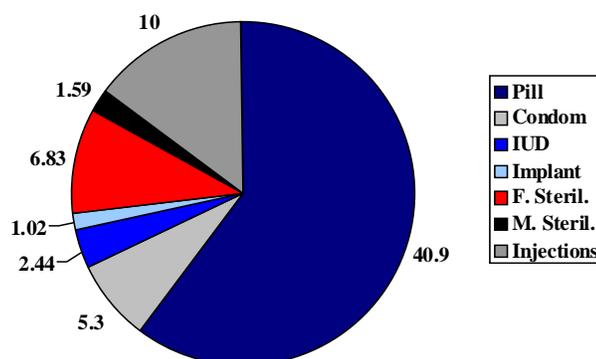


Short-term contraceptive methods, on the other hand, have seen a trend of fairly consistent increase in use during the last 30 years. The pill, in particular, has grown rapidly in popularity and now constitutes the most popular method. Since the early 1990s, an increase in pill use has largely driven the continuing rise in total CPR in Bangladesh. In 1985, the pill contributed about 28 percent of the modern contraceptive mix and that portion had grown to 55 percent by 2004.

Current service delivery statistics for 2007 (through August) show that the pill remains the dominant method of choice among users seeking services from reporting outlets (figure 3). The pill alone accounts for 60 percent of all contraceptive methods provided to users, while all LTPMs together

constituted about 20 percent. It is important to note that while 70 percent of all FP acceptors report using contraceptives to limit their family size, substantial numbers of these “limiters” are relying on the pill to realize their reproductive goals rather than using a more efficient and permanent method such as tubal ligation or NSV.

Figure 3
Distribution (%) of Modern Contraceptive Use by Method
Type—2007
 (Source: Directorate of Family Planning MIS)

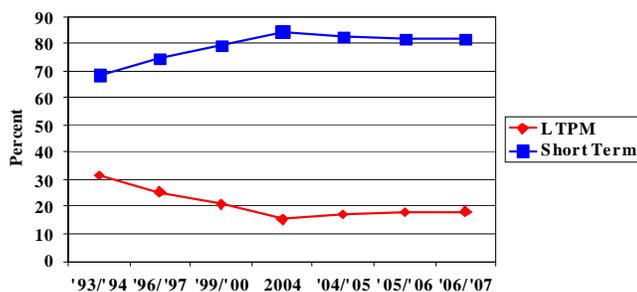


According to the 2004 Bangladesh DHS, contraceptive discontinuation rates are very high for all methods in Bangladesh: about half of Bangladeshi couples discontinue their FP method within one year, a rate much higher than other countries in the Asian region. Worldwide, discontinuation rates for the IUD are generally lower than for other modern methods, yet the 12-month IUD discontinuation rate in Bangladesh was reported to be 35.4 percent in 2004, not much lower than that of oral contraceptives (46.5 percent) and injectables (48.7 percent). As a consequence, almost half of those using the most popular methods are actually discontinuing within one year. EngenderHealth is completing a study on IUD discontinuation rates that should prove very useful in understanding this situation further.

Service delivery statistics compiled by the DGFP provide information on the total number of contraceptive services provided to FP acceptors (users). Since 2004, these data suggest a different pattern in the role of LTPMs and short-term contraceptives in the contraceptive mix for modern methods—a pattern where the widening divide between the two categories of contraception has stopped and may even be narrowing a bit (figure 4). Representative household-level data are the best for determining actual prevalence, and the results from the 2007 DHS are anticipated soon and should shed light on the actual role of LTPMs in current contraceptive use.

Figure 4
Portion of Long-term and Permanent versus Short-term Methods in Bangladesh Over Time

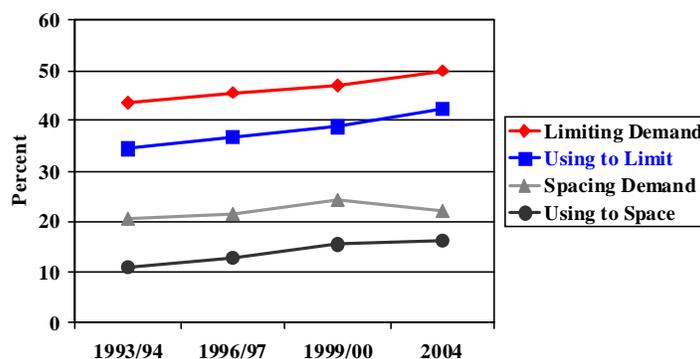
(Source: Bangladesh DHS 1993-2004 and Family Planning Directorate MIS 2004-2007)



Current indicators of success in reducing overall fertility in the country and recent project performance data show that the provision of LTPM services, while serving more men and women each year, has not kept up the promising service statistics seen just ten years ago. Clearly, significant weaknesses in service delivery and a stagnating demand are only widening the gap between the unmet demand for these methods and their actual use (figure 5).

Figure 5
Demand and Use of Family Planning for Spacing and Limiting in Bangladesh by Year

(Source: Bangladesh DHS 1993/1994, 1996/1997, 1999/2000 & 2004)



In 1997, the ICDDR,B MCH-FP Extension Project produced an extensive report, entitled *Bangladesh Family Planning Programme: Lessons Learned and Directions for the Future*. The findings and recommendations of this report are strikingly similar to those found today, ten years later, and therefore of great concern. A comparison of the findings in 1997 with those in 2007, shows progress in critical areas, but in some cases, these gains have been lost:

“By 1990, it was clear that the downward trend, which had begun in 1985 for sterilization and IUD performance, was not a temporary problem but a performance pattern. The debate began (and continues unabated), on whether there is a role for the clinical methods in the present and future programme. Also, questions are raised regarding the demographic impact of the programme as well as issues related to the sustainability of the programme itself. Answering these questions requires a critical look at present realities regarding clinical contraceptives.” (From page 19 of the 1997 report titled, *Bangladesh Family Planning Lessons Learned and Directions for the Future*. See Appendix E for an excerpt of the key findings from this report.)

II. MAJOR FINDINGS AND RECOMMENDATIONS

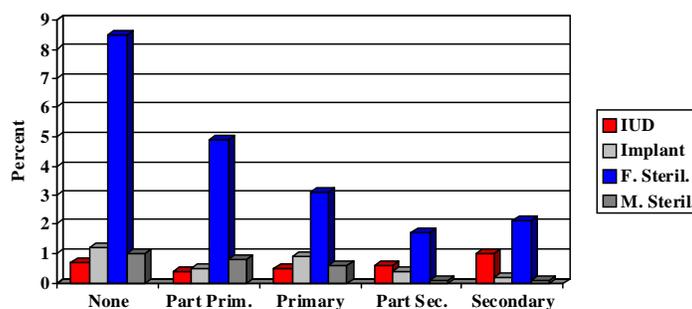
ACCESS TO AND PROVISION OF LTPM SERVICE DELIVERY

The Client and LTPM Use

Acceptors of LTPM services in Bangladesh are in the minority, particularly when compared to their reported desire for FP services. In 2004, only about seven percent of the population of reproductive age were current users of LTPMs in Bangladesh.

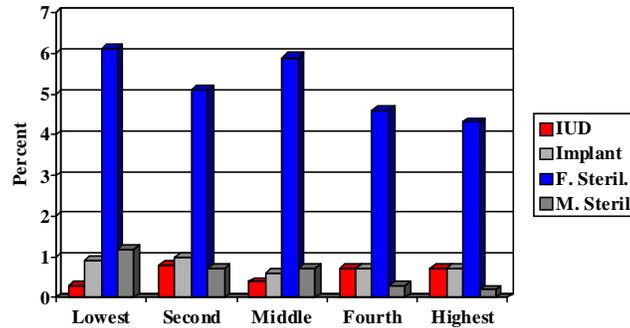
Socioeconomic characteristics of LTPM users: Women in Bangladesh are likely to have married early and to have completed their desired family size earlier than in other countries. Half of Bangladeshi women are married by the time they are 15 years old and about four of five women are married by their 18th birthday (Bangladesh DHS, 2004). Childbearing also begins early. About 28 percent of married women 15 to 19 years old have already had a child, and about 76 percent of 20- to 24-year-old women have had at least one child. Consequently, potential users of LTPMs are likely to have had one or more children and still be fairly young when they choose (or could potentially choose) an LTPM to limit or space future pregnancies.

Figure 6
LTPM Use and Education Level
(Source: Bangladesh Demographic and Health Survey 2004)



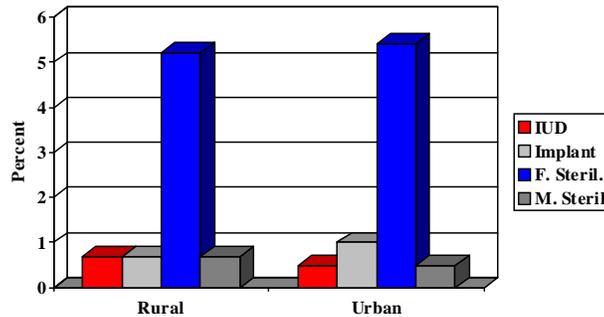
Although LTPM use is quite low in the general population of reproductive age, acceptance of NSV and tubal ligation is higher among those with no or low levels of education (figure 6). It is difficult to determine why this is the case, and this should be further examined to determine if service access or insufficiencies of communication program efforts (particularly for LTPMs) contribute to this pattern.

Figure 7
LTPM Use and Wealth Index Level
 (Source: Bangladesh Demographic and Health Survey 2004)



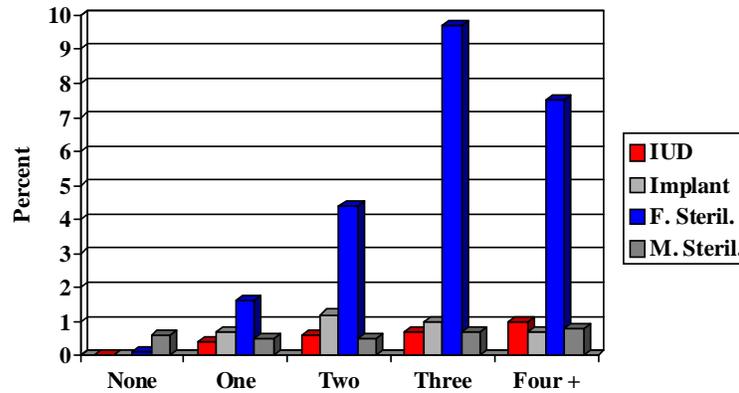
Data from 2004 suggests that the use of LTPMs is more popular among the less wealthy, particularly for NSV (figure 7). However, the low numbers of total LTPM users relative to the entire population of reproductive age makes it difficult to determine just how much differentials in wealth affects LTPM popularity. The larger numbers of acceptors of tubal ligation illustrate that this permanent method is used more frequently among those in the lower to middle ranges of wealth.

Figure 8
LTPM Use and Rural/Urban Residence
 (Source: Bangladesh Demographic and Health Survey 2004)



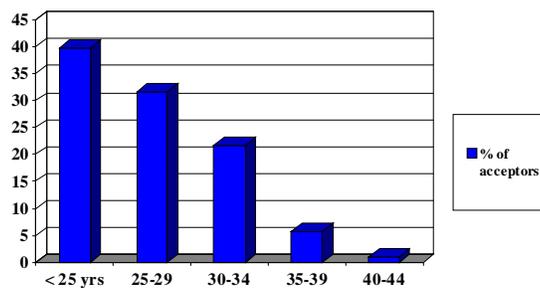
Urban or rural residence seems to have virtually no impact on the likelihood of LTPM use (figure 8). Indeed, the prevalence of LTPM use is essentially identical within rural and urban populations. This fact suggests that the acceptors of LTPMs may be more willing and likely to travel to the point or facility where LTPM services are offered. Another contributing factor to the fact that place of residence does not appear to affect the likelihood of LTPM use may be due to the GOB's use of "roving teams" or periodic service delivery "camps" that temporarily offer services at a variety of locations that may be closer to where prospective clients live (although it should be noted that this practice can be relatively expensive, and related recurrent cost requirements for this service delivery approach may become a sustainability consideration over time).

Figure 9
LTPM Use and Number of Living Children
 (Source: Bangladesh Demographic and Health Survey 2004)



As one would expect, the number of children a woman has directly relates to the likelihood of her acceptance of tubal ligation as a FP method (figure 9). This is consistent with permanent methods being chosen after completing desired family size. The relationship between the number of children and acceptance of permanent methods is also linked to the eligibility requirements for public sector services. According to the current GOB policy that applies to all provision of LTPMs, a person must be at least 25 years old, have at least two children (the youngest being at least two years old), and be married (not single, divorced, or widowed) to qualify for provision of a permanent method. However, this seems to be a rule more leniently applied for men who request NSV. Even in the case of the long-term methods that are not permanent (such as IUDs and injectables), an acceptor is required to be married and have at least one child. The number of children a woman has seems less of a determinant of acceptance for IUDs and implants, even after having three or more children.

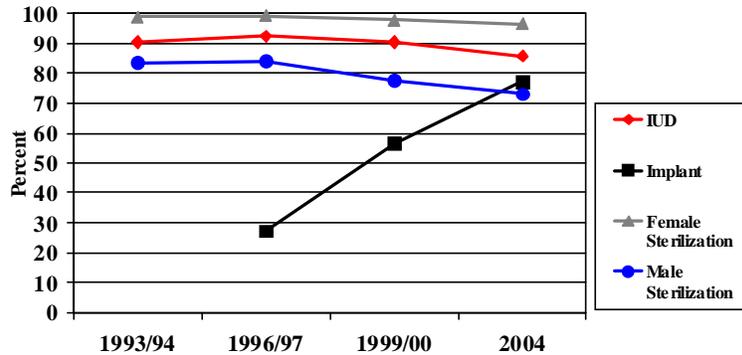
Figure 10
Women's Age at Time of Sterilization by Age Cohort
 (Source: Bangladesh DHS 2004)



Women who have chosen tubal ligation as a method of contraception tend to be fairly young, with a median age at acceptance of 27 years. Most acceptors of tubal ligation services have the procedure done when they are less than 30, and, interestingly, the frequency of tubal ligation acceptance declines within the older age groups (see Figure 10). This pattern appears counterintuitive but may suggest that a woman's choice of a permanent method more likely occurs shortly after completing the desired family size rather than waiting until the end of reproductive age.

