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# USAID/BANGLADESH: POPULATION AND FAMILY PLANNING PROGRAM ASSESSMENT

**APRIL 2010**

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## ACRONYMS

ACPR	Associates for Community and Population Research
ADB	Asian Development Bank
AMTSL	Active management of the third stage of labor
ANC	Antenatal care
ARI	Acute respiratory tract infection
BCC	Behavior change communication
BCCP	Bangladesh Center for Communication Programs
BDHS	Bangladesh Demographic and Health Survey
BRAC	Bangladesh Rural Advancement Committee
CHA	Community Health Assistant
CPR	Contraceptive prevalence rate
DFID	Department for International Development
DG	Democracy and Governance
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
ECP	Emergency contraceptive pill
EMOC	Emergency obstetric care
EOP	End of project
EPI	Expanded program of immunization
FFPO	Food for Peace Office
FHA	Female Health Assistant
FP	Family planning
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
GCC	Global climate change
GHI	Global Health Initiative
GOB	Government of Bangladesh
HA	Health Assistant
ICDDR,B	International Center for Diarrheal Disease Research, Bangladesh
IEC	Information, education, and communication
IUD	Intrauterine device
LAPM	Long-acting and permanent methods
MCH	Maternal and child health

MOHFW	Ministry of Health and Family Welfare
MR	Menstrual regulation
MWRA	Married women of reproductive age
NGO	Non-governmental organization
NIPORT	National Institute of Population Research and Training
NPC	National Population Council
NSDP	NGO Service Delivery Program
NSV	No-scalpel vasectomy
OC	Oral contraceptive
ORS	Oral rehydration salts
PNC	Postnatal care
POP	Progestin-only pill
PPFP	Postpartum family planning
PPH	Postpartum hemorrhage
PRICE	Poverty Reduction by Increasing the Competitiveness of Enterprises Project
PSI	Population Services International
RSDP	Rural Service Delivery Partnership
SACMO	Sub-Assistant Community Medical Officer
SHOPS	Strengthening Health Outcomes through Private Sector
SMC	Social Marketing Company
SPS	Strengthening Pharmaceutical Services
SSFP	Smiling Sun Franchise Program
SWAp	Sector-wide approach
TA	Technical assistance
TFR	Total fertility rate
TL	Tubal ligation
UFHP	Urban Family Health Initiative
UNFPA	United Nations Population Fund
UPHCP	Urban Primary Health Care Project
USAID	United States Agency for International Development
USAID/B	USAID/Bangladesh
USAID/PHNE	Population, Health, Nutrition and Education Office
WHO	World Health Organization

## **EXECUTIVE SUMMARY**

### **THE CHALLENGE**

Bangladesh is facing an unprecedented demographic crisis. If current projections hold true, the population of the country is almost certain to grow from the current estimated 160 million to almost double that number before it becomes stable between 2060 and 2080. This growth, moreover, will weigh on the development prospects of a country that already has a population density exceeding 2,600 per square mile—three times more than India, five times more than China, and greater than any country in the world except city-states.

The Government of Bangladesh (GOB) is developing a new population policy and a new population sector plan. Some members of the working group developing the policy document are urging that the draft policy call for the attainment of a total fertility rate (TFR) target that is below replacement level, e.g., 1.7 children per family, in the near future. If achieved, that could stabilize the population at 205–220 million by 2050. The draft sector plan, meanwhile, calls for a Contraceptive Prevalence Rate (CPR) of 72% (all methods) by 2011, and 74% by 2015—targets which some observers believe to be unrealistically optimistic. Either scenario will require a significant increase in the CPR from its current level of 48% modern method use, and will require the participation of millions of additional family planning (FP) users.

Achievement of significant increases in the level of FP practice will face some major obstacles: CPR growth has stalled nationally and remains significantly lower in the eastern part of the country; the FP service delivery system is under-staffed and over-burdened; the availability of contraceptive supplies is occasionally disrupted; behavior change and advocacy efforts in support of FP and population initiatives are virtually absent; and long-time observers suggest that the country's senior-most leadership does not share previous governments' commitment to a strong population program.

### **OBJECTIVES OF THE ASSESSMENT**

Several factors are influencing the country's population growth, including the average age at marriage and first birth, migration, the death rate—and contraceptive use. The latter point is the most susceptible to immediate action by the GOB, and by assistance interventions supported by USAID. Identification of ways to increase the CPR is therefore the primary focus of this assessment and stands at the center of many of the assessment team's recommendations. Given the magnitude of the challenge, however, the team recognizes that a broader, more participatory strategy is needed—one that would engage hitherto uninvolved or under-involved parties (the private sector, other GOB ministries, civil society, other elements of the USAID assistance program) in service delivery and advocacy efforts. The challenge is to move toward the implementation of those changes and improvements now, as every year's delay adds nearly two million more people to the population, significantly worsening the problem. The primary objectives of this assessment, then, were to (1) identify the major factors impeding further increases in the CPR and propose actions that address those factors quickly and decisively; and (2) identify opportunities for an expanded response to the population crisis.

