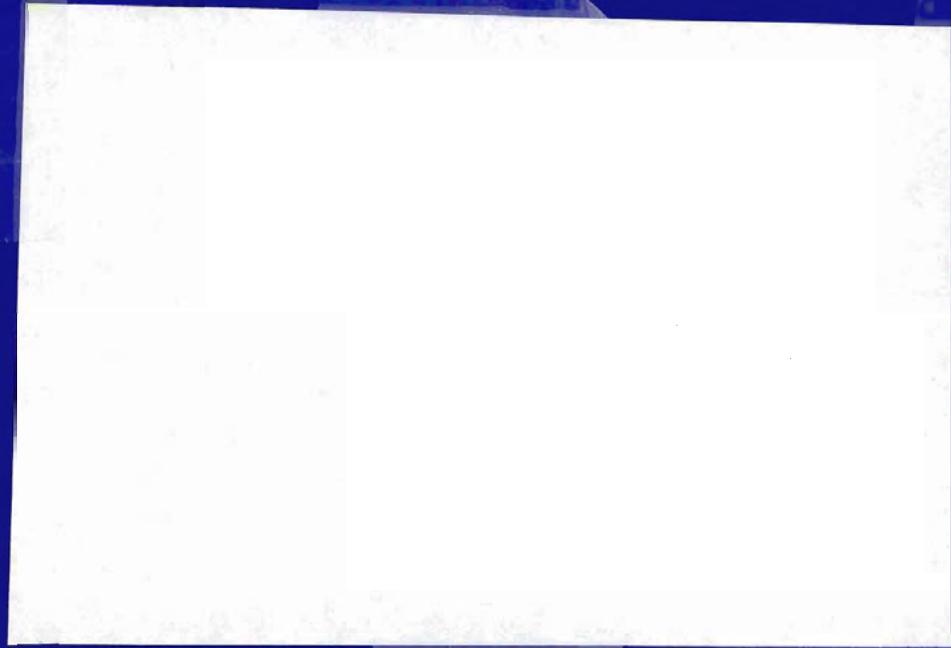


**TRIP REPORT:
VISIT TO BANGLADESH
TO FINALIZE CA/NGO
AMENDMENT PROPOSALS**

MAY 8 - 25, 1992

**FAMILY
PLANNING
MANAGEMENT
DEVELOPMENT**



Family Planning Management Development (FPMD) is a five-year project designed to provide practical solutions to the management problems faced by senior- and mid-level family planning program managers in both the public and the private sector. FPMD is a world-wide project, assisting family planning managers in Africa, Asia, the Caribbean, Latin America, Eastern Europe, and the Near East. It is implemented by Management Sciences for Health in collaboration with The Centre for Development and Population Activities (CEDPA).

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MAY 8 - 25, 1992

**Saul Helfenbein
Peg Hume
Sara Seims**

FAMILY PLANNING MANAGEMENT DEVELOPMENT

**Project No.: 936-3055
Contract No.: DPE-3055-C-00-0051-000
Task Order No.: TAS 97 BA**

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I. BACKGROUND

In February/March 1992, the FPMD team and Keys MacManus of A.I.D. were in Bangladesh at the request of USAID/Dhaka to assist the A.I.D. funded Cooperating Agencies to prepare five year proposals, and to provide guidance on how to streamline the proposal review, approval and monitoring procedures.

USAID's request for FPMD assistance in these areas was based on the success of FPMD's UIP program and the recognition by some members of USAID's Office of Population and Health (OPH) of the need to more closely integrate various components of USAID's portfolio.

During the visit, the team worked with all parties to establish the strategic directions of quality, expansion and sustainability for the CA program. Team members provided in-depth assistance to each of the five CAs on revising their proposals to explicitly reflect these strategic goals and follow a common proposal format. The team also proposed a framework for a portfolio approach to project review, approval and monitoring.

In addition, the team prepared brief issues papers for OPH on key areas such as sustainability, innovative approaches to service delivery and strategic planning.

II. PURPOSE/SCOPE OF WORK

USAID/Dhaka asked the FPMD team and Keys MacManus to return to Bangladesh to help finalize the CA proposals, to continue the streamlining effort, and conduct a strategic planning workshop with the CAs and selected NGOs. Susan Ross, the FPMD/CTO joined the team for much of this TDY.

Upon arrival in Dhaka, the team learned that completion of the CA proposals and preparation of a scope of work for a follow-on buy-in to FPMD would be the two OPH priorities for this visit; further streamlining efforts would take place only after work with the CAs on their proposals was finished.

III. ACTIVITIES

1. Finalization of CA Proposals

Following a standard outline, each team member worked extensively with an individual CA to complete its proposal. This process took several days. All proposals were submitted to A.I.D. on May 17. On May 21, OPH provided comments and suggestions for revisions to each CA. The remainder of the TDY was spent assisting the CAs to incorporate OPH revisions and helping them prepare the budget back-up tables.

See Annex 1 for excerpts from three program proposals outlining technical priorities of three of the five CAs in the areas of quality, expansion and sustainability.

2. Discussion of Scope of Work of Buy-in to FPMD

The team spent a significant amount of time discussing the scope of work for a buy-in to FPMD. OPH management, Keys MacManus and Susan Ross stressed the need to use FPMD skills and knowledge of Bangladesh to assist USAID address national family planning program needs.

In particular, the FPMD team was requested to prepare a scope of work which would include completing the CA proposal streamlining system, developing a full management information system, providing in-depth management support to CAs and two of the largest NGOs, collaborating with Rapid to promote decentralization policies, and assisting the CAs prepare and implement sustainability plans. For the draft scope of work for this buy-in see Annex 2.

3. General Meetings with CAs, OPH, and Team

- a. Review of contractual and budget issues related to the CA proposals.
- b. Overview of the strategic planning process
- c. Division of responsibilities for functional areas such as IEC, Research and Training among CAs with predominant capabilities in these areas.
- d. Special meetings with OPH to finalize CA proposal format and budgetary information.

IV. CONCLUSIONS

1. The team continues to be extremely impressed by the scope, quality and standards of the CA/NGO program which contributes about one quarter of the current contraceptive prevalence of 34% (modern methods).
2. The CAs are very much aware of the need to introduce innovations into their programs so that national family planning goals might be achieved.
3. Each CA has a particular niche and a predominant capability which can benefit the other CAs.
4. All recognize the need to continue to work together promoting quality, expansion and sustainability.

ANNEX 1:

Excerpts from Three Program Proposals

PROJECT PROPOSAL
FOR REFUNDING FPSTC
FOR 1993-1997 PERIOD

I. Program description

The goal of FPSTC is to strengthen the ability of the National Program to offer and expand quality sustainable FP services as a means of reducing fertility.

This section describes the activities to be undertaken over the next five years to reach the proposed objectives. For each activity to the extent possible, measurable outputs are provided.

Activities and outputs

A. Quality improvement (QI)

Objective : To provide well trained clinical personnel and offer clients increased choice in contraceptive methods in order to improve quality of service delivery.

1. Monitor and provide on-the-job training to all projects with special emphasis on low performing NGOs. 150 monitoring and technical assistance visits will be conducted for 5 low performing projects and 1125 visits for the 45 high performing projects over the 5 year period.
2. Phase in 25 projects by 1995 (15 1st year, 5 2nd year, 5 3rd year) to integrate MCH and community development with FP activities. This will result in more satisfied clients and reduce the drop out rates which currently are on the average over 30%.
3. Establish contraceptive supply links between NGO projects and SMC to provide more choices to clients over the 5 year period. The availability of a greater variety of contraceptives will be available to 7,60,000 ELCOs covered by the NGOs.
4. Emphasize training and monitoring of personnel and services delivering clinical methods. The result will be a 42% increase in the use of clinical methods in the method mix by 1997.
5. Train 30 FWV by 1993 to support effective use of More Effective Methods (MEMs). The result will be access to clinical referral at the community level to support NGO motivation efforts to use more effective methods.

B. Expand Coverage (EC)

Objective : To enable local NGOs to use local resources more efficiently in increasing coverage in sites covered by national programs.

1. Support 50 NGO programs to provide contraceptive services, emphasizing closer integration with Government program. These programs will result in approximately 440,000 active users or a 46% increase in the number of active users currently reached by 48 NGO programs by 1997.
2. Start 4 new NGOs family planning projects in low performing areas such as Chittagong and Sylhet by 1995. Preference will be given to expansion into needy areas which are located closest to sites where the FPSTC program is already active. The projects will be based on the use of volunteers supervised by government field workers. This will result in increase of approximately 22,600 active users.
3. Train FWs in 30 selected NGOs by 1994 to provide door-to-door injectable contraceptives. The increase in the availability of injectables on a door-to-door basis will promote an increase of 42% users of more effective methods in the method mix.
4. Provide contraceptives to FPSTC sub-projects on a continuing basis from 1993 - 97. This will result in a continuing, uninterrupted, timely contraceptive (OC, Condom, IUD, Injectables) supply to all 50 NGOs.