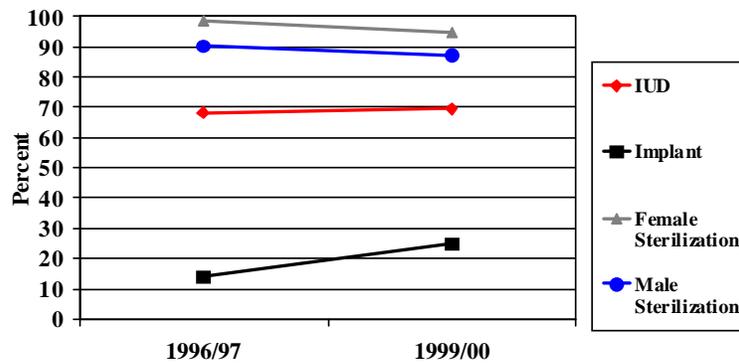
Knowledge of LTPMs

Figure 11
Knowledge (as a percentage) of LTPMs Among
Currently Married Women in Bangladesh by Year
 (Source: Bangladesh DHS 1993/1994, 1996/1997, 1999/2000 and 2004)



Among married women, there are high levels of awareness or general knowledge of LTPMs (figure 11). Awareness of implants has grown steadily since the mid-1990s; however, over the same time period, there has been some decline in women’s knowledge of both the IUD and male sterilization (including NSV).

Figure 12
Knowledge (as a percentage) of LTPMs Among
Currently Married Men in Bangladesh by Year
 (Source: Bangladesh DHS 1996/1997, 1999/2000)



Unfortunately, there is less information available about the knowledge among men about LTPMs, and that which is available is from more than seven years ago. The data show that men have similarly high levels of awareness of permanent methods for both men and women (figure 12). Male awareness of IUDs and implants are noticeably lower than among women. Given the important role men often play in Bangladesh on the contraceptive choices of their spouse and the influence men can bring to bear on a woman’s decision to discontinue a given method, lower levels of knowledge among men for these two long-term methods may affect their popularity among women.

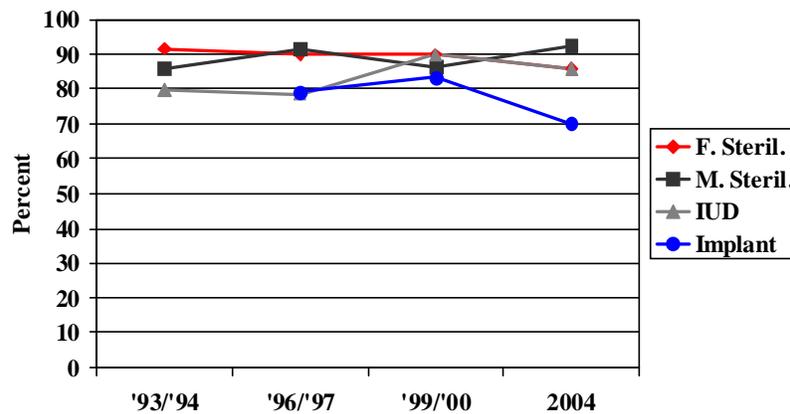
General awareness of LTPMs, therefore, does not seem to be a major constraint to use. However, more detailed knowledge of specific methods appears limited and incomplete. There are also misconceptions about certain methods (particularly the IUD), and the lack of more detailed knowledge about specific LTPMs appears to be a continuing problem. Several informants observed that there is a regularly encountered belief among women that the IUD can migrate within the body and cause other problems. The team also consistently met reproductive age men working outside of

the health sector who had never heard of NSV. When asked what these men knew about FP, they mentioned the pill and condoms but had very little to no knowledge of other methods for men or women.

Access to LTPM Services

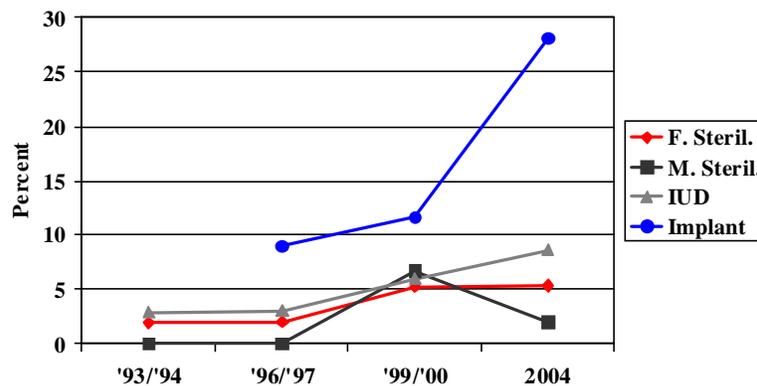
The public sector is by far the most common source of LTPM services in Bangladesh. This has been the case for many years and the public sector provides services to around nine out of 10 clients accepting permanent methods (figure 13).

Figure 13
Portion of LTPM Users Citing the Public Sector as Their Source of Service by Method and Year
(Source: Bangladesh DHS 1993/94, 1996/97, 1999/00 and 2004)



Some users of LTPMs do turn to NGOs for services, although NGOs remain a minor source of services for the population as a whole (figure 14). The main exception is the implant and, for this specific method, NGOs have been a growing source of service for clients, tripling the portion of clients served in the seven-year period ending in 2004. Dramatically, the NGO community has moved from being the source of implant services for one in 10 implant clients to one in four by 2004.

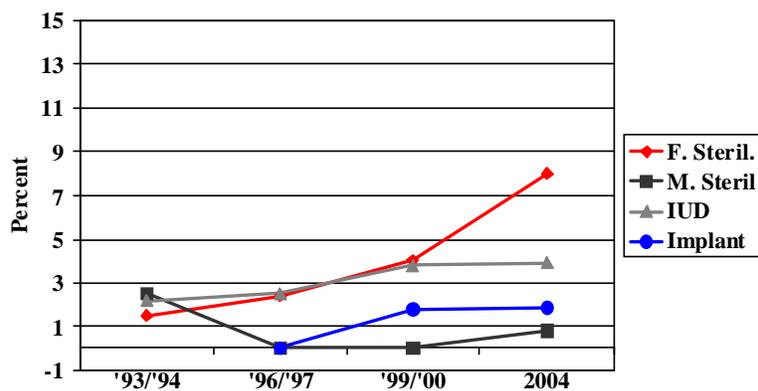
Figure 14
Portion of LTPM Users Citing NGOs as Their Source of Service by Method and Year
(Source: Bangladesh DHS 1993/94, 1996/97, 1999/00 and 2004)



Encouragingly, the number of clients turning to NGOs for IUD and tubal ligation services has also been slowly increasing. However, less than one in 10 LTPM users relies on NGO sources for other LTPM services (Bangladesh DHS, 2004).

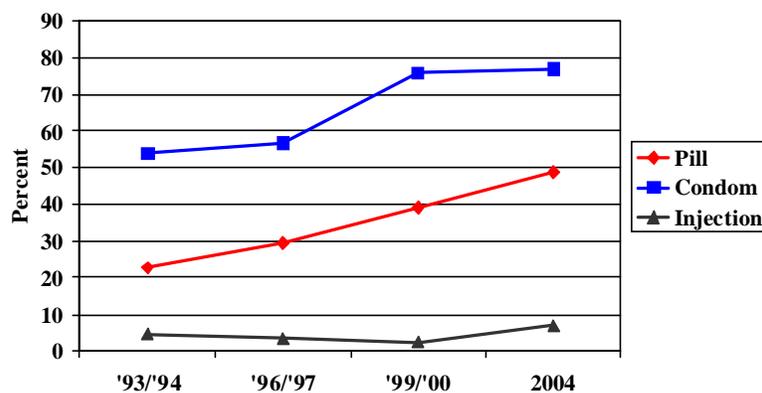
The commercial sector remains a very minor source for LTPM services and only a small fraction of current LTPM users seek services from commercial outlets (figure 15). Although a minor source, there has been recent growth in services from the commercial sector or for-profit providers, particularly for tubal ligation. Private providers and commercial healthcare outlets tend to be in urban areas and probably orient services to higher income groups.

Figure 15
 Portion of LTPM Users Citing the Private (commercial) Sector as Their Source of Service by Method and Year
 (Source: Bangladesh DHS 1993/94, 1996/97, 1999/00 and 2004)



Although the public sector has consistently been the preferred source of LTPM services, the same is not the case for short-term methods, a fact that may provide encouragement to program administrators seeking the involvement of the non-public sector in the provision of LTPM services. For short-term methods, the role and popularity of the public sector as a source of services have been declining, offering greater opportunities for commercial and NGO service outlets.

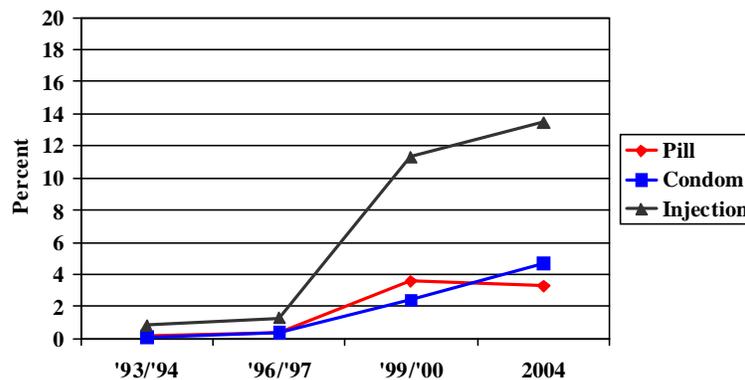
Figure 16
 Portion of Short-term Contraceptive Users Citing the Private (commercial) Sector as Their Source of Service by Method and Year
 (Source: Bangladesh DHS 1993/94, 1996/97, 1999/00 and 2004)



The private commercial sector has assumed an increasing role for short-term methods over a 10-year period (figure 16) and is now the preferred source of services for three out four condom users and about half of current pill clients. Over recent years, however, injectable clients have rarely turned to private commercial sector providers, which is surprising given that medical stores could potentially provide easy access to periodic injections by acceptors.

Although relatively few short-term contraceptive users rely on NGOs for their services, there has been some recent growth in the popularity of the NGO outlet among some users (figure 17). This is particularly true for injectables.

Figure 17
Portion of Short-term Contraceptive Users Citing NGOs as Their Source of Service by Method and Year
 (Source: Bangladesh DHS 1993/94, 1996/97, 1999/00 and 2004)



Provision of LTPM Services

Although the portion of total contraceptive prevalence contributed by LTPMs has been declining in Bangladesh, the total number of LTPM services delivered through the tracked healthcare network has seen some recent increases. Service delivery information assembled by the DGFP now includes reports from collaborating NGOs. This improvement in reporting is, in part responsible for the steady rises in the overall number of services delivered in all sectors measured during the period from 2000 to 2005.

The Service Delivery Network

Since the public sector is the major provider of LTPM services, it is important to understand the extremely complex structure of that service delivery network. The MOH currently has about 84 deputy directors, 84 assistant directors for FP (ADFPs), 50 assistant directors for clinical contraception (ADCCs), 480 FP officers (FPOs), 26 medical officers (CC), 63 medical officers (clinic), 716 medical officers (MCH), 480 assistant technical FP officers (ATFPOs), 464 senior family welfare visitors (FWVs), 1,440 FP assistants, 5,694 FWVs, 4,500 FP inspectors (FPIs), 23,500 family welfare assistants (FWAs), and 2,500 subassistant community medical officers (SACMOs), all under the DGFP.⁶ Additionally, there are a large number of doctors and nurses who are under the DGHS who could be potential providers of LTPM services but who are currently not providing these services. Since many of these positions are currently open and unfilled, it is important to see the discussion on the next page of this report on staffing vacancies.

Under the DGFP, the sites active in LTPM service delivery exist at many levels:

⁶ Please note that these positions, marked by acronyms, are for illustrative purposes and are not meant to give the reader a full understanding of the names of the positions nor the role they play in the service delivery network. More information on this can be found by visiting the GOB website [www:\dghs.org.bd](http://www.dghs.org.bd)

- National level organizations, namely the Maternal and Child Health Training Institute (MCHTI) and the Mohammadpur Fertility Services and Training Institute (MFSTC), located in Dhaka and staffed with skilled professionals with moderate case loads
- The National Institute of Population Research and Training (NIPORT), established in 1979 to impart training to all categories of MCH and FP personnel, which provides training directly and through 20 regional training centers and 12 FWV training institutes
- FP model clinics, which function as extensions of the 13 medical colleges at the national and district levels
- District hospitals and maternal and child welfare centers (MCWCs) at the district level
- Upazila Health Complexes and a few MCWCs at the sub-district or “Upazila” level
- Health and family welfare centers (H&FWCs) at the union level
- Community clinics (CCs) at the grass roots level, staffed by FWAs who provide informational service

There is the potential to expand FWAs’ job description to include service delivery and possibly to provide NSV and IUD services. Additional training and supervision would, of course, be required but the resulting increase in service provision and access could easily outweigh these costs, as has been demonstrated in other countries.

Aside from the 13 medical colleges and district hospitals, urban populations are targeted for service delivery by facilities run by the Ministry of Health and Family Welfare (MOHFW). The responsibility of providing health and FP services to urban areas lies primarily with the Ministry of Local Government and Rural Development (MLGRD), which administers them through city corporations and municipalities. Actual services are delivered through a few large programs, such as the Urban Primary Health Care Project (UPHCP) and the Smiling Sun franchise program. Both rely on local NGOs to operate facilities and provide services. Some other NGOs have their own programs in RH and FP, including LTPMs.

Since 1998, city corporations and municipalities have introduced expanded health and FP services in phases. The UPHCP, for example, is active in six city corporations, including the six large divisional cities and five municipality areas, and is comprised of 24 comprehensive reproductive healthcare centers (CRHCs), 173 primary healthcare centers (PHCs), and satellite clinics, with around 1,000 community cadres. Along with other RH services, PHCs provide condoms, pills, injectables, and IUDs. The CRHCs provide LTPM services.

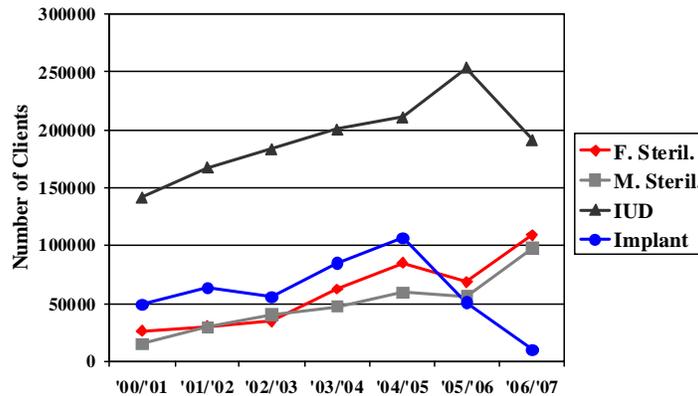
This multi-tiered network is extensive and is designed to cover the entire country. A diagram of the national service delivery network is provided in Appendix G and illustrative figures regarding service provision through the MLGRD can be found in Appendix H.

Factors Influencing Service Provision

Contraceptive availability and shortage: Service delivery performance for certain LTPMs has also suffered from problems in contraceptive availability. In December of 2005, for example, service sites began reporting shortages or stock-outs of implants, with 30 percent to 50 percent of facilities without implant supplies. This shortage situation for implants lasted until July of 2007 and accounts for the rapid decline in total services for implants during the period from 2004 to 2007.