### **KEY FINDINGS AND RECOMMENDATIONS**

The team analyzed the gaps, weaknesses, and opportunities in four key areas, including 1) the population policy environment in Bangladesh; 2) the overall USAID/Bangladesh assistance program; 3) the country's family planning services delivery system; and 4) the country's progress in achieving contraceptive security. On the basis of that analysis the team proposed, for each of the above areas, recommendations for consideration by USAID/Bangladesh. The team applied

four criteria to these prospective interventions: their potential to produce meaningful **impact** on population growth; the **speed** with which they could be implemented; their synergistic/complementary relationship to other interventions; and their **feasibility** within the USAID Mission's management and financial constraints. All of the interventions, moreover, were considered in the context of guidelines set forth in the Global Health Initiative (GHI). Each of those recommendations, moreover, was placed into one of three timeframes (near-term, intermediate, and long-term) in an attempt to provide a temporal structure for program development and design activities, and to underscore the need for a long-term USAID commitment (i.e., 15–20 years) in support of the Bangladesh population program.

## **The Population Policy Environment**

### *Gaps and Weaknesses*

- Weak political commitment during the past decade.
- Little GOB engagement outside of the Ministry of Health and Family Welfare.
- Laws and regulations that impede delivery of and access to FP services.

### *Opportunities*

- Sustained advocacy efforts can gain GOB and popular support for implementation of the GOB population policy.
- USAID technical assistance can play an important role in helping the GOB review and revise restrictive legal/regulatory barriers.

### *Recommendations*

- USAID policy dialogue regarding legal and regulatory barriers to FP use.
- Technical assistance for the National Population Council (NPC) to help mobilize an all-Government (GOB) response to the population crisis.

## **The USAID Assistance Program**

### *Gaps and Weaknesses*

- USAID has had no substantive response to population issues until very recently, and even now the Agency lacks one outside of the Mission's health and family planning assistance program.

### *Opportunities*

- There is strong potential for other components of the Mission assistance program to participate in a broader response to the population crisis.

### *Recommendation*

- Mobilize/enlist other programs and initiatives as part of a comprehensive population assistance strategy (e.g., Global Climate Change, P.L. 480 Title II program, Democracy and Governance programs with elected officials, etc.).

## **Family Planning Service Delivery**

### *Gaps and Weaknesses*

- Declining number and effectiveness of outreach workers.
- Limited reach and coverage of USAID-supported NGO programs.

- Non-involvement of other potential partners.
- Lack of behavior change communications support for the FP program.

#### *Opportunities*

- GOB plans to recruit 10,000 new fieldworkers.
- Promising performance of NGO programs; there is room for expansion.
- There is a potential role for private-sector and professional associations.
- Good GOB BCC plan in place; needs implementation.

#### *Recommendations*

- Provide technical assistance to develop an updated training course and counseling tools for Family Welfare Assistants (FWAs), and possibly Community Health Assistants (CHAs).
- Improve training capacity of the National Institute of Population Research and Training (NIPORT).
- Support and facilitate accreditation of non-government institutions for training of FP providers.
- Conduct research into high discontinuation rates for selected contraceptive methods, possible approaches for an increased role for the private sector, and other topics.
- Continue support for key NGO programs; provide TA to develop “contracting out” mechanism.
- Extend service delivery into urban slums.
- Enlist other participants in service delivery (professional associations, private providers).
- Strengthen the behavior change communication (BCC) program.
- Improve contraceptive security.

### **Contraceptive Security**

#### *Gaps and Weaknesses*

- Persistence of supply stock-outs.
- Lack of advocacy for contraceptive security.
- Limited range of contraceptive products and methods.
- Limited number of sources for contraceptive products.

#### *Opportunities*

- Adequate funding for contraceptive procurement.
- Readiness/capacity of commercial sector to play a larger role.
- USAID’s comparative advantage as a source of technical assistance.

### *Recommendations*

- Establish a GOB chain of accountability.
- Reassess the procurement process (forecasting, time line, procedures, and sources).
- Increase GOB accountability by declining to provide “emergency” supplies of contraceptives.
- Include emergency contraceptive pills and progestin-only pills in the GOB and Social Marketing Company (SMC) programs.
- Develop a long-term procurement and financial plan for the SMC.
- Review policies and laws that impede broader participation of the commercial sector.

## **SUMMARY CONCLUSIONS AND RECOMMENDATIONS**

The conclusion of the assessment team is that a significant gap exists between the Bangladesh population/family planning program, as that program is currently implemented, and the measures that must be incorporated into the program if it is to achieve its demographic goals. This assessment offers several recommendations that, if adopted, can help to close this gap. However, it is important to keep in mind the added burdens that these recommendations would place on USAID/Bangladesh: Taken together, they call for an expanded, multi-sector program that would effectively reposition population as the centerpiece of a Mission-wide response to the country’s most daunting development challenge.