C. Strengthen Sustainability (SS)

Objective : To involve indigenous local NGOs in mobilizing local initiatives and voluntary community participation so as to strengthen institutional viability of family planning programs at the local level.

1. Graduate 4 NGOs by 1996 from FPSTC and hand over to other donors and prepare 6 more NGO for graduate status by 1997: Ten NGOs will have developed institutional and managerial capability to continue programs on their own.
2. Continue to publish monthly Journal "Projanmo", which emphasizes program and institutional sustainability by promoting community commitment and raising issues of importance to NGOs. 12 issues of Projanmo will be published yearly from 1993 - 1997 to reach 4000 subscribers. Paid subscriptions and advertizing will recover 17% of production costs by year 5.
3. Conduct two 3-day workshops each year from 1993-97 for 50 NGO Project Coordinators. Twenty workshops will be conducted to improve management capability of project coordinators.
4. Conduct two 3-day workshops per year for community leaders and NGO heads from 1993-97. 250 leaders will be trained in strengthening NGO leadership in and relationships to the community.

5. Send 3 professional staff of FPSTC per year for short term training to US or regional institutions in order to increase technical and managerial competence. Fifteen staff will receive training by year 5.
6. Send 10 FPSTC staff and 20 NGO project coordinators on observation study tours (6 per year from 1993-1997) to country's in the region in order to learn how to strengthen community involvement in FP programs.
7. Establish income generating projects in 25 NGOs by 1997. The result will be increased financial ability to cover 2 % of project costs over the 5 year period on an average.
8. Plan with NGOs to mobilize community support to cover costs of FP projects. The result will be that 5% of annual budgets will be covered on an average over the 5 year period by community contributions, sale of contraceptives, service charges and donations of physical facilities.

D. Functional specialities

D.1 Coordination

Objective : To provide leadership via the FPCVO as a means of promoting greater coordination between the NGO and Government programs.

1. As secretariat of the FPCVO from 93-97, reconstitute and broaden membership to include NGO representatives from each of the 64 districts and from CA and donor organizations. As a result FPCVO agendas will focus on understanding and solving local problems.
2. Organize 2 FPCVO meetings per year from 1993-1997 to coordinate NGO, GOB and donors followup the recommendations with Government, donors & NGOs. Results will be identification of problems, issues and recommendations concerning NGO program implementation.
3. Organize four 3-day Divisional Workshops one per year from 93-96 for 150 participants per workshop to discuss FP policy issues for ministerial officials, FP Directorate officials, local Government FP personnel, and NGO leaders. Results will be a series of recommendations to promote integration of government and NGO programs.

D.2 Training

Objective : To provide basic and refresher training for project managers/coordinators, supervisors, office assistant, field workers, community volunteers and community leaders for FPSTC supported NGO projects, other NGOs supported by CAs and other donor agencies.

1. Review and modify curricula for training NGO project coordinators, supervisors and office assistants/accountants of all NGOs through 1993-97. The result will be increased job relevant training in the 5 categories of basic courses, 6 categories of refresher courses and 3 categories of specialized courses for 1363, 2369 and 500 participants respectively.
2. Develop a training program evaluation system by 1993. The results will be the institution of a system to assess the effectiveness of training and ensure continued improvement.
3. Explore possibilities with government and other NGOs to provide training services and generate increased revenue for FPSTC. The result will be the recovery of 35% of the cost of running the Training Unit at the end the project period in 1997.
4. Develop 2 categories of courses by 1993 to train 1000 community volunteers and one category of course on income generation to train 250 community leaders. The results will lead to increased coverage and potential for sustainability.
5. Provide basic and refresher training for NGO personnel from other CA and other donor projects. The expected results are 330 participants trained in year 1; 326, in year 2; 326, in year 3; 326, in year 4; and, 326, in year 5.

Summary Outputs

1. <u>FP services</u>	5 years total	1	2	3	4	5
i) ELCO	760,132	555,205	623,900	715,446	744,133	780,132
ii) Active users	440,000	310,396	350,159	380,255	417,292	440,000
iii) Non clinical methods	246,360	207,965	224,102	228,153	242,029	246,360
iv) Clinical methods	193,569	102,431	126,057	152,102	175,283	193,569
2. <u>FWV Training</u>	30	-	30	-	-	-
3. Publication of Projanma (copies)	240,000	48,000	48,000	48,000	48,000	48,000
4. <u>Training Unit of FPSTC</u> (basic and refresher courses)						
i) Project Manager	576	113	116	117	115	115
ii) Supervisors	1,167	226	243	233	234	231
iii) Office Assistant/ Accountant	242	48	48	48	49	49
iv) Field Workers/Village Organizers	1,084	294	238	130	212	210
v) Community Volunteers	2,047	106	281	834	413	413
vi) Board Members	500	100	100	100	100	100
vii) Program Officers/ Project Managers(TOT)	250	50	50	50	50	50
5. <u>NGO staff to be trained</u> <u>in CNFP (basic and refresher</u> <u>courses)</u>						
i) Field Workers	772	47	181	246	152	146
6. <u>Meeting & workshop</u>						
FPCVO meetings	10	2	2	2	2	2
Divisional workshop	4	1	1	1	1	-
Project Coordinator workshop	20	4	4	4	4	4



**Amendment of
Cooperative Agreement
No.388-0071-A-00-9119**



**Association for Voluntary Surgical Contraception
(AVSC)
Dhaka, Bangladesh**



I. PROGRAM DESCRIPTION:

Voluntary sterilization has been a prominent component of the national family planning program since the mid-1960's. Beginning in the mid-1970's annual voluntary sterilization performance continuously increased peaking in 1983/84 at 552,167. Since then, however, performance has declined. By 1990/91 the number of sterilizations performed had dropped to 165,300, the lowest number since 1979/80. Likewise for IUDs, the number of insertions has fallen substantially in recent years. Meanwhile, contraceptive prevalence has gradually risen, from 7.7% in 1975 to nearly 40% in 1991 with most of the rise taken up by the increased use of other temporary methods of contraception especially oral contraceptives, injectables, and condoms.

While there is agreement that the increase in the availability and use of temporary methods is a very positive and welcome development in a program which had previously emphasized permanent methods, the GOB nevertheless views the decline in voluntary sterilization and IUD performance with considerable concern. In both its Third Five Year Plan (1985 to 1990) and Fourth Five Year Plan (1990 to 1995), the GOB set ambitious goals for increasing contraceptive prevalence. The latest plan, for example, sets the goal of increasing CPR from 40 to 50%. During all years thus far under the two plans, the sterilizations and IUDs actually performed has fallen far short of the numbers originally projected for achieving the goals of the national family planning program.

The GOB has shown considerable commitment to improving the quality of services in its family planning program. For example, in the early 1980's it investigated a sudden increase in mortalities associated with sterilization and as a result promptly introduced a new anesthesia regimen in the program and retrained doctors when the cause of the mortalities was determined to be associated with anesthesia overdoses. In 1983 it established field surveillance teams to monitor sterilization services, and in 1986 the purview of these teams was expanded to all clinical contraception services and they became known as the Family Planning Clinical Surveillance Teams (FPCSTs). As a result of such attention to medical quality, national sterilization mortality rates dropped dramatically in the 1980's to levels well below the internationally expected levels. Unfortunately, deaths have risen again and all involved in the delivery of VSC are seeking solutions to problems in quality of care.

The GOB has also responded positively to concerns about quality in the nonmedical area, such as with voluntarism and informed choice in decision-making of family planning clients. For example, in the late 1980's it eliminated fixed targets for field workers and per case payments to referral agents, and it worked to make temporary methods more easily available so as to give clients effective choice with a variety of other methods. In this regard, the program has been quite successful.

These strategic issues of expanded coverage and quality services set the framework for AVSC's program in Bangladesh.