Figure 18
Total National Service Delivery for LTPMs
2000-2007

(Source: Directorate of Family Planning Service Statistics)



In January of 2007, a similar contraceptive shortage situation began for the IUD. It is estimated that 30 to 40 percent of service delivery sites across the country reported stock-outs of IUDs and continued to do so until July of 2007. The lack of IUDs over these six months would account for the drop in the total numbers of IUDs delivered during the 2006-2007 implementation year (figure 18).

Supply outages and shortages of specific LTPMs should have been foreseen and avoided. These problems had a dramatic negative effect on the provision of LTPM services nationwide. However, the longer term decline in popularity of LTPMs among potential users can not be attributed solely to contraceptive supply difficulties.

In urban areas, services offered through the MLGRD's Second Urban Primary Health Care Project (UPHCP-II) experienced increases in overall FP services delivered for the years 2003 to 2006. LTPM services also increased with rises in the total acceptors from 2004 to 2006 of 20 percent for IUDs, 35 percent for implants, 30 percent for tubal ligations, and 57 percent for NSVs. The total numbers of LTPM services provided in urban areas during this timeframe, however, remain relatively low and are negligible when one considers the total reproductive age population in urban areas that are theoretically served by the urban centers. Indeed, LTPMs constituted only about nine percent of the total FP services provided for the four years ending in 2006 by UPHCP-II facilities.

Public sector staffing: There is a widespread problem of unfilled service delivery positions within the public sector program due to a lack of policy to execute a recruitment and hiring process for the existing vacancies based on current staffing needs. The total number of vacancies in the FP service ranks of the GOB is significant. Around 15 percent of all positions, or 5,461, are vacant (appendix I). Some position types, like deputy director (in charge of a district) have very high vacancy rates. Consequently, the duties of the deputy director are currently being performed by ADFPs or ADCCs, in addition to their respective job duties. The ADCC has many clinical responsibilities, is in charge of training, and also acts as a regional supervisor. As a result, both supervision and management at the district levels is commonly compromised. For some categories of workers, such as FWVs, the work force is aging and large numbers are scheduled to retire in the near future. Thus, the problem of unfilled positions could worsen, given the increasing demand for services and the lack of GOB initiative to immediately make staffing needs a priority before the existing work force is gone and institutional and mentoring capacity is lost.

The situation for mid-level positions in districts is similarly strained. Some mid-level positions, like the medical officers (CC or clinic) are entirely absent. At the sub-district, *thana* level, a significant number of FPOs, ATFPOs, and medical officers who provide MCH and FP are also vacant. Consequently, there are substantial numbers of vacancies among both clinical and non-clinical staff. Access to and availability of FP services is adversely affected as a result.

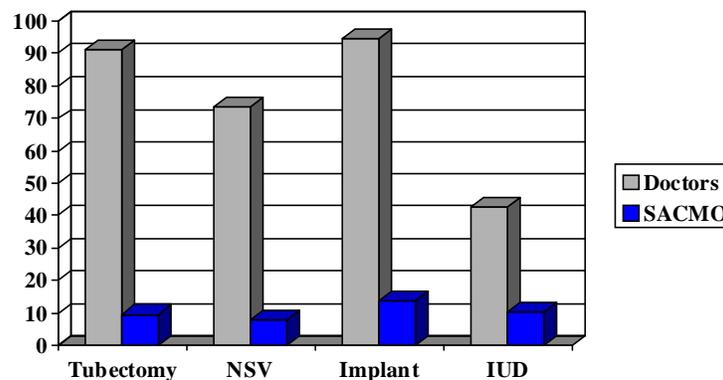
Training needs in LTPM service provision: One of the key reasons for the decline in LTPM services has been an insufficient number of trained providers and the lack of institutional capacity to keep adequately and appropriately trained staff at all facilities. This is largely due to a lack of policy that provides employee incentives and promotion schemes that allow an employee to stay in the same location, maintain job satisfaction, and receive accommodation for performance.

At one time, NGOs, such as the Bangladesh Association for Voluntary Sterilization (BAVS), conducted most of the permanent methods service provision training for both the public and NGO sectors. However, in the 1990s, BAVS became relatively inactive. After this period of little to no training, United Nations Population Fund (UNFPA) provided support to train the doctors to perform VSC. Many of these trained doctors were from the health section of the MOHFW. Interviews during this assessment suggested that these doctors were not utilized adequately in the DGFP service delivery system and that an atmosphere of poor cooperation and participation further slowed service delivery. This development left a serious skill deficit that has yet to be fully replaced, particularly for the public sector.

In November 2000, the MOHFW and the Association of Voluntary Surgical Contraception International conducted a clinical contraception assessment, *Review of Sterilization Services in Bangladesh*. A principal recommendation from this assessment was that the GOB should develop a long-term strategy and program to institutionalize LTPMs, including the ability to train staff.

Figure 19
Percentage of Doctors and SACMOs with LTPM Provision Skills in the Public Sector

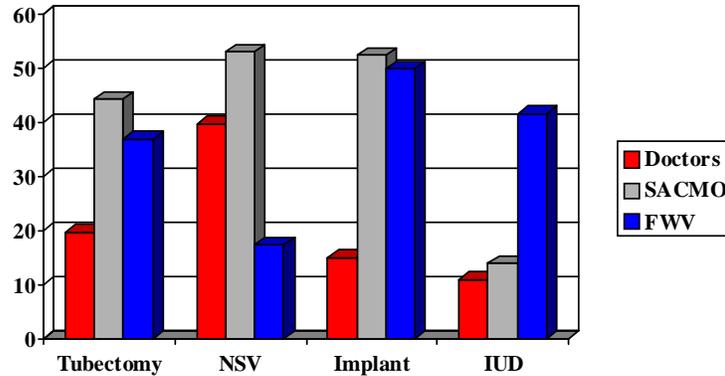
(Source: Training Database of Clinical Family Planning Service Providers, ACQUIRE/Bangladesh 2006)



Using a system of self-assessment, ACQUIRE/Bangladesh obtained information on the existing skills of service providers in the public sector in areas where they worked. The responses show that 9 out of 10 doctors believe they have the skills necessary to offer clients tubal ligation and implants (figure 19). However, about a quarter of doctors say they do not possess the skills needed to offer NSVs. Surprisingly, fewer than half of the doctors say they are skilled to offer IUD services. This statistic may also be due to the fact that IUD insertion is largely the domain of female service providers and that there are more male doctors than females in active service within the public sector. Only 10 percent or less of SACMOs reported that they believe that they are adequately skilled in LTPM service delivery. Of course, reported belief in having a skill and actually having sufficient skills to deliver quality service can be two different things. Self-reporting a lack of skill may also reflect a desire for training, insecurity in the level of knowledge possessed, or lack of interest in providing a particular service.

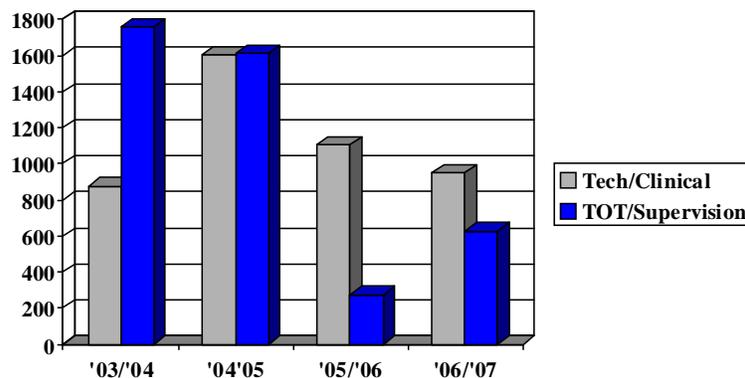
Figure 20
Expressed Need for Training in Specific LTPMs by Percent
of Public Sector Service Providers [N= 219 doctors, 1,178 SACMO
and 2,693 FWV)

(Source: Training Database of Clinical Family Planning Service Providers, ACQUIRE/Bangladesh 2006)



Among service providers surveyed in the public sector, about half of SACMO staff expressed a desire or need for additional training in tubal ligation, NSV, and implant service delivery (see Figure 20). Significant numbers of doctors also believe they need additional or refresher training for LTPMs. FWVs, although usually experienced providers, also express interest in additional training to improve or update skills for LTPM services. The difference in expressed need for IUD training is again probably linked to the gender of the service provider and the dominant role female providers play in IUD service delivery, as well as their perceived knowledge.

Figure 21
Total Persons Trained by ACQUIRE/Bangladesh by
Type of Training and Implementation Year
 (Source: ACQUIRE MIS)

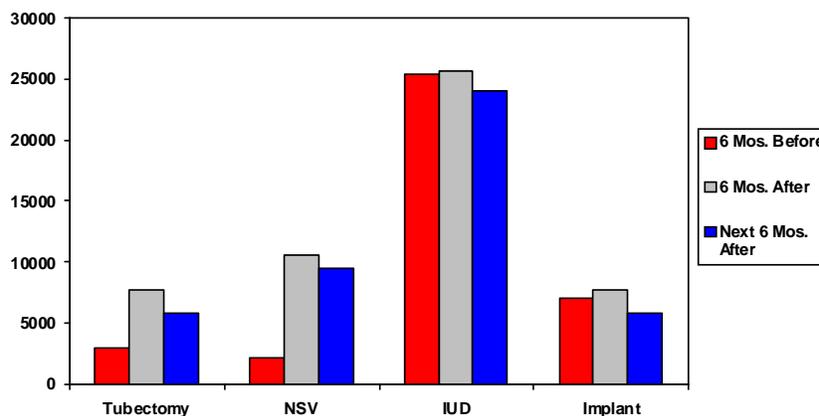


A major intervention of ACQUIRE/Bangladesh has been the training of service providers and managers. The total number trained was higher in earlier years and has been declining as other types of training activities were added (such as community and religious leader advocacy training) (figure 21; see also report section on Behavior Change and Communication).

During the period between 2000 and 2003, ACQUIRE/Bangladesh undertook an analysis of the impact of training and other interventions (supervision, counseling protocols, and the like) on the provision of LTPM services at assisted facilities in 20 districts. The assessment took a total of all services provided by the facilities by method during the six months prior to the implementation of interventions and the number of services delivered in the first and second six-month periods after the implementation of improvement activities. For tubal ligation and NSV, the total number of procedures performed increased dramatically, doubling for tubal ligation and increasing about five

fold for NSVs (figure 22). However, by the second six-month period, the number of procedures declined. Interestingly, for IUDs and implants, there was virtually no change.

Figure 22
LTPM Service Delivery Totals at Facilities Before (6 months)
and After (6 & 12 months) ACQUIRE Implementation
Interventions in 20 Districts
 (Source: ACQUIRE/Bangladesh, 2000-2003 data)



ACQUIRE conducted a series of LTPM sensitization meetings with GOB FP staff at all levels. FP staff were given a one-day orientation and conducted a training needs assessment for LTPMs for various parts of the country. Initially, technical training was given to FWVs. The recipients of the training were selected on a best practitioner basis from each district. The selection process apparently did not lead to successful results. A new effort was then begun in which FWVs, female SACMOs, and a few female physicians were selected from all the districts as a result of discussions with the DGFP. This approach was carried out in a phased approach. Training coverage now reaches about 70 percent of all FWVs in participating districts. The main content of the training was on IUD-insertion, infection prevention, and counseling.

From July 2001 to September 2003, EngenderHealth introduced activities related to clinical FP methods in 24 districts. From October 2003 to September 2004, LTPM training was undertaken in another 16 districts. The coverage was extended to another 24 districts during the period from October 2004 to September 2005. Since September 2006, the ACQUIRE Project has been operating in all 64 districts.

From 2006 to 2007, ACQUIRE worked with NIPORT and DGFP to strengthen its capacity to conduct IUD, infection prevention, and LTPM counseling training courses. In the 2007-2008 fiscal year ACQUIRE will complete the capacity building activity with NIPORT, so that NIPORT can take the full responsibility for providing resources for IUD training. Despite these needed capacity-building activities, future recurrent training requirements for the service delivery network will continue to tax the ability of indigenous training systems to sufficiently respond.

Supervision and LTPM Service Provision

Supervision for clinical services represents a major weakness within the public sector service delivery network. Inadequacies in effective supervision exist at all levels. For example, the number and planning of visits by immediate supervisors is limited. The content and activities of the supervisory visits are often not systematic and frequently lack a consistent supervision protocol.

In an informal interview, the DGFP mentioned that each divisional director is supposed to spend seven days each month on field surveying of services and facilities. However, divisional directors are apparently unable or unwilling to make the required number of visits. There was variation among the regions or districts regarding visits. Some supervisors seemed to be quite active in fulfilling their supervisory roles, while others were not. Upazila-level supervisors are supposed to be spending 14

days each month on supervision, a routine that is often not maintained. One reason for this is that some staff, like medical officers and senior FWVs, report that they are overburdened with other duties.

Because the system lacks transparent, regular, and systemic performance management, much of the service provision is being conducted without formal feedback and monitoring. The nature of the reporting structure itself also contributes to supervisory dysfunctions. For example, the FWAs, who work closely with FWVs at the union level, are required to report to an FPI, who often works at the Upazila level. Within this context, FPIs often find it difficult to effectively supervise an average of 40 FWAs, as they were originally only supposed to supervise six to 10 FWAs at the union level. This situation is further affected by staff vacancies and compounded by FPIs not having adequate technical skills in place.

The ACQUIRE Project and the GOB have invested substantial time and effort in developing forms, data flow networks, and data analyzing capacity to improve decision making and supervision. During field visits at the Upazila and union levels, it was observed that data are regularly compiled and forwarded to respective supervisory offices. However, these submissions are rarely acknowledged, and feedback is infrequently given on the content, performance, or progress over time. This may be due to a lack of personnel to compile and provide this information or a lack of understanding of its importance to service delivery.

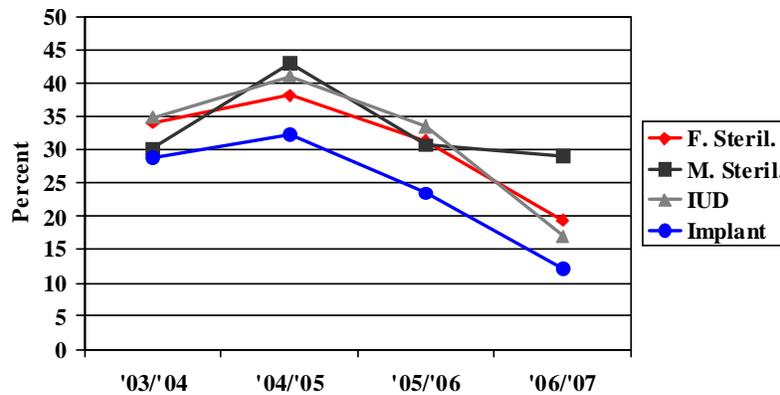
The findings mentioned above are similar to the ones generated by the ACQUIRE Project's internal performance reports. The ACQUIRE Project has done substantial work at all levels in improving the supervisory capacity of GOB FP staff. For example, ACQUIRE made clinic standards checklists, worked with the GOB to ensure that registers are available to field facilities, and offered training to different levels of supervisors and DGFP MIS point persons. In spite of these initiatives, tangible improvements in the quality of the supervisory management have not been noted.