The recommendations also call on USAID to undertake an ambitious policy dialogue agenda with the GOB to encourage the Government to adopt and implement essential measures that it has previously sidestepped for economic or political reasons—or because of bureaucratic inertia. These include steps to adopt a genuinely broad-based response to population issues; mobilization of an expansive BCC strategy; measures to address critical human resource constraints; definitive steps to improve contraceptive security; and openness to an expanded private-sector role in such areas as domestic manufacturing and/or importation of contraceptives, training/certification of service providers, and delivery of FP services.

Adoption of these recommendations will require additional resources, including funding, management, and technical personnel, and commitment of leadership at the highest levels of the USAID Mission and U.S. Embassy. Perhaps most importantly, it will require patience and faithfulness in maintaining a long-term (15–20 year) commitment to the task.

### **Conclusions**

- USAID contributions have created a solid foundation for future high level of impact.
- USAID is actively seeking to reinvigorate the population program, asking the tough questions needed to identify new directions.
- USAID emphasis on the financial sustainability of projects may be limiting access for the poor and prospects for expansion, and limiting delivery of FP services.
- USAID’s response is not yet commensurate to the challenge of population growth.
- NGO projects are meeting their objectives but are limited in their coverage and impact (the exception is SMC contraceptive sales).

- The GOB is giving inadequate attention to contraceptive security, human resource requirements, program operations, and BCC; as a result, the capacity of the FP service delivery program is declining.

### **Recommendations**

The assessment team proposes that USAID:

- Expand the depth and breadth of the population assistance program.
- Advocate for increased GOB commitment to contraceptive security, cross-sectoral engagement of all ministries, and elimination of dysfunctional restrictions on private-sector providers.
- Seek opportunities to work collaboratively with GOB partners.



# I. INTRODUCTION

## BACKGROUND

### Bangladesh—The Demographic Challenge

Bangladesh is facing an unprecedented demographic crisis. If current projections hold true, the population of the country is almost certain to grow from the current 150 million to almost double that number before it becomes stable, projected to happen after 2050. This growth is the product of “population momentum”—the large number of women entering childbearing age. Successes in family planning (FP) and concomitant declines in fertility are significant, but the country’s Contraceptive Prevalence Rate (CPR) has stalled,<sup>1</sup> and the population bulge of past high fertility will drive population growth for the next 40 years. Moreover, this growth will weigh on the development prospects of a country whose population density already exceeds 2,600 per square mile—three times more than India, five times more than China, and greater than any country in the world except city-states.

The Government of Bangladesh (GOB) has announced a succession of Population Policies—most recently the Population Policy of 2004 (under revision as of this writing)—that recognize the dimensions of the crisis and call for an ambitious, cross-sectoral response from virtually all ministries and agencies of the Government. The current policy requires attainment of a net reproduction rate of one by the year 2010 in order to stabilize the size of the population by the year 2060. Some members of the working group developing a revised policy document are urging that the draft policy call for the attainment of a total fertility rate (TFR) target that is below replacement level, e.g., 1.7 children per family, in the near future. If achieved, that could stabilize the population at 205–220 million by 2050. The GOB is also developing a new population sector plan that sets a CPR of 72% (all methods) by 2011, and 74% by 2015—targets which some observers believe are unrealistically optimistic. Either scenario will require a significant increase in the CPR from its current level of 48% modern method use, and will require the participation of millions of additional FP users.

Attainment of significant increases in the level of FP practice faces some major obstacles. Some areas of the country (e.g., in the east) have a much lower CPR than the national average and will require concerted efforts to produce increases in the CPR; young marriage and childbearing are the norm throughout the country; and the overall FP program is relatively inefficient and supply-dependent in that most FP users rely heavily on temporary methods. Observers have noted, moreover, that the senior-most leadership of the GOB does not seem to share predecessor governments’ political commitment to the FP program, or the need to mobilize an all-Government response to the demographic challenge.

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<sup>1</sup>There is considerable concern that contraceptive prevalence has plateaued in Bangladesh. The increase between 2000–2004 was about 1.2% in modern method use per year. Between 2004 and 2007, the BDHS-07 reported an insignificant increase of .02% for the four years between surveys. Some experts suggest that this CPR level is not the result of a true plateauing of demand, but a result of major stock-outs in government-procured contraceptive commodities coincidental with the fielding of the BDHS-07. The positive news is that even with the plateauing CPR, fertility continued its downward trend. Given the magnitude of the demographic crisis, a declining or even a flattening of CPRs would be a disaster. The next round of the BDHS should answer the question of plateauing, but the absence of a significant increase would represent a failure for the GOB and all the stakeholders involved in family planning service delivery.

## **The USAID Program**

For several decades USAID has been the dominant provider of assistance to the Bangladesh population program. Indeed, most foreign and Bangladeshi stakeholders agree that USAID support for the Bangladesh FP program since independence was a key factor in the impressive increases in FP use and reductions in TFR achieved in previous decades. More recently, however, those same stakeholders mention a perceived lack of political and technical leadership on the part of USAID in the areas of population and family planning. The USAID Mission has indicated its intention to reverse that perception by bringing population issues to the forefront in its policy dialogue with GOB partners and the donor community, and by repositioning family planning as a strategic keystone of health, development, and economic growth programs.