The purpose of AVSC's work in Bangladesh is to assist the Government establish a capacity within the National Family Planning Program to improve quality, expand accessibility, and foster program sustainability of highly effective clinical contraceptive methods. As such AVSC will continue to work with its present portfolio of NGOs, the Ministry of Health and Family Welfare (MOHFW), and other



GOB and private sector agencies. Under its Fourth Five-Year Plan (FFYP), the Government of Bangladesh has set forth goals to increase contraceptive prevalence from 40 percent in 1990 to 50 percent by 1995. It also hopes to increase the proportion of all FP acceptors who use clinical methods from 42 to 55 percent over this period. By focusing on improved quality of care and expanding accessibility of clinical contraceptive services, the technical assistance programs managed and implemented by AVSC in Bangladesh are strategically designed to support the Government achieve its objectives for the FFYP (1990-1995).

The findings of a recent Voluntary Surgical Contraception (VSC) service delivery and training needs assessment of the Bangladesh National Family Planning Program (conducted in April 1992 by a team of Government officials and AVSC staff and consultants), and earlier discussions between Government and AVSC staff, have contributed to the development of AVSC's proposed program of technical and financial assistance. The assessment helped establish priorities, specific objectives and plans to develop VSC service delivery and training programs for both public and private sector agencies. These are outlined below as sub-agreement proposals.

AVSC plans to phase in, as well as phase out, varying levels of support over the next five year period with a series of inter-related short and long-term programmatic interventions. AVSC's proposed program of technical support will concentrate on three areas: Improved Quality Assurance, Expanding Accessibility for Clinical Contraceptive Service Delivery, and Sustainability of related program inputs. A list of these programs, as well as a description of the program activities is given below. The AVSC portfolio of projects will have close inter-relationships to ensure success and future program sustainability.

A. QUALITY ASSURANCE:

A-1: Develop a Decentralized and Sustainable Male and Female Sterilization Training Program [for Comprehensive and Refresher Training] Institutionalized Within the Government System [BGD-47-TR-2-B]:

- Continue to implement the NIPORT Project (BGD-47-TR-1-B) until it terminates on December 1992 which is the first phase of a project to institutionalize in-service training of Government physicians in Voluntary Sterilization as well as to expose them to other clinical methods such as IUDs and potentially Norplant. This project when completed will train, a total of 10 VSC trainers from 5 GOB facilities will be trained at the Mohammadpur Fertility Services and Training Center (MFSTC). These trainers will in turn train 105 GOB physicians to provide male and female sterilization services.
- In the second phase of this program (BGD-47-TR-2-B), it is planned that another group of 14 VSC trainers will be trained from an additional 7 GOB facilities which will serve as MOHFW's Comprehensive and Refresher VSC Training Centers. A total of 1,320 GOB physicians will be trained to provide clinical services. It is expected that this cadre of physicians [mostly MO/MCH, but also including AD/CC, MO/CC, and other district level clinicians] will be able to provide approximately 250,000-300,000 sterilizations annually. A total of 26,880 sterilizations will be performed during the actual practical training sessions for these GOB physicians. (Years I - III)



- Prior to the end of the second phase (BGD-47-TR-2-B), an evaluation of the project will take place to determine the extent to which the MOHFW has developed a capacity to institutionalize VSC training, for physicians, within its own existing infra-structure. The MOHFW and AVSC will then jointly decide the level of future technical and financial support needed, from AVSC and other interested parties, to ensure that quality VSC training can be sustained once external assistance is withdrawn. (Year - III)

A-2: Develop a Sustainable Refresher IUD, Injectable and FP Counseling Training Program for Paramedics and a Complementary Clinic Management Program for Clinic Supervisors/Directors in the NGO Sector [BGD 45-TR-2-B & BGD-45-TR-3-B]:

- Continue to implement the CA-NGO Paramedics Training Project [BGD-45-TR-1-B] until it ends on 31 December 1992. It is the first phase of a longer term project to institutionalize in-service training for paramedics in IUD, Injectable and FP Counseling. A secondary, but equally important, objective of this program is to train clinic supervisors/directors to manage clinic resources to better serve the needs of both service providers and prospective clients. During the first phase of this twelve month project, it is planned that 22 Clinical Master Trainers (CMTs) will be trained. These individuals will in turn train a total of approximately 100 paramedics working in USAID CA-NGO clinics in IUD, Injectable, and FP Counseling. In addition the CMTs will have trained approximately 100 clinic managers from the same facilities.
- In the second phase of this program (BGD-45-TR-2-B) it is planned that an additional 4 CMTs will be trained. This group, along with the former CMTs, will train 630 paramedics from the USAID CA-NGO clinics and an additional 300 clinic managers. By September 1995 it is expected that AVSC and the other USAID Cooperating Agencies will have developed a sustainable internal capacity to continue regular in-service refresher training for the paramedics and clinic supervisors employed by the NGO clinics they support. (Years I-III)
- In the third phase (October 1995-September 1997) of this program (BGD-45-TR-3-B) AVSC plans to replicate this paramedic/clinic manager training model for other NGOs who have expressed interest, but who are not part of the USAID CA-NGO group participating in the first two phases. These will all be NGOs that do not provide abortion or abortion-related services. A total of 175 paramedics will receive refresher training in IUD, Injectable, and FP Counseling. An additional 50 clinic supervisors/directors will receive training in clinic management. During the actual training sessions up to 4,025 IUD, 2,415 Injectable, and 2,415 FP Counseling Services will be performed by the NGO paramedic trainees.(Years IV-V)
- It is expected that this training program will improve IUD insertion techniques: reduce infections, complications, and unnecessary adverse side effects, as well as provide comprehensive FP counseling to clients. Another expected outcome is a substantial increase in the acceptability of effective clinical contraceptive services from the NGO sector. Upon completion of the training program, it is estimated that as a group the paramedic trainees will provide a total of 400,000 to 500,000 IUD, Injectable, and FP Counseling Services annually.



- It is expected that the CA-NGO Paramedic Refresher IUD, Injectable, and FP Counseling Training Project will also serve as a model for new GOB initiatives such as the USAID supported "Satellite Clinic Program". AVSC staff, and CMT trainers, will provide technical assistance as required to the Directorate of Family Planning in TOT and other relevant curricula development, TOT training technology, and infection control/OT management.

A-3 Provide Both Immediate and Long-Term Technical Assistance in Developing, and Periodically Revising, FP/VSC Service Delivery Standards, Manuals, and Training Curricula for the National FP Program [BGD-49-TR-1-B]:

- **Phase I:** Review and revise the program's outdated clinical contraception guidelines with an appropriate committee of trainers, service providers, and technical staff from AVSC and other relevant agencies. This phase includes the following steps: (Year - I)
 - Review and finalize the guidelines for all clinical contraception (i.e. Sterilization, IUDs, injectables, and Norplant) and temporary FP methods (i.e. oral contraceptives and condoms) offered in the Government program.
 - Print revised guidelines in Bangla.
 - Distribute Bangla version of revised guidelines to all service providers (i.e. physicians, nurses, FWVs).
 - Integrate and use revised guidelines in all training curricula and FPCST activities.
- **Phase II:** Reorient service delivery personnel to revised standards in district level workshops. This could be done in connection with the workshops for the introduction of on-site infection control, VSC training and supervision in the 12 districts/72 upazilas/ 360 unions which AVSC will focus its technical assistance during the October 1992-September 1995 time period. (Year I-II)
- **Phase III:** Review guidelines every twelve months using findings from training, trainee follow-up, and FPCST reports. Revise and redistribute up-dated guidelines at two-three year intervals (e.g. approximately September 1994, September 1996 and August 1997). (Years II - V)

A-4. Develop a Program of On-going Technical Assistance to the Directorate of FP to Establish a Strategy to Improve Infection Control, Regular Supervision, and In-Service On-Site VSC Training for District, Upazila, and Union Level Supervisors and Service Providers [BGD-48-TR-1-B]:

- There are several inter-related components in this planned pilot project (BGD-48-TR-1-B) which will serve as a model for the Directorate of FP to implement nationwide. During the period October 1992-September 1995 AVSC, through its medical staff and a team of VSC specialist consultants, will provide technical and financial assistance for supportive supervision, practical problem solving, and the provision of on-site refresher VSC training, OT management, and infection control guidance to facilities and individuals located in the 12 districts [and



corresponding 72 upazilas, and 360 unions] which have been identified as the sites where NIPORT (i.e. under the BGD-47-TR-2-B) will establish Comprehensive and Refresher VSC Training Centers. These select districts will simultaneously make qualitative improvements in their respective supervision, on-site follow-up VSC training, and infection control capabilities to ensure that all district/upazila level VSC supervisors and their respective service providers [through the union level] receive the orientation and skills to manage and/or provide appropriate clinical contraceptive services. It is expected that the following inputs and program activities will directly impact on a substantial increase in both accessibility and acceptability of high quality clinical contraceptive services for prospective clients. (Years I - III)

● Support to Existing Family Planning Clinical Supervision Teams

Phase I: Time-Frame: 6 months [January-June 1993]: (Years II)

- Conduct a 2 week contraceptive technology and skills up-date training session for the 8 physicians and 8 nurses who comprise the FPCST teams.
- Develop an on-site VSC training curriculum for service providers.
- Develop an on-site FPCST Supervision Manual.
- Conduct Comprehensive and/or Refresher VSC Training for all FPCST team members which will also be part of a larger Training of Trainers (TOT) exercise to ensure that FPCST team members are capable of providing appropriate and supportive on-site VSC training/supervision to GOB service providers.