As mentioned before, many positions remain vacant, and vacancy remains a consistent feature of the FP staff. It seems reasonable to assume that if the vacancy level were substantially reduced, it would have a positive effect on supervisory performance.

Service delivery assistance from ACQUIRE: USAID's assistance for improving LTPM services in Bangladesh has largely been provided through the ACQUIRE Project. See appendix F for an overview of all USAID-supported PHN programs in Bangladesh. The portion of the total LTPM services contributed by sites supported by ACQUIRE-supported sites has been substantial, particularly for NSV, which has been one focus of ACQUIRE's activities (figure 23).

ACQUIRE's peak direct impact on the total number of LTPM services delivered was during the 2004-2005 implementation year. The portion of services contributed by assisted sites declined from 1,743 that year to 966 in 2006-2007. Also, as the Ministry applies the tools and techniques it developed with ACQUIRE to other sites, some nonassisted facilities have been able improve their service outputs as well.

Figure 23
Portion of Total National Service Delivery for LTPMs
Contributed by ACQUIRE-Supported Sites, 2003-2007
 (Source: Directorate of Family Planning Service Statistics and
 ACQUIRE/Bangladesh MIS)



The Policy Environment and LTPMs

Several policies were identified by the team as relevant to the continuation and expansion of access to quality LTPM services.

Policies and Prevailing Practices on Client Eligibility

Discussions with informants and observations suggest that it is common for service providers to recommend contraceptive methods based on a client’s marital and parity status. For example, it is often the case that married couples who have not had a child are dispensed condoms and pills. Couples with one child are dispensed IUDs or implants, condoms, or pills. Those who have two or more children are considered to be the eligible candidates for permanent methods. Such a practice among service providers, when it occurs, presumes a reproductive lifecycle norm that may not reflect actual preferences or optimal contraceptive mix applications to individual client circumstances. When such practices are followed by service providers, a provider bias can shape the choice of a specific contraceptive method, and this tendency seems to be present in Bangladesh with regard to LTPMs. As a result, some long-term methods (such as IUDs and implants) may not be presented as a viable option for a client’s birth-spacing goals or for those who are unsure if they would like to have another child.

Current policy also guides the service provider in identifying eligibility for permanent methods. For example, for a woman to obtain a tubal ligation, she must be married, have at least two children, none of whom can be younger than two years old. At the same time, this policy appears inconsistent with recent communication efforts by the GOB, which is beginning to proclaim that one child is adequate. Anecdotal evidence suggests there are individuals with only one child who express a desire to adopt permanent methods. Indeed, data from the DHS show that there are those with only one child who have accepted permanent methods. Responding to this existing demand, however, is difficult, at best, as most government facilities and NGO clinics strictly adhere to the existing eligibility policy.

Policies and authority to provide services: Division of labor among different categories of service providers is strictly segmented; only certain providers are authorized to provide specific contraceptive methods. Current policy allows IUDs to be dispensed by FWVs and female doctors, implants and NSVs, by doctors. The existing policy, which defines which providers are authorized to provide specific LTPMs, effectively limits access. For example, doctors are available only at the district and Upazila levels. NSVs and female sterilizations are done mainly at the union and Upazila levels. Implants are usually dispensed only at the Upazila level.

Consequently, to obtain an implant, a client must go to the Upazila. Both the doctors and clients have to travel a considerable distance, and the clients sometimes have to wait for a few hours for the doctor to come to the union from the Upazila. The delay by the doctors in dispensing the service is not simply due to a lack of diligence, but rather because they usually have to perform some functions at the Upazila level before they proceed to the union to offer similar services.

A liberalization of the policy that authorizes more categories of service providers to offer LTPM services could effectively increase the availability of these services. In FWCs, for example, the physical amenities are adequate to provide implants. Indeed, tubal ligations and NSVs are already being done there. There are also qualified personnel, like SACMOs and FWVs, in the FWCs. The FWVs have been performing IUD insertions for a long time, and their current technical and medical knowledge and skill seem to be at a level that, with proper training and follow up, they could insert implants as well.

The SACMOs are arguably technically more qualified than FWVs. Their job is mainly giving treatments for basic ailments. The required skills to be a SACMO are consistent with those needed to support quality NSV services. This category of service provider, if authorized and trained to perform NSVs, would be well positioned to offer more client interaction and post-procedure follow-up.

Policies relating to contraceptive supply: Currently, the GOB imports and distributes seven types of contraceptives through its FP facilities. Existing contraceptive procurement policy dictates that the government is the main supplier of contraceptives for the entire country. Regarding LTPMs, the government, in effect, has a monopoly on the import and distribution of IUDs and implants. When the government's procurement system fails, the whole country faces shortages.

If deregulation of contraceptive supply importations were to occur that would allow the NGO and private sectors to import and distribute regulated and approved FP methods, it is almost certain that their availability could become more sustainable and less susceptible to wide-spread shortages (such as was noted above from 2005 to 2007). This would also allow the NGO and private sectors to play a larger role in complementing the GOB's overall objectives for the health and FP sectors.

Summary Findings and Recommendations—Service Delivery

1. **Finding:** LTPMs—particularly PM—are more frequently utilized or accessed by those with lower incomes and less education. Therefore, problems or constraints on the delivery of LTPM services are more likely to adversely affect the poorer, less literate population.

Recommendation: Ensure that service delivery sites and all associated information and counseling on LTPMs is provided in a way that is more accessible and acceptable to the illiterate and lower income populations. Include guidelines in service delivery site protocols that ensure that these sites are not perceived as complicated to navigate or unfamiliar to the lower income and illiterate populations so that they are afraid or disinterested in entering them. Staff should be aware of the constraints of this population and be sensitive to their needs.

2. **Finding:** Seventy percent of all FP acceptors report using contraceptives to limit their family size. However, substantial numbers of these “limiters” are relying on the pill to realize their reproductive goals, rather than using a more efficient and permanent method, such as tubal ligation or NSV. Discussions with informants and observations suggest that it is common for service providers to recommend contraceptive methods based on a client's marital and parity status rather than actual contraceptive needs. As a result, some long-term methods (such as IUDs and implants) may not be presented as a viable option for a client's birth-spacing goals or for those who are unsure if they would like to have another child.

Recommendation: Train counselors and method providers to better advise FP candidates of their contraceptive choices and help the potential acceptors select a method based on the individual's needs (to delay first pregnancy or limit or space further pregnancies) and not based on the individual's biographical data. Emphasize in all training and in training or trainers sessions that that providers and clients must clearly understand the benefits of short-term, long-term, and permanent methods in order to make a voluntary and truly informed decision.

3. **Finding:** The 12-month IUD discontinuation rate in Bangladesh was reported to be 35.4 percent in 2004, not much lower than that of oral contraceptives (46.5 percent) and injectables (48.7 percent). As a consequence, almost half of those using the most popular methods are actually discontinuing within one year. EngenderHealth is completing a study on IUD discontinuation rates that should prove very useful in understanding this situation further.
Recommendation: Examine this IUD discontinuation study carefully when completed and expand its findings as possible to reduce overall discontinuation rates for LTPMs.
4. **Finding:** Where a female service provider is not available, access to IUDs is substantially reduced due to prevailing concepts of modesty and culturally defined cross-gender sensitivities.
Recommendation: Give priority to supporting schemes to expand the number of skilled female service providers who are authorized and equipped to provide IUDs. At the same time, examine ways to reduce the stigma associated with men inserting IUDs to reduce this impact on service delivery.
5. **Finding:** Male awareness of IUDs and implants is noticeably lower than among women. Given the important role men often play in Bangladesh on the contraceptive choices of their spouse and the influence men can bring to bear on a woman's decision to discontinue a given method, lower levels of knowledge among men for these two long-term methods may affect their popularity among women.
Recommendation: In training counselors and service providers, encourage the inclusion of men in informational sessions and in the process of making FP decisions.
6. **Finding:** Women who have chosen tubal ligation as a method of contraception tend to be fairly young, with a median age at acceptance of 27 years, and most likely after completing their desired family size.
Recommendation: Increase emphasis on including permanent methods (for men and women) as an option post-partum for tubal ligation or NSV before the couple returns from the delivery and risks another pregnancy.
7. **Finding:** The widespread problem of unfilled service delivery positions within the public sector program, caused by a lack of policy to execute a recruitment and hiring process for the existing vacancies based on current staffing needs, is perhaps the most urgent and critical problem in the delivery of FP services in Bangladesh, particularly LTPMs. The lack of service providers represents a major constraint to LTPM availability. The most active and, in many ways, the most experienced category of public sector LTPM service provider, FWVs and FWAs, are rapidly being eroded through attrition (mainly retirements) and an absence of replacements. The areas covered by these providers is also increasing to compensate for the shortage of new recruits, and the client to provider ratio is increasing due to population growth and the expansion of coverage areas for those who remain. This effectively reduces the realistic capacity of these remaining workers to provide services and to conduct essential outreach work.
Recommendation: Take immediate action to inform the GOB and the donor community of this situation and provide assistance as requested to initiate an employment and training program to increase the recruitment and placement of adequate staff. An urgent program of priority recruitment, training and placement must be implemented to replace FWVs and FWAs and to increase the total numbers of these workers relative to the population served. Human resource planning and management practices within the MOH should be reviewed, and the service-provision needs of facilities should be incorporated within the transfer and reassignment process to ensure that facilities are staffed with the skills needed.
8. **Finding:** The numbers of trained providers are insufficient, and those who are trained are not adequately used in all facilities. There is an enormous recurrent training need within the public sector that is largely the result of high staff turnover and internal reassignment practices that do not take into account how transfers affect the ability of facilities to offer services. This creates a situation in which skills and capacity that were built previously are being rapidly lost, resulting in the need for frequent re-trainings for the same facilities. Furthermore, the existing capacity of

national training institutions (NIPORT, MFSTC, MCHTI, etc.) is insufficient to cope with the magnitude of the recurrent training needs facing the country.

Recommendation: Assist the GOB in developing and adopting a comprehensive and long-term strategy to institutionalize LTPMs, with a critical component that provides standards for the training and promotion of staff. Further strengthen local training institutions so they can meet the continuing training needs at the national and sub-national level. Decentralize training for LTPM services so that districts have greater capacities to formulate and implement training plans for LTPM services. Since current training protocols are largely skill or competency based for service delivery, more training content is needed to better respond to client-centered needs. The design, planning, and management of trainings should be strengthened to allow more of a trainee focus and to facilitate greater trainee follow-up once the trainee is on the job.

9. **Finding:** Supervision for clinical services represents a major weakness within the public sector service delivery network and inadequacies in effective supervision exist at all levels. The content and activities of the supervisory visits are often not systematic and frequently lack a consistent supervision protocol. Staff often report that they are overworked and, therefore, unable to carry out regular supervision visits. Supervision, although strengthened in some areas where the ACQUIRE Project has worked, remains inadequate and insufficient to fully support the expansion of LTPM services and the enhancement of quality of care.

Recommendation: Strengthen supervision systems through additional training and establishing regular mechanisms that foster management review and problem solving surrounding LTPM service delivery performance. Include mechanisms that introduce a program that recognizes facilities that achieve a quality of care standard for LTPMs and realize high volumes of satisfied users or user referrals for LTPMs. **Take immediate action to work with the GOB to rectify its staffing shortages and to implement a carefully organized and systematic training and supervision program.**

10. **Finding:** Current policies on client eligibility for permanent methods limit access to services and effectively eliminate this contraceptive option for those with fewer than two children, any one who is not currently married (including widows or divorcees), and those whose second child is younger than two years of age.

Recommendation: Support an active policy dialogue to modify the policies pertaining to client eligibility for LTPMs, particularly for permanent methods. Ideally, this service should be available on demand, but the policy-oriented operations research relative to this issue may help the GOB realize what is possible and acceptable in local circumstances for reducing or eliminating minimum eligibility requirements.

11. **Finding:** Division of labor among different types or categories of service providers is strictly segmented. Only certain providers are authorized to provide specific contraceptive methods. The way the existing policy defines which providers are authorized to provide specific LTPMs effectively limits access.

Recommendation: Work with the GOB to develop and implement a revised service provision eligibility policy that authorizes more categories of service providers to offer LTPM services to increase the availability of services. FWCs should be trained and certified to provide implants, since their service locations are adequate to provide this service. SACMOs should be trained and certified to provide NSVs, thus increasing the number of providers. Furthermore, SACMOs would be well positioned to offer more client interaction and post procedure follow-up.

12. **Finding:** Recent interruptions in the supply of contraceptives (IUDs and implants) through the government controlled system of contraceptive procurement and importation adversely affected LTPM use in the country. Access to IUDs and implants was reduced for long periods (6 months to 2 years) when substantial numbers (30 to 50 percent) of facilities reported stock-outs or shortages.

Recommendation: Use USAID capacity and experience to continue assistance to the GOB in forecasting and procurement of LTPM supply needs to reduce the likelihood of future contraceptive shortages. To reduce the potential negative impact of future contraceptive

shortages, explore options to liberalize the importation of LTPM contraceptives and supplies. The experience of the involvement of the private sector in the supply and distribution of condoms and pills may offer valuable examples that could be replicated for LTPMs.

13. **Finding:** Currently, the GOB imports and distributes only seven types of contraceptives through its FP facilities. Existing contraceptive procurement policy dictates that the government is the main supplier of contraceptives for the entire country and limits broader access and consumer choice. When the government's procurement system fails, the whole country faces shortages.

Recommendation: Given USAID's institutional capacity and experience in contraceptive supply and management, USAID should continue to play a role in assisting the GOB in monitoring the forecasting and procurement of its contraceptives and related supplies. Unless there is an emergency need, USAID should not, however, need to return to financing contraceptive supplies, as this is currently covered by the GOB under the World Bank loan.

In addition, work with the GOB to modify the regulation of contraceptive supply importations to include the NGO and private sectors. With a broader range of importers and distributors of regulated and approved FP methods, it is almost certain that their availability could become more sustainable and less susceptible to wide-spread shortages. This would also allow the NGO and private sectors to play a larger role in complementing the GOB's overall objectives for the health and FP sectors.

14. **Finding:** Urban LTPM service coverage is more incomplete than in rural areas with certain urban areas (such as slums) with little or no services. Urban LTPM services suffer from limited inter-ministerial coordination (urban areas are the domain of the Ministry of Local Government) and urban health facilities often focus more on general healthcare and, when doing any FP, offer mainly short-term methods.

Recommendation: LTPM service delivery for urban areas should be jointly planned (MOH, MLG, participating NGOs) and implemented to provide a greater integration of service areas and common referrals systems for urban clients.