## **Purpose of the Assessment**

USAID/Bangladesh believes that the situation described above presents both challenges and opportunities for the U.S. Government assistance effort in Bangladesh. On one hand, the apparent stalling of the family planning program has significant negative consequences for the country's development prospects. On the other hand, the USAID Mission has noted its readiness to support, within the Mission's resource and management constraints, additional and/or revised program interventions that address the root causes of this stalling. These interventions, it is hoped, will help renew and speed up the country's upward trend in contraceptive prevalence and its downward trend in fertility. The key purposes of this assessment are to help the Mission identify the root causes of the program's stalling, and to recommend specific approaches that might successfully address those factors. More specifically, the assessment team was asked to discuss "what is working and what is not"; to identify significant gaps and opportunities emerging from the team's review of the program; and to suggest for USAID's consideration new investments that would address key elements of the population challenge. The assessment team was asked, moreover, to fashion its program recommendations within the context of several new Agency-wide initiatives, most notably the Global Health Initiative (GHI).

## **Methodology**

The assessment team reviewed materials provided by USAID/Bangladesh, USAID/Washington staff, and personnel from the several projects examined in the course of the assignment. Key informants interviewed included staff from the USAID Mission, USAID/Washington, project leadership and staff in Dhaka and at field site visits, representatives of the Government of Bangladesh (GOB), long-time observers (expatriate and Bangladeshi) of the Bangladesh FP program, and other donor agencies involved in the program. At the end of the first week of fieldwork, USAID's Office of Public Health, Nutrition and Education (PHNE) arranged a consultative roundtable of over 50 political, technical, program management, and donor representatives—a meeting that was a particularly rich source of information and advice for the team.

During the second week of the assessment, the team visited project operations in Jessore and Chittagong (Team "A") and Sylhet (Team "B"). The team relied heavily on these visits to address PHNE instructions that the team try to identify "what was working" and "what was not

working” at the project level<sup>2</sup>; identify gaps in USAID’s program response; and perhaps most dauntingly, try to identify the key factors behind the geographic differentials (in contraceptive use and fertility) reported in the 2007 BDHS. Prior to its departure for field visits, the team prepared interview guides to facilitate comparability and subsequent sharing of data when the team reassembled in Dhaka. The team reunited in Dhaka at the beginning of week three of the assignment to compare and discuss members’ findings and preliminary conclusions, and to reach consensus regarding the overall findings, conclusions, and recommendations that would be included in the assessment report. Toward the end of week three and into week four, the team participated in debriefings with USAID/Bangladesh and Embassy personnel, and with key stakeholders in the FP program. At the conclusion of the 24-day visit to Bangladesh, the team returned to Washington, where it briefed USAID/Washington personnel on the team’s findings and recommendations.

## **Structure of the Report**

The scope of work for this assessment required a performance review of the five key projects in USAID/Bangladesh’s population assistance program—the Bangladesh Social Marketing Company (SMC); the Smiling Sun Franchise Program (SSFP) implemented by Chemonics International; the Mayer Hashi project implemented by EngenderHealth; the MaMoni project implemented by Jhpiego and Save the Children; and the MEASURE DHS III project managed by ICF-Macro. The team was not asked to evaluate these activities, but did identify a number of project-specific issues for Mission consideration and action. The team’s findings and recommendations regarding those five projects are attached to this report as Annex D, “USAID Project Review.”

The scope of work for the assignment also called on the team to propose for USAID’s consideration a population assistance strategy that would reflect the magnitude and urgency of the country’s population crisis, and would suggest how the Mission’s existing portfolio might be tuned and expanded better to address the challenges posed by that crisis. The bulk of this paper addresses this second requirement of the scope of work.

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<sup>2</sup> The PHNE Office asked the assessment team to review the performance of each of USAID’s key projects—the Smiling Sun Franchise Program (SSFP); Mayer Hashi; MaMoni; and the Social Marketing Company (SMC). PHNE pointed out, however, that the assessment was not intended to serve as an evaluation of these activities, but rather as an effort to extract project-based lessons that might inform the development of a more strategic approach to the population challenges facing the country. Moreover, two of these projects—SSFP and SMC—are scheduled to undergo formal evaluations in the near future.



## II. TOWARD A POPULATION ASSISTANCE STRATEGY<sup>3</sup>

### THE NEED FOR A MORE INCLUSIVE APPROACH

As explained above, Bangladesh faces a demographic crisis of unprecedented proportions—a crisis which, given the country’s extraordinary population momentum, will have immediate and largely foreseeable consequences. Indeed, that momentum is of such magnitude that even a “perfect” program response will not forestall continued explosive growth in the population.

Well-designed and carefully implemented improvements in the existing program will play an important role in helping to check population growth. Given the magnitude of the challenge, however, a broader, more participatory approach is needed—one that will engage hitherto uninvolved or under-involved parties (the private sector, other GOB ministries, civil society, other elements of the USAID assistance program) in service delivery and advocacy efforts. Such an expansive approach to the demographic crisis will have greater potential to slow population growth and flatten a growth curve that, left unchanged, ensures a near doubling of the population. The challenge is to move toward the implementation of those changes and improvements now, because every year’s delay will significantly exacerbate the problem.