Phase-II: Time-Frame: 27 months [July 1993-September 1995]: (Year II-IV)

- Conduct joint AVSC/FPCST on-site visits to district/upazila/union level MOHFW facilities to develop model in-service training/ supervision strategies which can be replicated in other districts.
- Conduct VSC technology up-date courses for the 8 FPCST teams every 18 months.

● Assist in the Development of Infection Control Strategies and Programs for the National Family Planning Program.

Phase-I: Time-Frame: 6-12 months [October 1992-September-1993] (Year I)

- Conduct a comprehensive assessment of infection control practices for clinical contraception service delivery [This exercise may be conducted as part of the Situational Analysis scheduled for the same 12 districts mentioned below in the Sustainability Section.]
- Conduct national and district level workshops to develop a strategy to address needs.



- Compile baseline data to gauge progress with assistance from international and local infection control specialists.
- Adapt the infection control guidelines, materials, and curricula available from WHO, INTRAH and JHPIEGO for Bangladesh.
- Conduct Infection Control technology update workshops for key trainers of physicians, surgical teams, FWVs, and FPCST teams.

Phase II: Short- and long-term implementation steps are designed to integrate new Infection Control guidelines, materials, and systems into existing service, training and supervisory systems. (Years I - III)

- The plan is to conduct district-level orientations to new guidelines for all 12 Deputy District Family Planning Officers (DDFP), 12 Assistant Deputy Clinical Contraception Officers (AD/CC), and 12 Medical Officers Clinical Contraception (MO/CC) at the district level; 72 Medical Officers for Maternal and Child Health (MO-MCH), 72 Upazila Family Planning Officers (UFPO), 72 Assistant Upazila Family Planning Officers (AUFPO), 72 Senior FWVs and 72 FWVs stationed at the upazila level/UHC; and for 360 FWVs and 360 Medical Assistants (MA) at the union level/FWC; 3600 Family Welfare Assistants (FWAs) working at the ward/village level in the 12 districts designated as the project intervention area [Time-frame: 6 months].
 - Incorporate and use guidelines in curricula in all pre- and in-service training programs of physicians, nurses, and FWVs; and in the supervisory protocols of the FPCST teams. (Time-frame: starting from Phase II and continuing)
 - Evaluate changed practices and impact after two years, and after four years.
 - Adjust the program based on evaluation results. [Time-frame: soon after contraceptive technology update]
- **Assist in the Development of On-Site VSC Refresher Training for all Clinical Contraceptive Service Providers at the District, Upazila and Union Level: Years I-III.**
- **Phase I:** The plan is that all AD/CCs, from the 12 districts participating in the NIPORT BGD-47-TR-2-B Project will be trained as VSC trainers and supervisors for their respective district.
 - **Phase II:** AVSC medical staff and VSC specialist consultants, along with the AD/CCs [and at times with FPCST teams] plan to establish a regular schedule of joint on-site training visits to MOHFW facilities in these 12 districts.
 - Using the On-Site VSC Supervision Manual the joint teams will provide training to DDFPs, MO/CCs, UFPOs, AUFPOs, and senior FWVs to provide routine administrative and technical supervision to clinical contraceptive service providers. This will consist of formal VSC follow-up training to the MO/MCHs who received VSC training through the NIPORT-BGD-47-TR-2-B Project and a special refresher IUD, Injectable, and FP Counseling training program for FWVs at the upazila level and FWVs and MAs at the



union level. To accomplish the latter goal, AVSC will either arrange for the 72 upazila level senior FWVs to receive training as Clinical Master Trainers (CMTs) as part of the BGD-45-TR-2-B Project; or it will provide special training to this category of service providers/supervisors entirely as part of the BGD-48-TR-1-B Project. These activities will be conducted wherever possible in coordination with the Satellite Clinic Project.

AVSC's technical assistance will also address the following issues in the MOHFW Program:

- the need to improve all physical facilities [i.e Operation Theaters] where clinical contraception services are being delivered in the project intervention area;
- the need for closer coordination between the Health and Family Planning "wings" and their respective staff at all levels within the project intervention area;
- the need to develop a sense of local commitment and involvement in the program by engaging personnel at all levels in VSC/FP issues identification and problem solving, and to develop skills and job of personnel;
- the need to develop and maintain model service delivery standards in all service sites in the project intervention area so that they can serve as examples for trainees;
- the need for improvement in the GOB and NGO client referral systems through on-site refresher training of FWVs, FWAs, and other staff. Special attention will focus on making better utilization of the up to 3,600 FWAs working in the project intervention area who can be trained to motivate potential clients for clinical contraceptive services at union and upazila level GOB facilities; and,
- the need to develop effective mechanisms to utilize MIS and clinic records/data at the local level.

By integrating several different components into this project initiative [in the select 12 districts, 72 upazilas and approximately 360 unions], AVSC will assist the MOHFW to test and evolve on-site refresher training, supervision, and infection control standards which can serve as empirical models to improve the overall quality of service delivery throughout the project intervention area. Project strategies will also provide an opportunity for the MOHFW program to fit the components of the local program together into a harmonious working whole. This strategy is expected to yield better performance by service providers, more clients choosing effective contraceptive methods, and overall higher quality of VSC/FP service delivery. Since these 12 districts will contain the facilities designated to serve as national VSC Training Centers the proposed inputs and activities will help to ensure a proper caseload, as well as provide an opportunity for trainees to observe and serve clients in an appropriate environment. The lessons learned from this pilot district/upazila/union project initiative can be replicated for the National Family Planning Program. It should be mentioned that some of the facilities in the project intervention area already contain inputs from MDU, UIP, FPCST, and the proposed "Satellite Clinic Project". Thus there will be opportunities for program re-enforcement and effective utilization of project resources.



A-5. Develop a Program for the Introduction of Family Planning Counseling into the National FP Program [BGD-18-IE-1-B]: (Years II-III)

Phase I: Conduct a counseling assessment and program development exercise.

- Develop standards, curricula, and materials at national and divisional level workshops (Time-frame: Year II)

Phase II: Conduct pilot projects in selected areas to test counseling systems and materials. (Time-frame: Year II and III)

Phase III: Integrate family planning counseling into pre-service and in-service training curricula and programs for doctors, nurses, FWVs, FWAs, and other fieldworkers. This activity will be conducted in coordination with JHUPCS, the other CAs, NIPORT, and the Satellite Clinic Project. (Time-frame: Year II, III and beyond)

A-6. Support the Development of Clinical Contraceptive Method-Specific Information/ Educational Materials for Service Providers and Prospective Clients [BGD-16-IE-1-B]: (Years II-III)

Phase I: Assess needs and develop a program in collaboration with service providers. This project in all its phases may be closely coordinated with the FP Counseling Project outlined in A-5 above. (Year II)

Phase II: With technical, and some financial, assistance from AVSC, it is anticipated that JHUPCS will develop and pretest information and educational materials and conduct IEC activities in selected areas. (Year II)

Phase III: AVSC will assist with the dissemination of materials developed in Phase II and integrate those into all appropriate training curricula and service delivery programs. (Year II and III)

AVSC will work in collaboration with the JHUPCS and FPAB. AVSC's work in IEC will be contingent on the outcome of the national IEC strategy.