15. **Finding:** LTPM service delivery rests primarily within the public sector, with the result that the options for LTPM services are too dependent on the public sector. The commercial sector (particularly the Social Marketing Company (SMC)) and NGOs have played an increasingly successful role in making short-term methods more widely available through a variety of outlets. However, LTPM services, outside of the public sector, are limited for many potential acceptors. Consequently, the full potential of NGOs and the commercial sector remains largely untested.

Recommendation: Encourage new initiatives for LTPM service delivery in the private sector to determine what new roles these service sites could play in making these methods more easily accessible to a broader spectrum of potential users, particularly in urban areas. Consider using micro-finance schemes or a mechanism like the Development Credit Authority that would encourage the expansion of private and NGO franchises that would provide LTPMs as a specialty service.

BEHAVIOR CHANGE AND COMMUNICATION

A well-designed and effective BCC campaign reaching all levels of the LTPM service delivery system (individuals, communities, service providers, administrators, and policy makers) can have a profound effect on increasing the knowledge, acceptance, and ultimate use of LTPMs. In Bangladesh, considerable effort has been made to develop messages that will inform the provider and administrator and, to a lesser degree, the client. In spite of this, the use of LTPMs remains relatively low compared with the use of short-term FP methods (particularly pills, condoms, and injectables) and does not reflect the expressed demand for limiting and spacing future pregnancies.

The MOHFW of Bangladesh states that "the primary aim of its BCC campaign will be to shift health and FP service provision from a sectoral and provider-based system to an inter-sectoral, client-

oriented, demand-based system and emphasizing community and women's empowerment, with a focus on social and gender issues, the elderly and the poor.”

In support of the GOB's BCC campaign, a number of USAID-supported projects, such as ACQUIRE and NSDP, have provided assistance to the Information, Education and Motivation Unit of the DGFP office to produce BCC materials that are disseminated through a number of public and NGO channels. NGOs, such as Marie Stopes International, InHealth, and the UPHCP, have also initiated a number of BCC interventions to raise awareness and popularize FP in the country. All have recorded some successes, although, in general, these interventions seem to have so far been inadequate in building mass awareness among individuals on what LTPMs are available to them and how they can access them to limit or space their pregnancies.

A critical piece missing in the Bangladesh BCC program is a unified GOB and development partner approach that would support the MOHFW campaign. Many governmental agencies and NGOs are using BCC to promote FP methods, including LTPMs. However, while new projects are launched from time to time, there appears to be a duplication of effort and conflicting goals and objectives. A coordinated and integrated effort that includes national messages, such as the use of logo recognition of LTPM (also called branding of the methods), could achieve synergy and critical efficiencies and would most likely have a greater impact on increasing LTPM performance in the country.

Promotion of BCC messages

Promotion through Community Leaders

To reach the broader community, USAID, through its support to ACQUIRE, carried out meetings with 21,393 community-level stakeholders—such as members of Union Parishad, teachers, informal leaders, and NGO workers—during the last two years of the project. It is still not known what impact these meetings have had on LTPM service delivery.

In response to a performance improvement needs assessment carried out in 2004, ACQUIRE piloted an integrated communication campaign to “reinvigorate” LTPMs, with the focus on NSVs in four districts (Dinajpur, Chittagong, Chandpur and Cox's Bazar) and support from the Meridian Group International. The campaign was planned to roll out nationally. Unisocial, the social wing of Unitrend Ltd., was commissioned to carry out the campaign, which included mass media, printed BCC materials, and public relations activities. Importantly, two television commercial advertisements were produced after pre-testing and approval from the National Information, Education, and Communication Technical Committee. These advertisements aimed to raise awareness on male involvement in FP through accepting NSV as an easy and safe method, and they were aired by two private TV channels, ATN Bangla and Channel i, on July 11, 2007, in support of World Population Day. To cater to the needs of the wider population of the country, the commercials are now airing on the national channel, Bangladesh Television. A poster on NSV was also developed, and 100,000 copies were distributed in pilot areas. The effectiveness of these television spots and posters has still not been tested, but focus group interviews carried out by the assessment team found little to no understanding of these BCC materials.

In 2002, 10,000 pamphlets on NSV were also developed and distributed. Their primary audiences were service providers and the general community. As a job aid, it is being used during counseling to reinforce awareness of NSV as an available, permanent FP method.

The project has also produced and distributed through the DGFP a number of publications, including:

- 2,815,000 leaflets on permanent methods for eligible couples
- 10,000 festoons on female tubal ligation (to raise awareness and popularize the method and help service providers during counseling)
- 45,000 copies of Communication “Jogajog,” a guidebook for the service provider to enhance and clarify understanding and to minimize misconceptions and misunderstandings about permanent methods

- 4,000 informed consent leaflets to help counselors and aid clients in making informed and voluntary decisions
- 24,500 laminated clinical method cards to help counselors during counseling sessions on the methods
- 6,700 Voluntary Family Planning Charts (also known as the “Tiahr Chart”) to ensure informed and voluntary decision making by clients.

Most of the ACQUIRE Project communication materials were developed for service providers and participants for use in the different training and orientation sessions for health service providers, field staff, religious leaders, and community leaders. The service providers used these materials as job aids to counsel clients and answer frequently asked questions by the target groups. EngenderHealth has conducted pretests of these materials in consultation with BCC experts and DGFP officials to ensure that they respond to the local perspective of the targeted population.

During the team’s field visits, it was observed that service providers were using these tools in appropriate cases. However, these materials were only found in a few public facilities and it was uncertain how effective they were. The team’s informal previews of the materials with random participants (outside the project sites) found little to no understanding of the information provided, because many of the materials require a certain level of literacy or use terms the interviewee was unfamiliar with, such as “NSV” and “vasectomy.”

Promotion through Religious Leaders

ACQUIRE also developed a program to strengthen LTPM services through religious leaders, by informing Imams (Muslim religious leaders who lead prayers in mosque) about FP in the cultural and religious context of Islam. Imams have the potential to spread FP messages to millions of people in a very cost effective manner during the Friday prayers. The assumption is that building a nationwide pool of Islamic scholars, such as Imams, with the capacity to convey positive messages about LTPMs to their followers, will provide an effective mechanism for reaching the community. ACQUIRE has provided orientation sessions for 10,140 Imams during the past two years and is poised to work with the National Imam Association, Mosque Committee representatives, Qawmi Religious Leaders, Leaders of Influence (LOIs), and the Islamic Foundation of Bangladesh (IFB) to further their interest and understanding of the importance of LTPMs.

ACQUIRE has produced a series of training and resource materials for religious leaders and other Islamic community leaders. These materials are primarily distributed through the DGFP, IFB, Imam Training Academy (ITA), and selected NGOs. A brief review of the materials is found in appendix J.

A large number of religious leaders, particularly Imams, have been provided with these materials outlining the acceptability of FP in the Islamic tradition. The BCC resources are produced using high quality materials and carry a certain branding of the message by the use of a uniform color (orange) and cover format that includes the easily understood title, *Family Planning in the Light of Islam*. Interviews with stakeholders revealed, however, that many question whether involving the Imams (particularly the approximately 50 percent who are only trained to read the Koran but not to interpret it) will result in their communicating a significant amount of quality FP messages to their community. Many stakeholders felt that the Imams would not be comfortable giving messages about FP, particularly LTPMs, and would not find sufficient motivation to provide these messages without a fatwa or similar decree requesting that they do so. These comments are, of course, anecdotal and no studies as to the effectiveness of involving the religious leaders have been carried out to date, due to the relatively short duration of the intervention.

Furthermore, the production and distribution costs associated with the materials produced in the series *Family Planning in the Light of Islam* appear high relative to the value of the FP messages they contain. This is only an impression, since no studies have been conducted to measure their effectiveness in increasing the knowledge, acceptance, and use of FP.

The booklets *Family Planning in the Light of Islam* and *FAQ* are published in the name of the DGFP and the MOHFW. It is commendable that the majority of the review committee members were Islamic scholars of good repute of the country. However, neither the Ministry of Religion nor Islamic Institutes are included. Similarly, one or two introductory messages could have been given by renowned Islamic Scholars. In terms of content, the booklets discuss many issues directly or indirectly relating to FP. It is still unclear whether the expenditure associated with the production of the abridged English version was justified and whether the experience of other Islamic communities (such as in the Philippines) who have considerable experience with this kind of communication tool were consulted.

Concerns relating to hindrances from the Mosque Management Committees in strengthening support for FP also seems to be taken into account when reviewing ACQUIRE's work plan for its current and final year. The number of religious leaders reached by the ACQUIRE project is an achievement. However, to judge the effectiveness of the actions thus far, a careful study of whether this investment has resulted in an increase in the numbers of individuals accepting LTPMs must be completed before any additional investment is made. Furthermore, the ACQUIRE plan to hold radio and TV talk shows using scholarly Imams in the 2007-2008 work plan seems to be another delayed activity. Unfortunately, it would seem that organizing these talk shows shortly after or during the orientation sessions with the religious leaders might have enhanced the change agent effect.

Demand Creation Opportunities

Expansion of demand creation to non-public sectors: Historically in Bangladesh, programming strategies for FP methods, specifically LTPMs, have focused on making services available to poorer and predominantly rural clients, with the result that both providers and their clients view permanent methods as more appropriate and acceptable for the economically impoverished.

USAID support to the Social Marketing Company (SMC) has resulted in great strides in provider and client recognition and demand for targeted FP methods, particularly the short-term methods. This has probably, in part, contributed to the view that these methods are more acceptable to the client. A reapplication of the creation of logos or other techniques that provide easy recognition and familiarity (such as method-specific branding approaches in FP) may provide a much needed increase in LTPM use, particularly if they can be viewed as progressive and for the entire population, regardless of educational or economic status.

BCC messages targeting youth: Currently, Bangladeshi youth have limited access to RH information and services, particularly LTPMs, due to cultural norms that exclude youth from FP/RH information. The most common methods they know are condoms, followed by the pill. They receive this information informally, through frequently misinformed, inaccurate, and biased sources. This is not conducive to sustained behavior change.

Informal reports indicate an increase in pre-marital sex, mostly unprotected and unplanned, although evidence of this is lacking because unmarried youth have not been included in most service delivery or information sharing to date. Lack of availability of information outside the clinic setting or catering to the married, has meant that a large number of youth are not aware of their FP options. Married and especially unmarried youth are either sexually active or are at risk of having unprotected sexual encounters due to inadequate and improper information from peers or others. This can lead to unplanned and unhealthy pregnancies, the risk of unsafe abortions, and sexually transmitted infections, including HIV and AIDS. It is critical that this population receives adequate information and services that will allow them to make informed choices about their RH. An investment in this population alone would have significance in terms of the current population reached and would be a wise investment for the rest of their reproductive lives.

ACQUIRE is planning to pilot a young married (YM) program, and a number of significant activities are set to roll out in the last year of the project. A series of orientations are planned for GOB, NGO, and community-based organization service providers and administrators, along with the development of BCC materials on RH issues for young married couples. Since YM activities under the ACQUIRE

project have not yet begun, it is very difficult at this stage to assess their ultimate coverage and potential impact.

Summary of Findings and Recommendations—BCC

Considerable investment has been made in developing and implementing BCC messages in Bangladesh. In recent years, these interventions seem to have been inadequate in building mass awareness about LTPMs.

1. **Finding:** A review of the BCC materials for LTPMs prepared to date from all sources seemed to demonstrate a lack of cohesiveness. A national BCC strategy is needed to guide the identification of key audiences and the critical messages that should be targeted to them to promote LTPMs in a unified and coordinated fashion. Many governmental agencies and NGOs, including those supported by USAID, are using BCC to promote FP, including LTPMs, but there appears to be a duplication of efforts and conflicting goals and objectives.

Recommendation: Work with the GOB and other development partners to develop and implement a coordinated and integrated BCC campaign, including nationally recognized messages, such as the use of logo recognition (branding) of LTPMs. In future PHN programming, USAID/Bangladesh should consider using specialized mechanisms or organizations, supported through a local procurement mechanism or through USAID/Washington, that specialize in the development and provision of BCC messages, rather than relying on more generalized service delivery implementation mechanisms.

2. **Finding:** Misconceptions about given methods (particularly the IUD) and the lack of more detailed knowledge about specific LTPMs is a continuing problem and may not be entirely remedied through clinic-based counseling and information provision.

Recommendation: Place high priority on using USAID funds to supply the specific expertise needed to strategically develop and launch a broad sector-based BCC campaign, using a variety of media and messages to meet the needs of the population, particularly at the community level. Include messages that:

- Focus on lifecycle needs (spacing versus limiting) and the use of LTPMs.
- Dispel misconceptions about NSV among men and women.
- Show NSV and tubal ligation as progressive, modern, and enjoyed by the rich as well as the poor.
- Are comprehensible by the large illiterate population.
- Focus on the large youth population entering a lifetime of FP needs. Involvement of mass media—such as TV, radio, and newspapers suited to the needs of the adolescents—as well as entertainment systems—such as private film viewing and reading materials geared to youth—could provide huge opportunities for increasing knowledge among the youth population.
- Use “satisfied customers” and “champions” as vehicles for spreading informed and positive messages about LTPMs. The use of “educated individual-led information sharing” can be a useful client-based method of increasing demand for LTPMs and other RH and FP services without relying on the formal service delivery systems.
- Portray IUDs and implants in terms of their relative ease of use and appropriateness to certain clients and couples, rather than being limited to only using the other short-term and traditional methods.

3. **Finding:** ACQUIRE developed and aired a television informational spot on NSV and developed a poster on NSV that was distributed in pilot areas. The effectiveness of these television spots and posters has still not been tested, but the assessment team did conduct its own focus group interviews. The team’s informal previews of the materials with random participants (outside the project sites) found little to no understanding of the information

provided. Many of the materials used for these focus groups required literacy or used terms the interviewee was unfamiliar with, such as “NSV” or “vasectomy.”

Recommendation: Complete post-testing of these materials before designing any others.

4. **Finding:** ACQUIRE also developed a program to strengthen LTPM services through religious leaders, using a series of training and resource materials for religious leaders and other Islamic community leaders. Interviews with stakeholders revealed questions about the potential effectiveness of this program as executed.

Recommendation: Carefully study if this program has resulted in an increase in the numbers of individuals accepting LTPMs and whether the approach is cost-effective before any additional investment is made. Consider changing the focus of the intervention to include work with Muslim Mufti to develop and publish a national or regional fatwa supporting family planning, particularly LTPMs, for the Muslim community that gives Imams the responsibility for providing quality messages about the acceptability of the methods at the community level. Exchange experiences with other countries that have made progress in using the Muslim leaders to promote FP (such as the Philippines).

5. **Finding:** Communication methods exist to develop and expand demand for LTPMs in Bangladesh—such as branding, use of satisfied customers and champions, and others—but have not been used adequately. Branding for short-term methods has been successful, though no similar effort has been made to brand LTPMs. USAID support to the SMC has resulted in great strides in provider and client recognition and demand for targeted FP methods, particularly the short-term methods.