Several factors are influencing the country’s population growth, including the average age at marriage and first birth, migration, the death rate—and contraceptive use. The latter item—the country’s contraceptive prevalence—is the most susceptible to immediate action by the GOB, and to assistance interventions supported by USAID. Increasing the CPR is therefore the primary focus of this assessment and stands at the center of many of the assessment team’s recommendations. As noted above, however, a narrow focus on the CPR would overlook many promising opportunities for additional interventions that could produce meaningful impacts on population growth. The primary objectives of this assessment, then, are to:

1. Identify the major factors that are impeding further increases in the CPR, and propose actions that address those factors quickly and decisively;
2. Identify opportunities for an expanded response to the population crisis; and
3. Provide recommendations to USAID/Bangladesh that reflect the need for a multi-sector, multi-ministry approach to the population challenges confronting the country.

The USAID Mission encouraged the assessment team to adopt this broader perspective, and indicated its readiness to consider seriously assistance opportunities that went beyond the strategy or focus of its current program. The team was also urged to keep in mind the country context of its recommendations, particularly the need to obtain GOB buy-in for recommendations directed at USAID. In other words, and as underscored in the Global Health Initiative, the Mission recognizes that success in meeting its objectives will depend on the GOB’s willingness and capacity to assume a leadership role in ensuring successful implementation of those recommendations.

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<sup>3</sup> The assessment team assumes that this document will be made available to a USAID Health Sector Strategy Development team expected to visit Bangladesh in May 2010. That team, in consultation with USAID/Bangladesh, will presumably determine whether or not any of the recommendations presented in this paper will be incorporated into the larger sectoral strategy developed in the course of the May visit.

## **GAPS AND WEAKNESSES: IDENTIFYING THE ELEMENTS OF A USAID STRATEGY**

A summary review of population policies and programs in Bangladesh helps to highlight the gaps in the country's response to its population crisis—gaps that USAID might consider as it plans its future work in the sector. Some of these gaps are clearly beyond the Agency's capacity to address within its financial and management constraints (e.g., systemic shortages of staff, equipment, and operating costs for the GOB health delivery system<sup>4</sup>). Others are consistent with longstanding Agency priorities (e.g., improving employment prospects for women), the successful implementation of which requires too long a timeframe for a strategy designed to increase the CPR and reduce population growth quickly. In order to make its recommendations both relevant and practical, then, the assessment team applied four screening criteria to the opportunities that emerged from the "gap analysis" discussed below. Specifically, the team limited its recommendations to prospective interventions characterized by (1) their impact on population growth; (2) their speed, i.e., the likelihood that an intervention could be designed, tested, and scaled up quickly; (3) a determination that, taken together, the interventions represent a strategic response to the demographic challenge rather than a collection of isolated or one-off initiatives that do not reinforce each other in a synergistic way toward a lasting increase in the CPR and/or a meaningful change in the country's response to the population dilemma; and (4) their feasibility within the USAID Mission's management and financial resources.

Each of the recommendations proposed herein is placed within one of three timeframes: near-term (these tasks should be incorporated into the Mission's assistance portfolio within 1–2 years); intermediate (conceptual work should begin now for activities that would be incorporated into the Mission's portfolio within 2–3 years); and long-term (USAID should begin now to lay the conceptual groundwork for interventions not likely to be implemented for 5–10 years). This grouping is meant to provide some temporal structure to the Mission's program design and development agenda, and to underscore the team's belief that USAID should expect to remain substantively involved as a donor in the Bangladesh population program for the next 15–20 years in order to help ensure the realization of that program's objectives.

Noteworthy for their omission from these criteria are USAID's concerns for program sustainability and cost recovery. The assessment team acknowledges that these are important elements of program design for the Agency and are hallmarks of the USAID Mission's current portfolio. In the judgment of the team, those considerations are secondary to the critical need for speed and effectiveness in adopting a population strategy designed to address an issue that threatens the country's ability to realize its development objectives.

On the basis of extensive discussions with key informants in Bangladesh, a review of briefing materials provided by USAID and others, and field visits to three regions of the country (Jessore, Chittagong, and Sylhet), the assessment team concluded that a strategic response to population issues in Bangladesh should address gaps, weaknesses, and opportunities in (1) the GOB policy environment; (2) the USAID assistance program; (3) the country's family planning service delivery program; and (4) contraceptive security. These are discussed below.

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<sup>4</sup> Although such concerns should be at the forefront of the USAID and Embassy policy dialogue with GOB partners and counterparts.