B. EXPANDING ACCESSIBILITY FOR CLINICAL CONTRACEPTIVE METHODS IN THE PUBLIC AND PRIVATE SECTOR OF THE NATIONAL FAMILY PLANNING PROGRAM: (Years I-III)

B-1: Continue to Introduce New [e.g. the No-Scalpel Vasectomy and perhaps Norplant] as well as to More Effectively Utilize Existing Clinical Contraceptive Technologies [e.g. IUDS and Injectables] in Government and Private Sector Service Delivery Sites:

- AVSC plan to continue to provide technical and financial assistance to five public and private sector institutions in order to integrate high quality and sustainable clinical contraceptive services into their larger comprehensive health and family planning service delivery programs. Each of the five projects, listed below, will comprise a final 24 month extension [i.e. October 1992-September 1994] of AVSC support. By that point in time it is expected that all AVSC inputs will lead to continued programmatic, administrative, and financial sustainability for on-going VSC service delivery and training activities. The continuing projects include:
 - The Badda Self-Help Center BGD-40-SV-2-B Project:
 - The World Vision of Bangladesh BGD-41-SV-2-B Project:
 - The Combined Military Hospitals BGD-42-SV-2-B Project:
 - The Kumudini Hospital BGD-43-SV-2-B Project:
 - The Chittagong Port Authority Hospital BGD-44-SV-2-B Project:
- Annex IIB provides a complete breakdown of the numbers of service providers who will be trained and the numbers of clients who will obtain clinical contraceptive services from these facilities. Over the next 24 month period a total of 45 physicians will be trained in No-scalpel Vasectomy and Mini-laparotomy procedures; 28 paramedics will be trained in IUD, Injectable, and FP Counseling; and 42 FP Counselors or FP Educators/Motivators will be trained in FP Counseling. This training will similarly lead to the provision of 3,690 No-scalpel Vasectomies and 4,210 Mini-laparotomies; 6,130 IUDs; 24,900 Injectables; 24,270 oral pill users; and 67,600 FP Counseling services provided by the these five institutions during their project life-times. (Years I and II)

B-2: The Expansion of Clinical Service Delivery into NGO or Private Sector Facilities [BGD-52-SV-1-2]; (Years III-V)

- AVSC will, starting in the third year of the Cooperative Agreement Amendment [i.e. after October 1994], plan to identify new private sector organizations in which to either introduce or expand the range of new clinical contraceptive technologies. These services will include No-scalpel Vasectomy, IUDs, and Injectables; and for facilities which meet clearly defined criteria, Mini-laparotomy and even Norplant services may be added.



- A total of four new sites will be identified for the introduction or expansion of select clinical contraception services annually. The BGD-52-SV-1-B Project will provide technical assistance to train physicians, paramedics, and FP counselors. Financial assistance will be provided for minor renovations of Operation Theaters, the procurement of Medical and Audio Visual Equipment, and the procurement of appropriate IEC materials. AVSC will not pay any recurrent costs [i.e. salaries, rents, or utilities] during its period of support.
- A total of 12 institutions will be up-graded to provide high quality VSC services. A total of 12 physicians, 12 paramedics, 12 FP Counselors and 60 Educators/Motivators will receive training in the provision of VSC service delivery. This training will subsequently lead to 1,400 No-scalpel Vasectomies, 3,600 Mini-laparotomies, 7,200 IUDs, and 14,000 Injectables being provided in these facilities during the period of AVSC technical assistance and support.

B-3: The Introduction of Select Clinical Contraception Services into Private Sector Clinics on a Fee for Service Basis [BGD-51-SV-1-B]: (Years III-V)

- AVSC plans to start, in the third year of the Cooperative Agreement Amendment [i.e. after September 1994], annually identifies five private clinics from each of the four administrative divisions, to introduce select clinical contraceptive services which clients will pay for on a fee-for-service basis. At the present time there are many private Ob.-Gyn. and Urological clinics which provide high quality medical care for fees. AVSC would like to make use of these clinics by testing a privatization modality which will assess whether a certain segment of society is willing to pay for high quality family planning services. At the present time most private Ob-Gyb. or Urological clinics refer clients interested in Vasectomy, Mini-laparotomy, IUD and Norplant services to the Medical College Model Clinics.
- AVSC will try to promote the provision of select clinical contraceptive services by annually identifying a total of five new clinics in each of the four divisions, to test a "privatization" modality aimed at increasing the accessibility, acceptability, and sustainability of these elective procedures.
- AVSC will conduct annual clinical contraception technology workshops in each of the four administrative divisions, for members of the Bangladesh Private Practitioners Association and other accredited organizations. Quality assurance monitoring will be done through these organizations with active assistance from AVSC.
- The BGD-51-SV-1-B Project will provide technical assistance to train Ob-Gyn. and Urology Surgeons to perform No-scalpel Vasectomies, IUDs, and Norplant procedures. Financial assistance will be provided for the procurement of NSV and IUD Insertion instruments, minor surgical supplies, and IEC materials.
- A total of 60 clinics will participate in this program. It is anticipated that Urology clinics will send physicians interested in learning how to perform the No-scalpel Vasectomy technique, while Ob-Gyn. clinics will send physicians interested in Norplant and/or IUD insertion.



- A total of 6,000 No-scalpel Vasectomies, 24,000 IUDs, and 6,000 Norplant procedures should be performed during the project life-time. If successful AVSC anticipates that many more private practitioners will express interest in receiving training to provide clinical contraception services on a fee-for-service basis.



B-4: Develop a Sterilization Reversal Capacity in the National Family Planning Program of Bangladesh [BGD-50-SV-1-B]: (Years II-IV)

Phase I: Conduct a comprehensive assessment of reversal services needs and capacity in Bangladesh, and develop a project for training selected expert surgeons and up-grading equipment and facilities, as may be required. (Time-frame: October-November 1993).

AVSC expects to support the development of 2 existing institutions [BGD-50-SV-1-B] to provide sterilization reversal services. At the present time the IPGMR and the Dhaka Cantonment Combined Military Hospital have individuals who have received training and are already performing sterilization reversal services on a limited basis. A needs assessment consultant will review the level of need for reversal, whether these two sites should up-grade their current capabilities by training a "second generation" of microsurgeons, or whether the MOHFW should perhaps identify new institutions outside of Dhaka that can develop a capacity to provide sterilization reversal services.

The MOHFW would like to introduce or up-grade its capacity to provide sterilization reversal services to appropriate couples. This Government decision takes into consideration several programmatic, cultural, and environmental/natural disaster related factors which act as constraints for interested couples who hesitate to accept sterilization as a safe and effective means of limiting fertility.

Phase II: Conduct international training for selected microsurgeons, procure and install equipment, follow up and provide on-site technical assistance to up to 4 microsurgeons. It is estimated that these microsurgeons will provide 960 sterilization reversal operations during the project life-time. (Year II-Year V)

- Equipment and training for microsurgery is expensive as this is a specialized field.



C. SUSTAINABILITY:

C-1: Conduct a Situation Analysis to Identify the Status of the National Family Planning Service Delivery System [BGD-15-SV-1-B]: (Year I)

- Plan and conduct a situation analysis with a local operations research firm and with active participation of Family Planning Directorate personnel. AVSC would take an active part in the planning of this situation analysis but it is assumed that the Population Council will provide technical assistance as required.
- Immediate use of the results in the 12 districts, 72 upazilas and 360 unions which will receive technical and financial assistance from AVSC as part of activities described in Sections A-1, A-4, A-5, A-6. This would allow the Directorate of FP, FPCST teams, and AVSC medical staff and VSC consultants to experiment with modalities aimed at improving the delivery of clinical contraception services.

C-2: Develop Long-Term Programmatic Sustainability for all VSC Programs and Activities Which AVSC Will Support During the Cooperative Agreement Amendment Time Period: (Years I-V)

The foundation of the entire AVSC program over the next five years rests upon the concept of program sustainability. AVSC will primarily be working with public sector programs of the Government of Bangladesh. By concentrating its efforts on training service providers to provide high quality VSC services and district/upazila level supervisors to conduct regular on-site refresher training, infection control and OT management team training sessions, the AVSC technical component will contribute to improved quality of care and expanded accessibility for on-going clinical contraception programs. AVSC will support the FPCST teams and other existing training institutes to develop practical supportive supervision and training programs to which the Government of Bangladesh is fully committed. AVSC expects to phase out most of its financial support to the programs described in Section A-1, A-4, A-4, A-5, and A-6 within the first three years of the Cooperative Agreement Amendment [i.e. September 1995]. By that time the MOHFW should have developed its own internal capacity to institutionalize VSC training, infection control, and supportive supervisory modalities into the National Family Planning Program. Any further support from AVSC would primarily be in the provision of technical assistance to refine and expand these to other geographic areas of the nation.

AVSC will also institutionalize program sustainability into its private sector programs and activities. The CA-NGO Paramedics Training Program is designed to establish a sustainable IUD, Injectable, and FP Counseling; as well as Clinic Management capacity in all NGOs supported by the USAID Cooperating Agencies by September 1995. At that point AVSC will modify and replicate this training model for other NGO clinics located throughout the country which have expressed interest in, but could not be included in the first two phases of the CA-NGO Paramedic Training Program. These will all be NGOs that do not perform abortion or abortion related services. AVSC will charge "tuition fees" for trainees during the third phase of this IUD, Injectable, and FP Counseling training initiative for the NGO/private sector.