Recommendation: Continue investment in branding, similar to what the SMC has done, to increase acceptability and recognition of FP methods, particularly LTPMs, that are available at delivery points. Consider using private or NGO sector organizations, such as the SMC, to apply proven branding techniques to LTPMs. Brand LTPMs as progressive methods and for the entire population, regardless of educational or economic status.

6. **Finding:** Currently, Bangladeshi youth have limited access to RH information and services, particularly LTPMs, due to cultural norms that exclude youth from information about RH and FP. Informal reports indicate an increase in premarital sex, mostly unprotected and unplanned, although evidence to this effect is lacking because unmarried youth have not been included in most service delivery or information sharing to date.

Recommendation: Invest in information and services targeted towards youth that will allow them to make informed choices about their RH and impact their decisions and actions for the rest of their reproductive lives.

HOST COUNTRY INFORMATION CAPACITY

The availability of method-specific data and service delivery statistics in Bangladesh is generally quite good. Data are generated from participating service statistics regularly on a monthly basis. Service information is also provided by collaborating NGO and other nongovernmental service delivery sites. This practice allows rapid assessments of the flow of overall FP services (including LTPMs) nationwide.

Household-level information (parity, age, and contraceptive use) is gathered and entered by FWAs for the entire country. This practice, in essence, creates a profile of most of the reproductive-age population and helps inform the government about how well services reach eligible couples. The network of FWAs operates primarily in rural areas and, consequently, similar information for large portions of urban populations is lacking. Service delivery information for urban areas, therefore, may also be incomplete and the role of LTPMs in meeting the FP needs of urban residents is difficult to estimate. As a result, the demand for and use of LTPMs in urban settings are not being considered by decision makers in the allocation of staff and supplies needed for adequate and quality service provision in these settings.

Data from the government's MIS is assembled at the Upazila level from all service delivery points within its region and is aggregated. These aggregated data then flow through the district and on to the national level. In general, sufficient service-delivery data is available to districts to allow district program managers to track the performance of LTPMs at various facility levels within their area.

Data quality appears fairly high. Since the system is dependent upon frontline service providers to enter the basic data, one issue common to such data-entry methods may be a tendency to underreport services (particularly those that are not linked to financial accounting or reporting).

Even though data on service delivery are available and of sufficient quality to inform decision making, whether or not such data are effectively used as a management tool may depend largely on the motivation and dedication of the individual program manager. As noted in the report section on service delivery, observations and interviews suggest that data may not be regularly used in the supervision and daily management of LTPM service delivery.

The service statistics collected nationally are most complete for those services delivered through the public sector. NGOs offering services must be registered and are expected to report service delivery data using standardized reporting forms. However, the methods for data generation and the quality of reporting remain largely within the domain of each individual NGO.

Private service providers generally do not report service statistics unless they are part of the national social marketing program or one of the donor-supported private sector health initiatives. Consequently, a regular measurement of commercial sector work in LTPM service delivery is limited or largely based on estimates. This general lack of information about what the for-profit clinical provider is doing underscores the fact that the commercial sector is largely invisible in both the planning and implementation arena for LTPM services.

Findings and Recommendations for LTPM Information Systems

Finding: Information generation systems and data quality for LTPM services are good and fairly comprehensive for rural areas. These information systems, however, have substantial gaps for urban populations. Performance and service delivery data are not always grouped or regularly used to inform supervision and decision making at all levels of service delivery.

Recommendation: Standard supervision protocols should incorporate a more rigorous review of service delivery summary data and supervision planning methods should insure that those sites with lower performance become a priority for site visits. Regular (ideally monthly) district-level reviews of summary LTPM service-delivery statistics should form a part of a system of recognition for sites with exemplary performance.

ANNEX A: SCOPE OF WORK FOR THE ASSESSMENT

Evaluation of Program Results for Permanent and Long Term Family Planning Methods in Bangladesh

(GH Tech/Mission revised- FINAL: 11-07-07)

United States Agency for International Development Office of Population, Health and Nutrition United States Mission Bangladesh

A. PURPOSE OF EVALUATION

The goal of the ACQUIRE project in Bangladesh is to work with the Government of Bangladesh to reduce the total fertility rate (TFR) by improving access to and expanding the use of Permanent and Long Term Methods (LTPM) for family planning. LTPM includes tubectomy, vasectomy, Intra Uterine Devices (IUDs) and implants. Recent service statistics in the country performance data show that the provision of PLTM services is falling short of expectations for three of the four methods (see Annex 1).

This evaluation will attempt to determine if LTPM services are improving in areas served by ACQUIRE and in the country generally. Since the ACQUIRE Project has been a major vehicle through which USAID has provided assistance for LTPM family planning services in the country, the evaluation will be used by USAID/Bangladesh to determine if changes in strategy are necessary to improve PLTM performance. The purpose of the evaluation has been modified to include an expanded assessment of the existing status and general needs of LTPM service-delivery in the country, incorporating but not limited to the contribution of ACQUIRE.

B. ACQUIRE PROJECT BACKGROUND

EngenderHealth is the prime implementing partner of the USAID global activity on the Access, Quality and Use in Reproductive Health (ACQUIRE) project. The project started in October 2002 and will continue through September 2008. Current cumulative Mission funding to ACQUIRE totals \$7,900,000 and the Mission expects annual funding to continue at about \$1,500,000 through September 2008.

Through this project, both permanent and long-term contraception services are provided in cooperation with the Government of Bangladesh (GOB) and NGOs. The ultimate goal of the ACQUIRE project is to contribute to the reduction of the fertility rate to the national goal of approximately two children per woman.

The project works according to evolving annual work plans. The specific **objectives** of Engender Health work plan for the ACQUIRE project in FY2007 are to:

1. Increase access to services that offer an appropriate range of clinical family planning methods and selected maternal health services.
2. Focus on improving demand generation efforts and assure informed choice and voluntarism for permanent FP methods.
3. Improve clinical training capacity of the Directorate General of Family Planning (DGFP) for PLTM, including decentralization of clinical training.
4. Improve leadership and management of service delivery system, including strengthening clinical supervision capability of the Directorate General of Family Planning (DGFP), and linking training with supervision.
5. Improve the technical and management skills of service delivery providers, managers and field workers.

The five items listed above also reflect the underlying assumption of the ACQUIRE project in Bangladesh: that by pursuing these objectives, the project will increase the successful adoption of PLTM, thereby reducing the Total Fertility Rate in Bangladesh. **The evaluation team will examine the validity of this assumption. New Evaluation objectives/questions are added in Section C. below.**

C. EVALUATION OBJECTIVES/QUESTIONS

1. General questions or issues for attention include:
 - Determine the overall progress and achievements in ACQUIRE activities and LTPM services.
 - Document the effectiveness of Acquire and other activities to increase access to services or facilities that offer an appropriate range of clinical family planning methods and selected maternal health services.
 - Determine the major constraints to accomplishing results and improvements in LTPM services.
 - Determine the extent to which ACQUIRE and other activities have improved technical and managerial capacity to deliver LTPM services.

- Determine what Best Practices have emerged from ACQUIRE activities and what have been Lessons Learned that can inform future efforts to further improve LTPM services.

2. In the context of evaluating the ACQUIRE Program, the scope is modified to include a greater emphasis on assessing the continuing needs of LTPM service delivery in Bangladesh, including a consideration of the contributions of ACQUIRE. This will mean that the evaluation of ACQUIRE-specific activities may not be as detailed as it might have been in the original scope of work. The team report will also provide general recommendations for improving LTPM services in the future.

3. Since ACQUIRE has just completed the negotiation and approval of the work plan for the last year of their project with the Bangladesh government and with USAID, any guidance on the ACQUIRE Program's next and final year of implementation will focus only on observations of the general appropriateness of the final year work plan and to point out any critical omissions.

4. Since the Mission has a separate team that will review Tiaht compliance during the same time, an assessment of such compliance is not part of this SOW. The GH Tech Team will, however, work closely with this Tiaht review team so that the teams can exchange information and learn from each other.

5. Any recommendations for the future should not necessarily be conditioned only on what has been done in the past and may consider approaches that involve the public sector, non-government organizations and the commercial sector.

D. METHODOLOGY

It is recommended that the Evaluation Team consider a mixed-method evaluation approach with a focus on PLTM clients and potential clients. To the extent possible, the approach taken should be participatory.

Mixed-method evaluation is the class of evaluation where the evaluator mixes or combines quantitative and qualitative evaluation techniques, methods, approaches, concepts or language into a single evaluation. The logic of inquiry includes the use of induction (or discovery of patterns), deduction (testing of theories and hypothesis), and abduction (uncovering and relying on the best of a set of explanations for understanding one's results). By using a mixture of quantitative and qualitative approaches, the evaluation team will gain insight on the impact of ACQUIRE activities (mostly from quantitative) and the processes (mostly qualitative) that lead to those impacts. Sequential and iterative approaches will be used to integrate the mixture of methods and will seek varying degrees of dialogue between quantitative and qualitative traditions at all phases of the evaluation.

Background Materials Review

Prior to conducting field work, the Team will review background materials such as Annual and Quarterly Reports, Indicators, Requests for Proposals, and other public documents related to the project. (Mission to provide a list)

TPM

The team will conduct a 2-day team planning meeting (TPM) upon arrival in Bangladesh and before starting the in-country portion of the assessment. The TPM will review and clarify any questions on the assessment SOW, draft an initial work plan, develop a data collection plan, finalize the assessment questions, develop the assessment report table of contents, clarify team members' roles, and assign drafting responsibilities for the assessment report. The TPM outcomes will be shared with USAID/Bangladesh and the health team will participate in sections of the TPM.

Key Informant Interviews and Site Visits

The Team will also collect information from key stakeholders and informants as follows:

1. Meet with the following stakeholder agencies/individuals (illustrative only – to be expanded to reflect changes in the scope noted above in section C):

EngenderHealth:	Dr. A.J. Faisel and staff
DGFP:	Mr. Abdul Mannan, DGFP and Dr. Abdul Khaleque Chakder, Line Director, CCSD
NIPORT:	Mr. Nasimul Ghani, Director General, and Dr. Akhtar Hossain, Director, Training
DGHS:	Dr. Saleh Ahmed Rafique, Line Director, Dr. Abul Khair Bhuyan, Program Manager, Reproductive Health
UNFPA:	Mr. Arther Erken, Country Representative
NSDP:	Dr. Robert Timmons, COP
FPAB:	Dr. Jahiruddin, Additional Director General
UPHCP:	Zaman Naser Choudhury, Project Director
Dhaka City Corporation:	Col. Dr. Showket, Chief Medical Officer

DFID:	Alison Forder
SMC:	Parveen Rasheed, Chief of Party
DELIVER:	Chief of Party
MCHTI:	Dr. Serajul Islam, Superintendent
MFSTC:	Director
BRAC:	Mr. Faruk Ahmed, Director, Health
Ad-din Center: Advisor	Dr. Rezaul Hoque, Director Program and Dr. A.K.Shamsuddin, Health

2. The team will visit project implementation sites including for example, clinics and health facilities providing PLTM services supported GOB and NGOs (to be modified based on changes to SOW in section C above):

EH/ACQUIRE focus districts:

Rajbari (high performing) and non-focus district Sylhet (low-performing)

Maternity and Child Welfare Center (MCWC)

Upazila Health Complex

Union H & FWC

NGO Clinic

Meeting at the districts:

DDFP/ADCC

FPCST

UHFPO/MO

UFPO/MO (MCH)/Sr. FWV

3. The clinic visits may be conducted in Dhaka (3 days), Sylhet (2 days), Rangpur (3 days), Rajshahi (3 days), Serajgonj (2 days), and Jhalakati (2 days) districts.
4. While visiting the clinics outside Dhaka, the team may meet with the local family planning and the local government authorities in the peripheral districts.

The details of daily activities, key informant interviews and site visits will be determined during the TPM and depend on the date the evaluation team starts work.

E. TEAM COMPOSITION

The contractor will provide a team of a Team Leader, a Host Country National, and a Reproductive Health Expert for the evaluation. The team members should represent a balance of several types of knowledge related to reproductive health in Bangladesh, as well as strategic planning and programming under the reengineered USAID operating system.

The team members must all have significant international health program experience. They should have some Bangladesh country or Asian regional experience, along with comparative experience in the reproductive health sector in other countries or regions of the world. At least one member of the team must have Bangladesh experience and be familiar with the structure of reproductive health service delivery in urban and rural areas.

Some experience in conducting evaluations or assessments is expected of all members, and experience developing strategies would be useful. Substantial experience in international health is required. Ability to conduct interviews and discussions in Bangla and provide accurate translations into English for at least one team member is essential. All team members must have professional-level English speaking and writing skills.

A general idea of the responsibilities and necessary skills/experience of the Team Leader is described below. The contractor will propose additional team members to complement the skills of the Team Leader. It is assumed at least one team member will be a host country national.

Team Leader - The Team Leader will be responsible for overall management of the evaluation, including coordinating and packaging the deliverables in consultation with the other members of the team. The team leader will develop tools for the assessment and a design plan and share it with USAID/Bangladesh. The team leader will develop the outline for the draft report, present the report and after incorporating USAID Bangladesh staff comments if necessary, submit the final report to USAID/Bangladesh within the prescribed timeline.

Skills/Experience:

The Team Leader should have:

1. At least 7 years working in the field of international reproductive health;

2. Knowledge of reproductive health issues in Bangladesh;
3. A good understanding of USAID project administration;
4. Excellent writing and communication skills;
5. Experience leading a team for international health program evaluations or related assignments; and
6. Advanced degree in Public Health or Related field

Team Members: 1) **Host Country National** and 2) **Reproductive Health Expert**

The Host Country National and the Reproductive Health Expert will serve under the Team Leader. Duties will be determined in consultation with the Team leader, but are likely to include: conducting and documenting interviews with potential and current PLTM clients, PLTM service providers and other key informants; providing translation services as necessary for Team Leader; and assisting Team leader as directed in all aspects of completing evaluation deliverables.

Skills/Experience:

The Host Country National and the Reproductive Health Expert should:

1. Have at least 5 years experience working in the field of international health;
2. Be proficient in Qualitative and Quantitative health program evaluation skills;
3. Be proficient in English and Bangla language* (reading, writing and speaking), be able to translate key informant interviews from Bangla into English accurately;
4. Have significant experience conducting health program evaluations;
5. Excellent writing and communication skills;
6. Computer skills; and
7. Advanced degree in Public Health or related field.

*Preferable for both team members to be proficient in Bangla but one team member may be sufficient.

F. LOGISTICAL SUPPORT

A six-day work week is authorized while the Team is in Bangladesh. The evaluation team will be responsible for all off-shore and in-country logistical support. This includes arranging and scheduling meetings, international and local travel, hotel bookings, working/office spaces, computers, printing and photocopying. A local administrative assistant/secretary may be hired to arrange field visits, local travel, hotel and appointments with stakeholders.