## **The GOB Policy Environment**

### *Gaps and Weaknesses*

The GOB Population Policy of October 2004 is an ambitious and forward-looking statement. It recognizes, for example, that the “*high rate of population growth and resultant increase in population size impede the process of achieving the objectives in various sectors of the economy. Therefore, those ministries and agencies whose target populations are overwhelmingly affected by population growth should share the burden of responsibility of population control and family planning.*” The policy further lists some 15 ministries of Government whose programs touch on population growth in direct and/or indirect ways, and mandates specific actions for each of those ministries. Illustrative tasks include the design and implementation of a vigorous family planning program (Ministry of Health and Family Welfare), public information campaigns on family planning, with special emphasis on adolescents (Ministry of Information); updates of the population curriculum in schools (Education); measures to reach adolescents (Youth and Sports); integration of population into GOB sector plans (Ministry of Planning), etc. The policy further established a National Population Council (NPC) headed by the Prime Minister, and including as its members “concerned Ministers and Secretaries, departmental chiefs, leading private sector organizations and population experts, social scientists and public health specialists [who] will monitor the implementation of the national population policy.” A newer population policy is being circulated within the GOB, and reportedly reaffirms the Government’s intention to implement an all-Government response to the country’s population crisis.

While the thrust of the current and draft policy statements is encouraging, most observers consulted in the course of this assessment suggest that the overall political environment is in fact far less supportive of a broad-based approach to the problem. In practice, they advise, the senior-most leadership of the Government views population as a health issue to be addressed by the health sector generally and the MOHFW particularly. No senior GOB official has stepped forward to champion population issues; no GOB advocacy or public education campaign is in place to enlist public support for population measures; and no other organ of Government outside the MOHFW has taken up the tasks laid out in the 2004 policy statement.<sup>5</sup> Moreover, no action has been taken to bring the country’s legal and regulatory regime regarding provider and client eligibility criteria for contraceptive methods into compliance with international standards. Current legal and regulatory barriers limit access to family planning by nonparous women, unmarried adolescents, and women who prefer an IUD or sterilization.

### *Opportunities*

- GOB policy statements are sound, but require sustained advocacy efforts to gain Government and popular support.
- USAID technical assistance and influence can play an important role in helping the GOB review and revise restrictive legal/regulatory barriers.

## **The USAID Assistance Portfolio**

### *Gaps and Weaknesses*

With regard to population issues, the USAID/Bangladesh assistance program reflects the same compartmentalization that characterizes the GOB population program. All of USAID’s population investments are provided in support of health and family planning interventions

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<sup>5</sup> One analyst summarized this inaction as perhaps the inevitable consequence of a vibrant democracy, wherein the path to electoral success is driven by the demands of voters for solutions to their immediate needs and problems. The longer-term threats of rapid population growth have little relevance in such contests.

managed by NGOs, by the Social Marketing Company, and, to a lesser extent, the GOB (contraceptives and logistic support). No other element of the USAID/B assistance program, i.e., assistance activities managed by offices other than PHNE, incorporates population messages, policy dialogue, or service delivery, despite the potential role some of those programs and projects could play as part of a broader population assistance strategy. Even its largest service delivery project is lacking in terms of FP services.

### *Opportunities*

Several elements of the USAID/B program offer opportunities for involvement in a Mission-wide response to the population crisis:

- The Global Climate Change (GCC) Initiative recognizes that the impacts of GCC, particularly sea-level rise, flooding, drought, and severe weather events, will have serious demographic, as well as ecological and economic impact on the country.
- The Mission's Food Security program includes a P.L. 480 Title II maternal and child health (MCH) program that reaches up to seven million married women of reproductive age (MWRA) on a regular basis, but which does not yet include an FP information or service component.
- The Mission's work with local parent-teacher associations and school management committees offers an opportunity to sensitize parents to the challenges their children will face in a more crowded Bangladesh, and can engage children as change agents for smaller family size, the impact of population growth on development, environment, etc.
- USAID's work with elected officials and parliamentarians provides opportunities to enlist population champions at the national and local levels of government.

## **Family Planning Service Delivery**

### *Gaps and Weaknesses*

The delivery system for health and family planning services suffers from several constraints. It is inadequately funded by the GOB (Government resources committed to the health sector—estimated at approximately 3% of the total budget—are the lowest in South Asia); and the number of GOB personnel who drove past program success and who are currently needed for program outreach have decreased, while their skills have not been updated and they have been redirected to non-FP activities. NGOs, while playing an essential role, reach only 15% of the population; the private sector (with the exception of the SMC) is expensive, extremely limited in its coverage, and constrained by legal and regulatory barriers to its broader participation as an FP service delivery program. Both the public sector and NGOs are scarce and inconsistent and provide little useful information for current or prospective FP users. Finally, and perhaps most importantly, the GOB has been unable to satisfy the most fundamental requirement of a successful FP program—assuring a regular, reliable, and uninterrupted supply of contraceptives to the population it serves.

### *Opportunities*

- The GOB has announced its intention to recruit 10,000 new fieldworkers within the next 5–10 years to replace Family Welfare Assistants (FWAs) who are retiring. USAID has an excellent opportunity to influence the quality of FP counseling and services nationwide and for years to come by helping to speed up the recruitment process and design a replacement training curriculum for new personnel (the current curriculum was designed 30 years ago and does not reflect current best practices or WHO standards and protocols developed in more recent years).