AVSC will also phase out all technical and financial support to the five public and private sector institutions it is now supporting. AVSC has already indicated that during the second phase of technical and financial assistance [i.e. October 1992-September 1994], each of its recipients will have to undertake a greater commitment to ensure that project inputs are sustained after external support is withdrawn. In the projects where AVSC provides financial support for project staff salaries and partial rents or utilities, all anticipated increments will be the responsibility of the sub-grantee. The private sector sub-grantees [i.e. Badda, World Vision, and Kumudini Hospital] have also agreed to absorb all essential project staff by the end of the final 24 month project life-time. The public sector sub-grantees [the Combined Military Hospitals and the Chittagong Port Authority Hospital] cannot guarantee that project staff will be absorbed into the Government system once AVSC financial support is withdrawn. However they have agreed to allocate sufficient resources to ensure program continuity within their facilities.

AVSC proposed plans to introduce, or expand, VSC services into existing NGOs or private sector institutions [e.g. maternity hospitals] will from project inception rely upon a financial commitment from the interested service delivery sites to assume all recurrent costs. AVSC will only provide technical assistance for training service providers and financial resources to up-grade facilities to provide VSC services. AVSC will also assist in the procurement of surgical, medical, and audio-visual equipment; as well as in the purchase of appropriate IEC materials. It is expected that all AVSC support to any new private sector recipient will terminate within a 18-36 month period.

AVSC will also introduce modalities to assess the demand for high quality VSC services in private Ob.-Gyn. and Urology clinics. AVSC will not provide financial resources to pay for recurrent costs, such as salaries, rents, or utilities. It will focus technical assistance on training physicians, and perhaps other categories of medical practitioners. AVSC's financial resources will be used primarily to conduct periodic workshops for private sector practitioners and to procure essential surgical and medical equipment and IEC materials.

AVSC will also routinely provide technical assistance for its sub-grantees in:

- management of service delivery;
- record keeping;
- client information;
- referral;
- counseling;
- coordination with local family planning personnel; and,
- other components of good quality service delivery.

A guiding principal for all AVSC assistance is that technical and financial support, for both the public and private sector, will be phased out and finally withdrawn as soon as the organization has an established and functioning program with appropriate volume and good quality. This should occur within 36 months. (Years I-V)



D. FUNCTIONAL SPECIALIZATION

AVSC's functional specialization is in quality assurance and its program is to develop a sustainable refresher IUD, injectable and FP counseling training program for paramedics and a complementary clinic management program for clinic supervisors/directors in the NGO sector. (This specialty is explained in A-2 above.)

Quantifiable outputs of the projects mentioned above are given in the subsequent table.

AMENDMENT PROPOSAL

FAMILY PLANNING ASSOCIATION OF BANGLADESH

Cooperative Agreement No-388-0071-A-00-9109

(FY 93 — FY 97)

Submitted to

USAID/Bangladesh

Office of Population and Health

Dhaka, Bangladesh

by

Family Planning Association of Bangladesh (FPAB)

2 Naya Paltan, Dhaka-1000

Bangladesh

May 17, 1992

I. PROGRAM DESCRIPTION

FPAB plans to undertake the following activities with USAID funding during the next 5 years to achieve the desired objective through the implementation of the under mentioned sub projects and functional speciality.

- i. Use of Voluntary Agencies in Population Activities (UVAPA).
- ii. Family Planning in garments factories.
- iii. NGO Commodity Distribution Projects
- iv. IEC (Commonality with all CAs)

Activities and Outputs.

A. IMPROVE QUALITY ASSURANCE (QA)

A major thrust of FPAB will be to improve quality assurance throughout the 5 year C. A. FPAB will undertake the following activities :

- * Provide basic training to 400 new volunteers in 100 new project areas to offer quality family planning and IEC services to the project area.
- * Provide high quality refresher training to 800 volunteers in the 200 project areas to augment their knowledge and skills for the promotion of family planning.
- * Provide basic training to 200 group leaders, 100 from on going projects and 100 from new areas, to equip them with high quality supervisory techniques. Each group leader supervises about four volunteers.
- * Provide refresher training to 200 group leaders to augment their knowledge and skills for the promotion of quality family planning and supervisory techniques.
- * Provide TOT Staff Development Training to 25 Field Officers to augment their skills in quality assurance and program management. Each Field Officer is responsible for 50 Field Workers and provides supervision and support to these workers.
- * Provide logistics management training to 21 store assistants to meet adequate supply situation and project management for quality assurance. This support is also provided to the other CA/NGOs.
- * Provide staff development training to 10 National Office Staff on their respective fields in the areas of program management, Population program, MIS, Financial Management and Logistics Management.
- * Provide basic training to 30 field Assistants and 10 paramedics on project orientation, family planning methods, contraceptive technology, side effects, contradiction and IEC.
- * Procure quality assurance manual and orient 25 Field Officers in quality assurance manual in a two day workshop in year I. These Field Officers will in turn orient group leaders/field workers on the quality assurance manual in subsequent project years.
- * Develop in collaboration with JHU experts quality and appropriate IEC materials keeping in view the IEC strategy scheduled to be developed by the end of August 92. These IEC materials include production of films, video cassettes, print materials. Appropriate emphasis will be given to the needs of the special groups, youth, women, and specific communities. (More details will be provided on FPAB's role in IEC in section I.D.)
- * Provide quality and appropriate IEC back up support including in country training of five IEC personnel on IEC quality assurance.

- * Provide quality family planning services to 231,120 new users and 183,000 active users (per USAID definitions of new and active users) on temporary methods and 56,900 in clinical methods and refer 62,160 clients for clinical methods to bridge the gap between awareness and acceptance level. Ensure that all clients receive follow-up care that reinforces proper use, client understanding of temporary side effects and warning signs, and client knowledge of where to go in the event of a serious side effect. (Definition of new user/active user as per USAID definition).
- * Test and introduce appropriate quality of care guidelines/indicators into program supervision, reporting, and monitoring forms into computerized and non-computerized management information system (MIS).
- * To minimize dropout rate, provide continuous QA screening, counselling, follow-up of all methods.
- * Conduct mid term evaluation of the projects to ensure that quality programs are being delivered and desired goals are achieved.
- * Seek technical Assistance from and continue to provide clinical training through CMTs for clinical staff who will provide backup support on the side effects of contraceptive.
- * Extend infrastructural support for govt. doctors with the assistance from AVSC and other USAID contractors.
- * Collaborate with coordinating CA in conducting OR which will identify issues and interventions for further improvement of Quality service delivery.

B. EXPAND COVERAGE

Between 1993 and 1997, FPAB activities will focus on expanding coverage to the underserved and unserved areas of Bangladesh, specifically through establishment of new voluntary agencies in the low CPR areas of Chittagong and development of family planning services targetted to garment industry workers in Dhaka, Narayanganj and Chittagong. This strategy is based on FPAB's long experience working with industrial and organized sectors, and in recognition of the fact that female factory workers are a growing segment of the female population. FPAB is well qualified to undertake this activity, having 12 years' experience working in the urban slum areas where these factories are located, and with a well established volunteer base which has better coordination and influence with the owners of these factories. In addition, FPAB already has clinics located in the garment areas.

In the next five years, FPAB will undertake the following activities :

- * Extend family planning services to 433,600 eligible couples (UVAPA and garments projects) and recruit 231,120 new clients, 239,900 active users on all method 183,000 on temporary (method and 56,900 in clinical methods) and refer 62,160 clients for clinical methods to narrow the gap between, awareness and practice level.
- * Expand geographical coverage mainly in Chittagong Division and other underserved and unserved areas in Bangladesh, through the involvement of 200 local level NGOs under the UVAPA project (100 of which will be in new project areas).
- * Expand family planning services to 150 garment factories with approximately 14,900 users.
- * Coordinate the IEC activities of USAID CAs and implement NGO IEC strategy recommendations being conducted by JHU.
- * Increase and expand management capability of head quarter personnel, mid level managers and field level personnel.
- * Extend services to meet the needs of special groups including women and young, low parity couples.