G. DELIVERABLES (No change)

The following deliverables will be required from the evaluation team:

1. A draft assessment methodology/design developed (including key informants and geographic focus) and submitted to USAID Bangladesh PHN staff by the evaluators before field visit is made. The design may be modified after further discussions with USAID.
2. A debriefing presentation will be made to the USAID staff within four days of completing the field visits.
3. PowerPoint copies of all presentations/briefings for the Office of Population, Health and Nutrition's use.
4. A draft report of the findings and recommendations, which is concise, actionable and solution oriented, will be developed by the evaluators and presented to USAID prior to departure from country.
5. Based on preliminary feedback to the draft report from USAID, a final report will be prepared within two weeks of departure from country and submitted to USAID for comments and feedback.

The evaluators will be responsible for reviewing USAID comments on the draft report, and correcting any factual inaccuracies or omissions while being aware that this is an independent evaluation and that the findings and recommendations may not necessarily be reflective of USAID suggested revisions or comments. An electronic and 10 hard copies of the report, which will be no more than 40 pages not including annexes, should be sent to USAID within two weeks of the receipt of the comments. The draft format for the evaluation report is as follows:

- a) Executive summary (4-5 pages)
- b) Introduction
- c) Program background
- d) Methodology
- e) Observations, findings and conclusions
- f) Recommendations for future
- g) Annexes (including but not limited to list of persons and organizations met, any questionnaires developed)

H. ESTIMATED LEVEL OF EFFORT

TITLE	Tasks and Work Days	Work Days in BANGLADESH	TOTAL LOE
Team Leader	<ul style="list-style-type: none"> • 3 days document review (out of country) • 5 days travel • 2 days TPM • 4 days meetings • 12 days field work • 6 days follow-up fieldwork/discussion/report writing • 5 days report revision/finalization (out of country) 	25 days	37 days
Reproductive Health Expert	<ul style="list-style-type: none"> • 3 days document review (out of country) • 5 days travel • 2 days TPM • 4 days meetings • 12 days field work • 6 days wrap/follow-up fieldwork/report writing • 2 days report revision/finalization (out of country) 	25 days	34 days
Host Country National	<ul style="list-style-type: none"> • 3 days document review • 2 days TPM • 4 days meetings • 12 days field work • 6 days wrap/follow-up fieldwork/report writing • 2 days report revision/finalization 	29 days	29 days
Local Administrative Assistant	<ul style="list-style-type: none"> • 2 days TPM • 4 days meetings • 12 days field work • 2 days wrap/follow-up fieldwork/report writing 	Est. 20 days	Est. 20 days
TOTAL		100 days	121 days

I. POINT OF CONTACT

Dr. Sukumar Sarker, Activity Manager, ACQUIRE project USAID Bangladesh Office of Population, Health and Nutrition

Tel: 880-2-885 5500 x 2313

Cell: 01713009878

Email: ssarker@usaid.gov

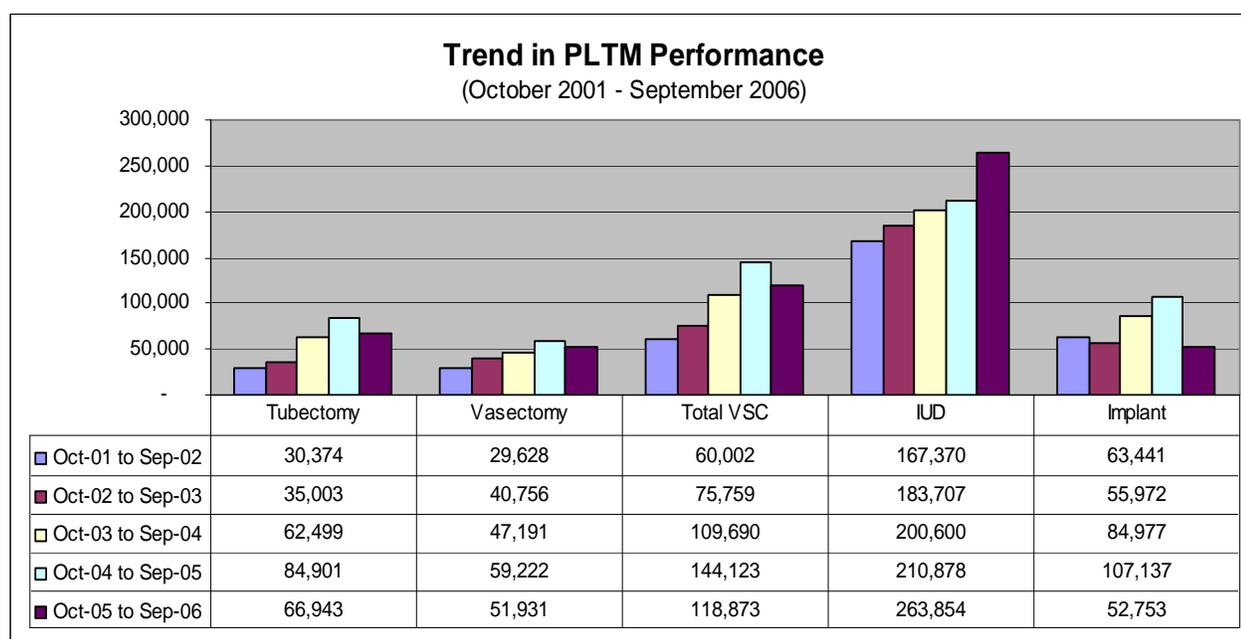
The “Project Achievement” column in the figure below illustrates the shortfalls in each method except for IUD, which exceeded the Project Estimate for the 2005-2006 workplan year:

Expected number of PLTM services that would be provided in the 64 districts during October 2006 – September 2007

	FP Methods/Service	Previous Workplan Year October 2005-September 2006		Current Workplan Year October 2006 –September 2007	
		Project Estimate	Project Achievement	Project Estimate*	Directorate General Family Planning Estimate
1.	Male permanent methods	90,000	66,943	92,895	250,000
2.	Female permanent methods	70,000	51,931	72,105	
Total VSC		160,000	118,874	165,000	250,000
3.	Intra Uterine Device	225,000	263,854	295,695	350,000
4.	Implant	125,000	52,753	135,000	171,250
Total PLTM		510,000	435,481	595,695	771,250

*EngenderHealth estimate for the current Workplan year depicted based on management experience of program staff

The graph below, based on national data from Directorate General for Family Planning, shows how PLTM performance, for all methods except IUDs, declined in the October 2005-September 2006 time period:



ANNEX B: KEY INFORMANT AND FACILITIES VISITED

USAID/Bangladesh

Denise Rollins, Director, USAID
Carey Gordon, Deputy Director, USAID
Sheri-Nouane Johnson, Director, OPHN, USAID
Mary Lynn McKeon, Deputy Director, OPHN, USAID
Sukumar Sarker, Activity Manager, OPHN, USAID

USAID Supported PHN Programs

Karen Beattie, Project Manager, ACQUIRE Project, EngenderHealth/New York
Dr. A. J. Faisal, Country Representative and his team, EngenderHealth/Dhaka
Ms. Perveen Rasheed, Managing Director, Social Marketing Company
Toslim Uddin Khan Head, Research and MIS, Social Marketing Company
James L. Griffin, Chief of Party, Smiling Sun Project (Former NSDP), Chemonics
Dr. Robery Kelly, Country Director, Bangladesh Aids Program, Family Health International
M. M. Kaiser Rashid, Acting Country Director, Deliver Project/Bangladesh, John Snow Inc.
Mohammed Anwer Hossain, Senior Logistics Specialist, Deliver Project/Bangladesh, John Snow Inc.
Mohammed Shahjahan, Director/CEO, Bangladesh Center for Communication Project (BCCP)

Government of Bangladesh

Mohammad Abdul Mannan, Director General, DGFP
S. M. Mosharaf Hossain, Deputy Director, DGFP
Dr. Saleh Ahmed Rafique, Line Director, Reproductive Health, DGHS
Dr. Khaleque Chakder, Line Director, CCSD
Dr. Md. Muzibul Hoque, DDFP in charge and his team, Tangail
Mr. Shahidul Islam, UHFPO and his team, Mirzapur Upazila, Tangail
Dr. Momotaz Begum, Medical Officer, Tangail
Dr. Shirin Begum, MOMCH, Tangail
Nasimul Ghani, Director General, NIPORT
Dr. Akhter Hossain, Director, Training, NIPORT
Dr. Serajul Islam, Superintendent, MCHTI
Mahmuda Begum, FWV, MCHTI
Md. Sirajul Islam, Deputy Director, UPHCP
Dr. Rafiqus Sultan, National professional Project Personnel, UNFPA/UPHCP
Rehena Begum, Director, MFSTC
Dr. Shohel Ally, Deputy Director, MFSTC
Rebeka Nightengale, Sr. FWV, Jhikogacha Upazila Health Complex, Jessore
Ullashi Biswas, FWV, FWC, Godkhali Union, Jhikorgacha, Jessore
Md. Shahidul Islam, UFPO, Jhikorgacha, Jessore
Dr. Chandra Shakhor, MOMCH, Jhikorgacha, Jessore
Dr. Sayed Akhter Hossain, DDFP in -Charge and his team, Moulvibazer
Modhusudon Pal Chowdhury, UFPO, Kulaura, Moulvibazer
Dr. Partha Sarathi Dutta, MOMCH and his team, Rajnoger, Moulvibazer
Others including FWVs, Sr. FWV, SECMO, FPI, FWA in Tangail, Jessore and Moulvibazer

NGO and Private/Commercial Sector

Dr. Jahiruddin, Additional Director General, FPAB
Dr. Yasmin H. Ahmed, Marie Stopes Clinic
Dr. Reena Yesmin, Marie Stopes Clinic
Dr. Mahbuba Begum, Project Manager, InHealth
Sakhwat Hossain, Program Manager, InHealth

Mohammad Azmal Hossain, Program Officer (Social Issues), EngenderHealth
Dr. K. M. Rezaul Hoque, Director. Planning and Capacity Building, Ad-din
Dr. Sajid A. Siddque, Clinic Manager, Paribar Kallayan Sangstha, Jessore
Dr. Md. Abdur Razzak, Program Manager, Paribar Kallayan Sangstha, Jessore
Faruk Ahmed, Director, Health, BRAC: not available during the assessment period
Dr. Sharmin Rahman, Private Physician
Several Medicine Shop owners and vendors
Various individuals including Acceptors and Potential Acceptors of LTPMs

Other Donors

Alison Forder, Health and Population Advisor, DFID/Bangladesh: not available during the assessment period
UNFPA – not available except during meetings with the government
Japan International Cooperation Agency – also not available

ANNEX C: CLINIC FACILITIES AND SITES VISITED

MCWC, Tangail District
 UH&FWC, Mirzapur, Tangail
 Maternal and Child Health Training Institute (MCHTI), Dhaka
 Ad-Din Hospital, Moghbazer, Dhaka
 MFSTC, Dhaka
 NSDP Clinic, Jessore
 Upazila Health Complex, Jhikorgacha
 UH&FWC, Godkhali, Jessore
 NSDP Clinic Moulivibazer
 Upazila Health Complex, Rajnager, Moulivibazer
 UH&FWC, Rajnager, Moulivibazer
 MCWC, Moulivibazer

Level of Facilities Visited

Location of Facility	Dhaka	Tangail	Jessore	Moulovibazer
Community Level		FWA, FPI, satisfied clients, pharmacy, acceptors and potential acceptors	FWA, FPI, satisfied clients, pharmacy, acceptors and potential acceptors	FWA, FPI, satisfied clients, pharmacy, acceptors and potential acceptors
Union Level		UH&FWC	UH&FWC	UH&FWC
Upazila Level		Upazila Health Complex	Upazila Health Complex	Upazila Health Complex
District Level		MCWC	MCWC NGO Implant Training Center NGO clinic	MCWC NGO clinic
National Level	MCHTI, MFSTC, NIPORT NGO Hospital (Ad-Din)			

ANNEX D: DOCUMENTS REVIEWED AND ADDITIONAL MATERIALS

ACQUIRE/EngenderHealth Bangladesh:

2007 Management Information System Data Base. Dhaka, Bangladesh, ACQUIRE Project.

Draft Meeting Report on Expert Consultation Meeting on Permanent and Long-term Family Planning Methods, February 01, 2007.

Family Planning and Reproductive Health Implementation Mechanism, FY07 Operational Plan Template, August 2007.

Key Success/Best Practices (not dated, approx 2004–2006).

Strengthening Delivery of Long-Acting and Permanent Methods (LAPM) of Family Planning Services in Bangladesh. Workplan October 2007– September 2008, Final Draft (20 September 2007).

Strengthening Delivery of Long-term Family Planning Methods (PLTM) and Selected Maternal Health Care Services in Bangladesh, Annual Report: October 2005–September 2006.

Strengthening Delivery of Permanent and Long-term Family Planning Methods (PLTM) and Selected Maternal Health Care Services in Bangladesh. Annual Progress Report (Draft), October 2004– September 2005. November 2005.

Strengthening Delivery of Permanent and Long-term Family Planning Methods (PLTM) Services in Bangladesh. Workplan October 2006– September 2007. Approved by Corporate Steering Committee Meeting (held on 06 December-06).

Strengthening Delivery of Selected Maternal Health Care Services in Bangladesh (Final Draft). Workplan October 2007– September 2008. September 2007.

Strengthening Delivery of Selected Maternal Health Care Services in Bangladesh, Workplan: October 2007–September 2008.

Bangladesh Directorate General of Family Planning:

2006 Training Database of Clinical FP Service Providers. Dhaka, Bangladesh, ACQUIRE Bangladesh Country Office.

2007 Management Information Systems August Report. Dhaka, Bangladesh: Family Planning, Maternal & Child Health and Reproductive Health Services, Ministry of Health and Family Welfare.

2007 Management Information Systems Data Base (multi-year). Dhaka, Bangladesh: Family Planning, Maternal & Child Health and Reproductive Health Services, Ministry of Health and Family Welfare.

Directorate General of Family Planning, Ministry of Health and Family Welfare and ACQUIRE Project/EngenderHealth, Results of the Performance Improvement Needs Assessment (PINA-2) to Strengthen the Supervision System.

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1978 Bangladesh Fertility Survey, 1975–1976: First Report. Dhaka, Bangladesh: Government of the People's Republic of Bangladesh and the World Fertility Survey.

1983 Bangladesh Contraceptive Prevalence Survey-1981. Dhaka, Bangladesh: MOHPC.

Ministry of Health and Family Welfare and AVSC International, Review of Sterilization Services in Bangladesh, October–November, 2000

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Bangladesh Health, Nutrition & Population Sector Programme. Annual Programme Review 2006 Part 1 – Main Report on Key Findings, Conclusions and Recommendations. April 2006.