- Several policy, legal, and regulatory requirements act as barriers to fuller participation of the private sector in provision of FP services. USAID technical assistance can help the GOB identify and eliminate these obstacles.
- USAID technical assistance and policy leadership (with the GOB and other donors) can play a key role in helping to ensure contraceptive security for Bangladesh.
- USAID support for a reinvigorated BCC program can ensure that FP users have the information they need to make informed decisions regarding their contraceptive and fertility choices.

## **Contraceptive Security**

### *Gaps and Weaknesses*

The national contraceptive supply is not secure, as demonstrated by recurring stock outages of injectable contraceptives, implants, and IUDs. This problem is exacerbated by the non-availability of a full range of contraceptive products and methods (especially emergency contraceptive pills (ECPs) and progestin-only pills (POPs)) within the Bangladeshi family planning environment, the existing restrictions on access to and provision of long-acting and permanent methods, and a too-heavy reliance on donor/public-sector sources for the national contraceptive supply. These gaps in contraceptive security contribute to high discontinuation rates among contraceptive users, a method mix skewed toward oral contraceptives, and the relatively high incidence of unintended and unwanted pregnancies reported by the 2007 BDHS.

The persistence with which stock outages have occurred during recent years is further indicative of (1) the current lack of awareness within the GOB and the MOHFW, in particular, of the critical importance to the national population program in ensuring a consistent contraceptive supply; and (2) the lack of accountability within the Government system for lapses in the contraceptive supply.

### *Opportunities*

- The GOB has access to sufficient funds, through its own and donor sources, to procure necessary contraceptives.
- The efforts of the Social Marketing Company have succeeded in creating a commercially feasible market for condoms and appear to be developing a similarly feasible commercial market for oral contraceptives.
- Bangladesh has a growing domestic pharmaceutical sector that is beginning to produce contraceptive products, especially oral and injectable contraceptives.
- USAID has significant comparative advantage as a source of technical assistance in commodity procurement and logistics management.
- USAID is well positioned with its GOB counterparts to initiate policy dialogue on (1) the importance of contraceptive security to the national population program, and (2) revision of any unnecessary regulatory constraints on the provision of long-acting and permanent methods (LAPMs).



### **III. THE ELEMENTS OF A USAID POPULATION STRATEGY**

This section of the assessment examines the aforementioned gaps, weaknesses, and opportunities in more detail and offers a number of recommendations to address them. In the judgment of the assessment team, adoption of the recommendations presented below will help to close the significant gap that exists between the Bangladesh population/family planning program as that program is currently implemented, and the measures that must be incorporated into the program if it is to achieve its demographic goals. However, it is important to keep in mind the added burdens that these recommendations, if adopted, will place on USAID/Bangladesh. Taken together, they call for an expanded, multi-sector program that would effectively reposition population as the centerpiece of a Mission-wide response to the country's most daunting development challenge.

The recommendations also call on USAID to undertake an ambitious policy dialogue agenda with the GOB to encourage the Government to adopt and implement essential measures that it has hitherto sidestepped for economic or political reasons—or because of bureaucratic inertia. These include steps to adopt a genuinely broad-based response to population issues; mobilization of an expansive behavior change communication strategy; measures to address critical human resource constraints; definitive steps to improve contraceptive security; and openness to an expanded role of the private sector in such areas as domestic manufacturing and/or importation of contraceptives, training/certification of service providers, and delivery of FP services.

Adoption of these recommendations will require additional resources—including funding, management and technical personnel, and the participation of leaders at the highest levels of the USAID Mission and U.S. Embassy. Perhaps most importantly, it will require patience and faithfulness in maintaining a long-term (15–20 year) commitment to the task.

#### **IMPROVING THE POLICY ENVIRONMENT**

USAID can affect the GOB policy environment by providing technical assistance and policy dialogue that (1) address outdated and/or dysfunctional laws and regulations that impede broader use of family planning services, and (2) help sensitize host country leaders and opinion-shapers to the need for substantive implementation of the GOB's population policy. USAID can also support advocacy efforts that (1) promote and legitimize more expansive GOB (political) investment in the population program; (2) stimulate a broad public conversation about the country's population dilemma and the steps needed to address it; and (3) help create the “supportive norm” for small or smaller family size and for large-scale adoption of contraceptive use.

#### **Review and Revise Outdated or Restrictive Laws and Regulations**

The GOB retains and enforces a number of laws and regulations that impede the delivery of family planning services. Section III.C.7 (“Contraceptive Security”) discusses these in more detail, but they include:

- Restrictions on the type of personnel who are allowed to insert IUDs (only female physicians and Family Welfare Visitors (FWVs), despite a shortage of physicians in the GOB health system and a large number of vacant FWV positions.
- Limits on the household provision of injectables.

- Rules regarding client parity limit the availability of injectables and of long-term and permanent methods (LAPM).
- Restrictions on the ability of the domestic commercial sector to participate as bidders for contraceptive procurement or freely to import FP commodities.