- I. As gradual phase out of UVAPA Project from the old and saturated area takes place, it is expected that the family planning program will be taken over by Govt. or other NGO representatives. At the same time, the existance of trained community volunteers in the project areas will contribute to program sustainability. The plans for phase out and replication of these projects in the new areas are shown as follows :

	Phase out	Replication in the unserved/low CPR areas
1992—93	25	25
1993—94	25	25
1994—95	25	25
1995—96	25	25
1996—97	25	—
Total	125	100

- II. The expansion of Garments project for five years are planned as follows :

1992—93	1993—94	1994—95	1995—96	1996—97	Total
30	30	30	30	30	150

OUTPUT TABLE

	5 Year Total	1 year	2 year	3 year	4 year	5 year
ELCO Coverage	433,600	411,200	422,400	433,600	433,600	436,600
Active Users	#	#	#	#	#	#
Non Clinical Methods	183,000	141,700	149,400	157,600	170,600	183,000
Clinical Methods	56,900	40,170	25,520	36,000	46,450	56,900
New Users	231,120	49,800	50,880	45,600	45,600	39,240
Referrals	62,160	12,180	12,360	12,540	12,540	12,540
MCH visits/services Immunizations						
Training						
Volunteers Trained						
Basic	400	100	100	100	100	x
Refresher	800	x	600	x	200	x
Group Leaders trained						
Basic	200	200	x	x	x	x
Refresher	200	x	100	x	100	x
Field Officers trained						
Total staff dev.	25	25	x	x	x	x
Refresher	25	x	x	25	x	x
Store Assistants trained	21	x	21	x	x	x
Field Assistants trained						
Basic	30	6	12	12	x	x
Refresher	30	x	x	x	30	x
Paramedics trained						
Basic	10	2	4	4	x	x
Refresher	10	x	x	x	10	x
Community volunteers orientation	250	50	75	75	50	x
Workshop/Garment factory oversee	4	1	1	1	1	x

C. INCREASE SUSTAINABILITY

Through activities that draw upon FPAB's unique experiences, skills, and approach, FPAB seeks to contribute to the overall development and sustainability of the national family program in Bangladesh. In particular, FPAB is committed to offering services of such quality that client demand will be high, and to developing the base of support for family planning in the communities where services are provided, so that these services will be less dependent on the availability of external support. FPAB activities will strengthen sustainability at three levels : program sustainability, institutional/managerial sustainability, and financial sustainability. These are addressed individually below.

i. Program Sustainability

FPAB will work to strengthen the base of support for family planning in the communities and factories in which we work, and to develop linkages with government and other agencies, as appropriate. Specifically, FPAB will :

- * Collaborate with local indigenous voluntary agencies to involve the community in an effort to assist them to manage their own programme after FPAB phase out. Phase out plan has been shown in Section I.B.
- * Hold a one day orientation workshop in Year I (Dhaka and Chittagong), Year II, Year III and Year IV to create awareness among the garment factory owners on the need and health rationale for family planning and its positive impact on the productivity of the industry.
- * Coordinate with Govt/NGO representative for their workers to take over family planning programs from 125 local agencies after FPAB funding has ceased. The agencies will ensure resupply to the clients from the Govt./NGO sources and 250 community volunteer will be provided with one day training throughout the funding period which will contribute to program sustainability.
- * Integrate community volunteers into the activities of FPAB so that they are well acquainted with the programmes and can play an increasing role over time.
- * Improve the efficiency of community FP by funding projects aimed at clients being resupplied from the contraceptive source, rather than door-to-door.
- * Actively participate with Govt. and CAs/NGOs to develop a strategy for currently underserved areas such as Chittagong.

ii. Institutional/Managerial Sustainability

FPAB believes that institutional/managerial sustainability will be promoted through an ongoing effort to develop the skills and capabilities of the indigenous NGOs through which FPAB works. Specially, FPAB will :

- Provide ongoing support to local level NGOs and their members through training in leadership, development and introduction of family planning services, undertaking IEC activities, orienting local community leaders, and income generation.
- Provide basic and refresher training as necessary to volunteers, group leaders, and field officers to strengthen the organizational and management capacity of volunteer agencies. The detailed plan is provided in Annex II (3b detailed output)
- Augment the skills and improve the knowledge of FPAB program and finance personnel by supporting in-country skill development training and/or one to two years graduate level training for the Project Director and four overseas training by Year III, contingent on the outcome of the Training Needs Assessment to be undertaken on behalf of all CAs.

iii. Financial Sustainability :

FPAB has a long tradition of delivering cost-effective family planning services through a vast volunteer network which in turn mobilizes significant community support. This successful project design, characteristic of all of FPAB's USAID funded activities, has and continues to generate resources, both cash and in-kind, as well as leading to cost-savings.

During the next five years, FPAB will continue and expand its successful initiatives for promoting financial sustainability. These efforts are at two levels : at the FPAB organization level and at the level of FPAB-supported sub projects. The activities may be categorized under three headings :

1. Mobilizing cash collection
2. Acquiring land and assets
3. Cost-saving, cost-sharing, and cost-recovery within sub-projects.

Cash Collection

FPAB will continue cash collection through Association membership fees, donations from the Government and individuals, and fund raising. This revenue will contribute to the support of USAID funded projects as well as non-USAID projects. Membership fees are collected from members on an annual or life basis, per FPAB's Constitution. Fund-raising activities (for which seed money is provided by IPPF each year) include annual raffle draws for different district branches, which produce additional funds for program activities.

Acquiring land and assets

FPAB has been very successful in obtaining community contributions in the form of donated land and buildings to support family planning service delivery. Volunteers attached to different district branches seek these donations from private individuals within the local area, and also maintain rapport with district administration to receive Government property at nominal or subsidized rates. This strategy will be continued in the USAID funded UVAPA project in the next five year period.

Cost-saving, Cost-sharing/Cost recovery

In the effort to promote financial sustainability through cost-saving, cost-sharing, and cost-recovery, FPAB will :

- Continue to reimburse only out-of-pocket express for UVAPA volunteers, looking to the local communities to provide salaries, rent, office furniture, etc. as needed to support family planning services. These cost to FPAB are less than one-third of what it costs to support a regular full-time field worker.
- Continue to charge nominal fees for all types of contraceptives. These sales have and will continue to support program costs.
- Continue the concept of MCH cards which have been introduced in all FPAB clinics. MCH card holders pay an initial amount of Tk. 5 as an admission fee and Tk. 1 for subsequent services including family planning. Experience to date has indicated community acceptance of this approach.
- Provide services for which fees can be charged, such as ear and nose pricking, circumcision, pathological testing of blood, urine and stool analyses, pregnancy testing, and prescription services.

Projections of the revenues that will be generated through these illustrative activities are included in Annex III of this proposal.

Further, and in support of the efforts of all CAs in this area, FPAB will document successful and cost-effective community involvement initiatives over the next five year period.

D. FUNCTIONAL SPECIALIZATION

FPAB will undertake functional specialities in the areas of IEC and contraceptive logistics.

i. Information, Education and Communication (IEC)

The need for increasing NGO support towards the national family planing program in Bangladesh has been well established. The Govt. in its planning document has made an explicit statement on the importance of NGO role in achieving the national goal within the planned period. With the increasing demand in different sectors of the family planning program, the Govt. resources are limited to provide IEC support through its own network of services. On

the other hand, most of the NGO programs are engaged in service delivery without having adequate IEC support for their field personnel. There is growing need for appropriate back up IEC support of many kinds for the NGO efforts. With the passage of time, FPAB has acquired considerable expertise and infrastructure for developing pragmatic IEC programs and has augmented the NGO needs in a limited scale. By now, FPAB has distributed its booklets, posters, films and other IEC materials to many NGOs but due to resource constraints it cannot meet the NGO requirement even up to their minimum required level. Recently FPAB organized a workshop on "IEC Strategy Development for FPAB" with 46 participants among which 23 were from different NGOs, donors and Govt. agencies. The workshop concluded that there is a great need for coordinating IEC activities by the NGOs as well as by the Govt. and the participants recommended that FPAB be assigned the responsibility of coordinating the supply of IEC materials for the NGOs. The participants also stressed building upon institutional capacities of FPAB for helping other NGOs in this important aspect of family planning program.

During the FY 92-97 period, FPAB will manage the process by which the FP/IEC strategy will be developed and implemented which will consist of the following steps :

- Identification of common NGO IEC needs.
- Formulation of overall NGO/IEC strategy and submission of detailed budget to USAID for approval.
- Work with skilled IEC experts, both national and international, to meet the common IEC needs of the NGOs (Including development and testing of print materials, audiovisuals and mass media).
- Adaptation of IEC materials for the NGO program.
- Documentation of successes of the CA/NGO program so that lessons may be shared and the Bangladesh contribution recognized.

ii. NGO Contraceptive Distribution Scheme

Objective :

FPAB will take delivery of and distribute 122,102,000 pieces of Condoms, 42,736,000 cycles of Pills, 183,000 pieces of IUDs and 1,526,000 doses of Injectables to the sub-grantees of the Asia Foundation (TAF), Pathfinder International (PI) and to FPAB's own projects funded by USAID. FPAB has had almost ten years of successful experience in this area.