Barkat-e_Khuda, John Stoeckel, Nancy Piet-Pelon, Bangladesh Family Planning Programme Lessons Learned and Directions for the Future, MCH-FP Extension Project (Rural), International Centre for Diarrhoeal Disease Research, Bangladesh, April 1997.

E-Alam, M., Bradley, J. and Shabnam, F. 2007 IUD Use and Discontinuation in Bangladesh, Draft Report. Dhaka, Bangladesh: ACQUIRE Project.

Huq, M. N. and Cleland, J. 1990 Bangladesh Fertility Survey 1989: Main Report. Dhaka, Bangladesh: National Institute of Population Research and Training.

Mahboo-E-Alam, Jan Bradley and Fatem Shabnam, IUD Use and Discontinuation in Bangladesh (Draft), ACQUIRE Study Report, October 2007.

Mitra, S. N. and Islam, S. 1985 Bangladesh Contraceptive Prevalence Survey-1983: Final Report. Dhaka, Bangladesh: Mitra and Associates.

Mitra, S.N., Larson, A., Foo, G. and Islam, S. 1990 Bangladesh Contraceptive Prevalence Survey-1989: Final Report. Dhaka, Bangladesh: Mitra and Associates.

Mitra, S.N., Larson, A., Foo, G. and Islam, S. 1993 Bangladesh Contraceptive Prevalence Survey-1991: Final Report. Dhaka, Bangladesh: Mitra and Associates.

Mitra, S.N., Lerman, C., Ali, N., Islam, S., Cross, A. and Saha, T. 1994 Bangladesh Demographic and Health Survey 1993-1994. Dhaka, Bangladesh and Calverton, Maryland: National Institute of Population Research and Training, Mitra and Associates, and Macro International, Inc.

Mitra, S.N., Ahmed Al-Sabir, Anne R. Cross and Kanta Jamil 1997 Bangladesh Demographic and Health Survey 1996–1997. Dhaka, Bangladesh and Calverton, Maryland: National Institute of Population Research and Training, Mitra and Associates, and Macro International.

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Useful Links:

www.usaid.gov/bd

www.infoforhealth.org

<http://library.info.usaid.gov>

Additional Materials reviewed on CD

Please also find additional materials reviewed on the CD accompanying this report.

ANNEX E: EXCERPT FROM ICDDR BANGLADESH 1997 REPORT

BANGLADESH FAMILY PLANNING PROGRAMME: LESSONS LEARNED AND DIRECTIONS FOR THE FUTURE

Barkat-e-Khuda
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April 1997

Executive Summary

The success of the Bangladesh National Family Planning Programme is reflected in an almost two-fold increase in the contraceptive prevalence rate (CPR) over the past decade, resulting in a substantial decline in fertility for the same period. Maintenance of the current prevalence and fertility levels over the next decade will require an additional 4 million users. If the national goal of replacement fertility is to be reached by 2005, the total number of contraceptive users will have to more than double to 21 million.

CROSS-CUTTING ISSUES

- (1) The needs and intentions of the family planning programme have changed from providing MCH and family planning to providing an Essential Service Package (ESP), which includes reproductive health. This will pose a major challenge to the programme in terms of both the human and material resources required by the programme components for the introduction of the package.
- (2) The management of the family planning programme is oriented more toward the interests of providers than the needs of clients. The family planning programme is still affected by a history of target-orientation. While there are no official targets in today's programme, there is still a "target mentality" which permeates the delivery of certain services, especially sterilization and IUD. Special days or camps are organised to offer these services, with an emphasis on the number of clients served rather than on ascertaining and responding to the needs of clients.
- (3) There is inadequate cooperation and coordination between the Family Planning and Health Directorates. This is apparent in the delivery of health and family planning services at most levels. Clients receive services from different personnel at different times. However, there is marked improvement in coordination at the community level where services are now provided through combined Satellite Clinic JEPI spots.
- (4) There are internal conflicts between medical and non-medical staff within the Family Planning Directorate. This occurs primarily between the TFPOs and MOIMCH with regard to: pay scale and status; financial drawing and disbursement authority; and career advancement opportunities.
- (5) Staff who were hired under the development budget have lower morale than staff who were hired under the revenue budget. The discrepancies in the financial benefit package influence job performance. Family planning programme staff included in the development budget have less job security and are not eligible for retirement benefits. Staff included in the revenue budget are entitled to a provident fund, gratuity and a pension.
- (6) There is a lack of accountability in the public sector. In the family planning programme, it particularly affects staff performance, personnel management and supervision, and supplies and

equipment. There is no formal performance appraisal for staff, and no system of rewards for good performance or consequences for poor performance. A fair and operational "personnel policy" is not in place. There is a lack of clarity in job descriptions throughout and a confusion in the direct-line supervision for the personnel at the field level. Also, drugs and other medical supplies are lost in the system or missing from clinics.

(7) There is inadequate cooperation and coordination' between government and non-government organisations. This has resulted in areas being poorly demarcated between the organisations, duplication of activities, and overlap in work between field staff. While there have been improvements, the cooperation and coordination will require continuous attention because of the large number of NGOs involved in health and family planning.

(8) The health and family planning programme is donor dependent. Almost 60 percent of the MCH-FP programme is funded by donor agencies. The donors will not be able to maintain this level of funding for an extended period, which has obvious implications for sustainability. In order to sustain its activities, the programme will need to work toward a balance of self-sufficiency in order to reduce its dependency.

ANNEX F. OVERVIEW OF USAID PHN PROGRAMS IN BANGLADESH



USAID | BANGLADESH

FROM THE AMERICAN PEOPLE

PROGRAM OBJECTIVE: INVESTING IN PEOPLE—HEALTH AND EDUCATION

Smiling Sun Franchise Program (SSFP)—The Smiling Sun Franchise Program (SSFP) aims to maintain and expand the availability of sustainable NGO health services and products in a way that reduces reliance on USAID funding for recurrent costs, while expanding the availability of key family planning and health products and services to the poor. The program will thereby continue to achieve the population and health targets of the Government of Bangladesh (GOB) and USAID. The program will create a health franchise built around the current NGO network supported by USAID, which allows for the sharing of costs associated with marketing among all the clinics and provides a system to cross-subsidize services for the poor and rural communities. Currently, this project provides basic healthcare to approximately 1.8 million people per month, most of whom would otherwise have no access to healthcare at all.

Program Area: Health
Program Element: Maternal and Child Health/ Family Planning and Reproductive Health/ Tuberculosis
Partner: Chemonics International, Inc.
Funding: \$46,497,895 as of October 01, 2007
Dates: October 01, 2007 – October 30, 2011
Name of CTO: Belayet Hossain
GOB Ministry: Ministry of Health and Family Welfare

Social Marketing Company (SMC)—SMC is a non-profit company that implements social marketing programs and complements public sector distribution of contraceptives and oral re-hydration salts (ORS) to reach vulnerable populations in Bangladesh through 210,000 pharmacies, 3500 Blue Star service centers, kiosks and other outlets. SMC opened an ORS factory in 2003 and is developing new products for family planning, health and nutrition. A follow-on project will begin in January 2007.

Program Area: Health
Program Element: Maternal and Child Health/ Family Planning and Reproductive Health / Tuberculosis
Partner: Social Marketing Company
Funding: \$14,040,000 as of September 30, 2007
Dates: August 1997 – September 30, 2011
Name of CTO: Mohammad Nasiruzzaman
GOB Ministry: Ministry of Health and Family Welfare

DELIVER—Provides technical assistance to improve GOB management, procurement and logistics capabilities to ensure continuous availability of high quality contraceptives and essential health products at service delivery points. Without this technical assistance, the country would face serious commodity crises which would result in unintended births.

Program Area: Health

Program Element: Maternal and Child Health/ Family Planning and Reproductive Health
Partner: John Snow Inc.
Funding: \$14,700,000 as of September 30, 2007
Dates: September 2006 – September 2011
Name of CTO: Mohammad Nasiruzzaman
GOB Ministry: Ministry of Health and Family Welfare

Access, Quality and Use in Reproductive Health (ACQUIRE)—Through this project, USAID provides both permanent and long-term contraception services in cooperation with the GOB and NGOs. The project provides training, assists in strengthening the organization and management of long-term family planning service delivery, strengthens the relationship between NGOs and the Ministry of Health and Family Welfare and works to improve the coordination of contraception service provision at the field level. The project also works to reduce cultural barriers and increase demand for permanent and long-term family planning methods in the country. ACQUIRE activities contribute to the maintenance and further reduction of the national fertility rate to the national goal of approximately two children per woman.

Program Area: Health
Program Element: Maternal and Child Health/ Family Planning and Reproductive Health
Partner: EngenderHealth
Funding: \$10,338,000 as of September 30, 2007
Dates: October 2002 – September 2008
Name of CTO: Sukumar Sarker
GOB Ministry: Ministry of Health and Family Welfare

Central Contraceptive Procurement—Provides limited commodity assistance to the Social Marketing Company. While the majority of contraceptive commodities come from the GOB, USAID provides contraceptives to fill the critical gaps not met by the GOB, primarily oral contraceptives and injectables. These contraceptives significantly contribute to increasing the national contraceptive use rate for modern methods.

Program Area: Health
Program Element: Family Planning and Reproductive Health
Partner: Social Marketing Company
Funding: \$96,038,500 as of September 30, 2007
Dates: August 1997 – September 2008
Name of CTO: Mohammad Nasiruzzaman
GOB Ministry: Ministry of Health and Family Welfare

ACCESS Project: Safe Motherhood and Newborn Care—The goal of this project is to improve maternal and newborn health outcomes by promoting healthy maternal and newborn healthcare practices at home and increasing appropriate and timely utilization of home and facility based services. Behavior Change Communications (BCC) and Community Mobilization are the core strategies of this project. BCC activities are conducted by the project counselors who identify and visit each pregnant woman in the project area four times during ante-natal and post-natal periods. During these visits, the counselors educate pregnant women and their immediate family members on home-based healthy maternal and newborn care practices including pregnancy care, birth planning, clean delivery practices, newborn care, and recognition of danger signs for mothers and newborn. The counselors also promote the utilization of healthcare services from appropriate facilities. Side by side, Community Mobilization activities aim to generate community support and participation in implementing and sustaining the project activities. ACCESS Project, in collaboration with Save the Children, USA, and two local NGOs, has been implementing this project in seven sub-districts of Sylhet. The project is expected to improve maternal health outcomes, and reduce newborn deaths by 12-15 percent over a period of three years.

Program Area: Health
Program Element: Maternal and Child Health/ Family Planning and Reproductive Health
Partner: JHPIEGO (Prime) and Save the Children, USA
Total: \$5,700,000 as of September 30, 2007
Dates: February 2006 – April 2009
Name of CTO: Krishnapada Chakraborty
GOB Ministry: Ministry of Health and Family Welfare

Health and Emergency Response Support—Supports the World Health Organization's polio eradication and urban immunization activities. Constant surveillance is essential to detect virus importation and reintroduction. Sustained immunization efforts through routine immunization, supplementary immunizations on National Immunization Days, and vigilant surveillance are required to ensure a polio free future for Bangladesh.

Program Area: Health
Program Element: Maternal and Child Health
Partner: World Health Organization
Funding: \$4,200,000 as of September 30, 2007
Dates: October 2002 – September 2008
Name of CTO: Sukumar Sarker
GOB Ministry: Ministry of Health and Family Welfare

Bangladesh AIDS Program (BAP)—Assists local NGOs to implement HIV activities with high-risk groups. Family Health International (FHI) works in partnership with the Social Marketing Company, John Snow International, and the Masjid Council for Community Advancement—a local faith-based organization—to provide technical assistance to NGOs to: educate people on HIV risk reduction, improve prevention efforts and the management of sexually transmitted infections; minimize the contextual and policy-related constraints, increase linkages between prevention and care, and improve monitoring and evaluation of HIV prevention programs. As a result of these activities, over three million high-risk individuals will be reached with prevention programs and over 2000 Imams will be trained on HIV/AIDS.

Program Area: Health
Program Element: HIV /AIDS / Tuberculosis
Partner: Family Health International
Funding: \$10,466,000 as of September 30, 2007
Dates: October 2005 – September 2008
Name of CTO: Sukumar Sarker
GOB Ministry: Ministry of Health and Family Welfare

MEASURE DHS+—Provides technical assistance and operational costs to the Bangladesh Demographic and Health Survey (BDHS), which is conducted every three years. Essential data to monitor the performance of public health programs are not adequately available through other means and are measured through the BDHS. The information assists policymakers and program managers in evaluating and designing programs and strategies for improving health and family planning services in the country. The BDHS methodology also enables data comparisons with demographic and health surveys worldwide.

Program Area: Health
Program Element: HIV / AIDS/ Maternal and Child Health / Family Planning and Reproductive Health
Partner: ORC Macro International
Funding: \$2,201,500 as of September 30, 2007
Dates: September 2002 – September 2008
Name of CTO: Kanta Jamil
GOB Ministry: Ministry of Health and Family Welfare

MEASURE Evaluation—Designs and conducts population-based surveys to measure the performance of NGOs in providing the Essential Service Package. Findings will provide Long-term and Permanent Methods of Family Planning in Bangladesh

information on a number of programmatic indicators. MEASURE Evaluation is also implementing the Urban Health Survey, which includes information on location, demographics and some socio-economic characteristics of slums in urban Bangladesh.

Program Area: Health

Program Element: Maternal and Child Health/ Family Planning and Reproductive Health

Partner: Carolina Population Center, UNC Chapel Hill

Funding: \$4,100,000 as of September 30, 2007

Dates: September 2002 – September 2008

Name of CTO: Kanta Jamil

GOB Ministry: Ministry of Health and Family Welfare

SUCCEED—This program is based on the underlying principle that effective intervention in the early years is the key to increased learning achievement in Bangladeshi primary schools. Work with the neglected lower grades of primary school, taken together with support to the development of children’s confidence, communication, cognitive and social skills before they enter school, will be fundamental aspects of this program. Such transition activities ensure that children are ready for school, schools are ready for children (providing a welcoming environment and learning opportunities), and family support for school is strengthened. Now in its third year of implementation, USAID/Bangladesh has trained over 2,186 pre-school instructors in interactive teaching methods to help prepare children for success in primary school, established 1,800 home-based and school-based preschools throughout Bangladesh, and served over 105,972 children between the ages of 4 and 5. Most of the instructors are local women who have attained at least a secondary education degree and who often have few employment opportunities in their communities. USAID is also developing illustrated storybooks based on local folk tales as well as “community learning corners,” which are being established as after-school learning resource centers for children in over a thousand villages, and creating a program to partner older children as learning mentors or “Reading Buddies” to help younger children from non-literate families learn to read. Finally, USAID works with over 5,000 members of School Management Committees to empower communities in the oversight of children’s education and to ensure that government resources are allocated responsibly.

For more information, please visit
<http://www.ghitechproject.com/resources/>

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