FPAB has trained manpower to procure, store and distribute contraceptives to the appropriate agencies. It has established an MIS in its national office to manage this project. FPAB enjoys an excellent relationship with the GOB logistics and Family Planning warehouse personnel.

During the proposed period FPAB will procure the following contraceptives from TEMO, the Central Warehouse of the Govt. and distribute them to the sub-grantees of the Asia Foundation (TAF), Pathfinder International (PI) and to FPAB's own two CBD projects and factory based program.

Period	Condom (Pieces)	Pill (Cycles)	IUD (Pieces)	Injectables (Doses)
1992—93	20,000,000	7,000,000	30,000	250,000
1993—94	22,000,000	7,700,000	33,000	275,000
1994—95	24,200,000	8,470,000	36,000	302,000
1995—96	26,620,000	9,317,000	40,000	333,000
1996—97	29,282,000	10,249,000	44,000	366,000
Total	122,102,000	42,736,000	183,000	1,526,000

ANNEX 2:

Proposed Scope of Work for Buy-In

Proposed Scope of Work for Buy-In to FPMD -- FY93-FY95
Submitted to USAID/Bangladesh, May 25, 1992

USAID's buy-in to FPMD will support major OPH goals of promoting decentralized family planning services by undertaking program-wide systems development, with particular emphasis on strengthening the USAID-supported CA/NGO program. The FPMD interventions will focus on the development of streamlined procedures for management of the CA/NGO portfolio, management development of CAs and selected NGOs, and systems development at the program level. While activities focused exclusively on the CA/NGO portfolio and those addressing broader program/systems issues are presented separately below, the potential for impact is significantly greater if they are undertaken concurrently.

I. NGO Management Development

A. Development of a Streamlined presentation, review and reporting system:

FPMD will continue to work with USAID and the CA/NGOs to complete the streamlining effort begun earlier. Specifically, FPMD will provide assistance in refining the portfolio/cluster proposal review process and developing a strategic monitoring system which will focus on overall program outputs rather than micro sub-project details.

1. Key indicators/data collection/proposal summary form.
LOE 4 weeks x 2 consultants, 2 airfares, plus interviewers.
(Sept/Oct 1992)

This consultancy will focus on (1) determination of key indicators for monitoring progress toward achievement of the strategic goals of improving quality, expanding services, and promoting sustainability; (2) collection of baseline measures; and (3) finalization of the proposal summary form to include these indicators. Consultants will use a combination of methodologies, which may include focus groups with program managers and service providers, to determine the indicators for quality, expansion, and sustainability. Selection of indicators will be influenced by the quality and importance of the information they provide as well as by the availability of data in the field. Collection of data which will serve as a baseline will be undertaken in collaboration with CAs and with The Population Council or another local research group, and will require the use of local interviewers.

Once indicators have been established, they will define the critical elements of the proposal summary form. Consultants will seek additional input on the draft proposal summary form from OPH and all CAs, and will propose a revised format for the first cluster proposal submission. This form will be one component of a system designed to provide USAID with the key information OPH needs to assist the CAs/NGOs progress towards quality improvements, service expansion and sustainable family planning services, and to measure the impact of these strategies over time.

2. Preparation of portfolios/first cluster approval.
LOE 3 weeks x 3 consultants, 3 airfares. (Nov/Dec 1992)

Consultants will assist the CAs to review their subproject proposals and to extract key information for filling out proposal summary formats. This will involve a review and analysis of the current CA subprojects with respect to their contribution to achievement of strategic goals. In consultation with OPH, consultants will prepare a standardized format for presentation of CA subproject portfolios to USAID for review.

Following preparation of the CA subproject portfolios, consultants will work with OPH to implement the methodology for cluster review of these portfolios, and will develop and initiate work on the "super-portfolio" analysis. Analysis of the "super-portfolio" will include identification of potential linkages with other USAID-supported projects, specifically UIP and SMC, to maximize program impact.

The key indicators determined earlier will serve to identify strategic monitoring priorities. Criteria will be developed for selecting sites for field visits and for implementing the general system of supervision by exception. Once the "super-portfolio" has been reviewed and approved, the team will develop the format for semiannual reports from the CAs to USAID, to include program and financial information, and will introduce this format to the CAs.

3. First semiannual cluster review.
LOE 3 weeks x 3 consultants, 3 airfares. (July 1993)

Consultants will assist OPH with the review of the first batch of CA/NGO reports which arise from the new system. The FPMD team will work with all parties to modify the system as necessary in order to institutionalize the "management by exception" system as part of the streamlined system. This activity will take place approximately 6 months after the first cluster approval.

B. Management Assistance to CAs/NGOs

1. Management reviews.
LOE 2 weeks/organization x 2 consultants/org; total 4 orgs; 8 airfares.

Consultants will undertake management reviews and prepare management development plans for CAs and NGOs in order of priority approximately as follows: FPSTC, FPAB, CWFP, and Swanivar, the latter two to be conducted in collaboration with their funding CA. The team will use standard protocols to review management systems including finance, MIS, allocation of roles and responsibilities, and criteria for decision making regarding subproject termination, extension, or graduation. In collaboration with the leadership of these organizations, the team will propose interventions for specific management improvements which will strengthen their capacity to achieve strategic goals.

2. Technical assistance to 2 organizations.
LOE 3 weeks x 2 consultants x 2 organizations x 4 TA visits/organization, 16 airfares.

Although it is not possible at this time to specify exactly which of the management areas will require the most attention, experience to date indicates that finance, MIS, and planning systems should be targeted. In addition, for FPSTC, additional assistance will be provided in reinforcing training capacities and marketing. The level of effort proposed is an estimate, based on experience which has shown that while technical changes in a particular system can be put in place within a few weeks, several follow-on consultancies are required to assist the organization understand, use and adapt the system improvements.

3. Sustainability analysis.
LOE 4 weeks x 2 consultants, 2 airfares.

This analysis will be focused on the CA/NGO program as a whole. Consultants will review issues of sustainability of NGOs within the national program as well as the institutional and financial sustainability of particular CAs and NGOs. With input from discussions, review of prior studies, and field visits, consultants will propose realistic levels of income generation for NGOs and strategies for reaching these targets, as well as mechanisms for assisting NGOs to achieve management efficiencies. Long term financial plans (strategic budgets) will be developed for selected CAs/NGOs.

II. Population Program Systems Development

The contribution of the CA/NGOs to continuation of effective contraceptive performance of the national program will depend on the efficient operation of the various components of the family planning service delivery and support systems such as logistics, supervision, satellite clinics, and support such as IEC. These need to function in order to ensure the availability of quality service for all forms of contraceptive service at every delivery level. The development of effective systems for the CA/NGO sector, however, can not be addressed in isolation of the two other contributors to service delivery: public and commercial. Therefore, any effort to develop basic systems to support sustained development of the CA/NGO program needs to address all components of the service delivery system.

A. Systems Analysis

FPMD will undertake an analysis of the major systems affecting performance of service delivery elements in USAID's portfolio, e.g. NGO subprojects, UIP projects, and satellite clinics. The major purposes of this systems analysis will be to identify the bottlenecks, causes of inefficiencies, and methods for increasing effectiveness of various mechanisms supporting service delivery, and strategies for strengthening linkages between sectors so as to maximize the comparative advantage of each sector.

1. **Systems Analysis:**
LOE 8 person months, 8 airfares.

Specific Scopes of Work will be prepared in consultation with OPH for methodology preparation, implementation, reporting and review activities related to the systems analysis.

B. Effective Decentralized management of service delivery:

FPMD will assist OPH to apply results of systems analysis to its overall goal of decentralization. FPMD will collaborate with OPH to determine options for input to ensuring feasible, replicable implementation of decentralized planning, management, and evaluation of family planning service delivery. This will involve coordination with other donors. FPMD anticipates activities in regard to the above will involve workshops for BDG family planning officials, donors, CAs/NGOs, related AID projects and collaboration with the Rapid Projects and other projects to develop approaches for effective decentralization and the designation of appropriate roles, functions, and service delivery strategies of the CA/NGO, public and commercial sectors in ensuring an operational decentralized management system.

1. **Decentralized service delivery**
LOE 3 person months, 3 airfares.

Specific Scopes of Work will be prepared in consultation with OPH for methodology preparation, implementation, reporting and review activities related to this activity.

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