**Recommendation:** USAID should engage the Directorate General of Family Planning (DGFP) in discussions of its policies regarding provider and client eligibility criteria for contraceptive methods.

International standards, other country experience, and medical norms should be shared within a context of policy dialogue—the desired outcome being a relaxation of requirements for provider type and client parity that unnecessarily limit the availability of injectables and of long-term and permanent methods. Such a dialogue could follow a broad-based analysis of the legal and regulatory environment for family planning services delivery in the public, NGO, and commercial sectors. The new SHOPS<sup>6</sup> or the Health Policy Initiatives Project could serve as sources for technical assistance in this effort.

### **Support Implementation of the GOB’s Population Policy**

As noted above, the GOB population policy of 2004 and the draft policy under review both capture the nature and magnitude of the country’s demographic challenge, and both set forth ambitious implementation plans to address that challenge. Regrettably, GOB population policy statements have gained little traction in the Government, and are virtually unknown at local governmental levels, either by potential advocacy groups or by the general public.

In the earlier phases of the Bangladesh population program, USAID effectively deployed RAPID presentations to educate policymakers, elected officials, academics, interest/advocacy groups, and media representatives to increase their awareness of the implications of rapid population growth. Similar efforts are needed again, and are discussed in the “Advocacy” section below. Also needed, however, are more targeted presentations—for the leaders and managers of the 15 GOB ministries responsible for implementing the Government’s population policy. These presentations would examine the specific tasks those ministries are nominally obliged to carry out under that policy; encourage intra-ministerial dialogue regarding the barriers to effective implementation of those tasks; and facilitate the development of ministry-specific action plans that would lay out their tasks, identify responsible action offices/individuals, and establish timetables for task execution.

**Recommendation:** USAID should work with the National Population Council (NPC) to develop an assistance plan that would strengthen the NPC’s ability to mobilize an all-Government response to the country’s population crisis.

The Health Policy Initiatives project could provide technical assistance for this activity. [N.B. As an initial step, USAID should realistically assess the readiness and capacity of the NPC to take a lead role in this effort. The NPC has not met in approximately two years and may no longer be the most visible, persuasive, or effective partner in furthering an initiative that will require considerable political weight and credibility to be successful.]

### **Advocacy for an Effective National Population Program**

Past successes have led to a sense of complacency on the part of the GOB and donors, with a resulting lack of political commitment at the national and local levels, lowered priority for a proactive family planning program, and reduced allocation of the human and financial resources

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<sup>6</sup> Strengthening Health Outcomes through Private Sector, managed by Abt Associates.

needed to address the population crisis. That crisis does, however, create the conditions for more vigorous demands—from within the Government, by the public, and by various stakeholders—for more assertive GOB action in response to the population challenge. A well-designed advocacy program can play an important role in mobilizing those voices. The elements of an advocacy program can include media campaigns, public speaking, commissioning and publishing research, or face-to-face discussion with the gatekeepers of the issue being promoted.

Bangladesh is blessed with an optimum environment for advocating population and family planning issues. It is rich in data (e.g., Demographic and Health Survey data), allowing advocacy to be empirically and fact-based. The past success in reducing fertility and the recognition of this success by the international community makes the decision to support the program easier for politicians and other gatekeepers (“*Success is never an orphan*”). The widespread acceptance of family planning means that support is not likely to generate serious political backlash for an official.

**Recommendation:** USAID should provide technical assistance to the GOB for development of an advocacy strategy and implementation plan, with stakeholder participation.

The plan would identify:

- The most important issues.
- The priority targets for each advocacy issue (e.g., national policymakers, parliamentarians, local policymakers, traditional leaders, religious leaders, media, the private sector, citizens, families, etc.).
- The advocates to carry the issues to the intended target audiences (e.g., NGOs, parliamentarians, local policymakers, traditional leaders, religious leaders, media, the private sector, celebrities, the GOB, etc.).

USAID should also support research and data utilization to drive the advocacy agenda, including BDHS, program evaluation, operations research, analysis and dissemination/utilization of data, and renewed use of RAPID-type presentations at a wide variety of venues.

## **MOBILIZE THE USAID/BANGLADESH ASSISTANCE PROGRAM**

Given the breadth of the country’s population crisis, virtually all elements of the GOB are needed to stage a meaningful, cross-sectoral response. A similar response is needed from USAID. Indeed, a U.S. Government policy dialogue agenda that urges GOB counterparts to undertake an all-Government population strategy risks losing credibility in the absence of mirror efforts by USAID/B itself.

Several of the USAID Mission’s programs and initiatives have strong potential to play useful supportive roles as part of a more comprehensive population assistance program, and should be mobilized, as appropriate, to play those roles. The “Opportunities” discussion above mentioned some of these program components, including the GCC Initiative, the maternal and child health (MCH) component of the P.L. 480 Title II program, the Mission’s education activities, and elements of the Mission’s Democracy and Governance (DCC) activities, to name a few.

**Recommendation:** USAID/Bangladesh should review its entire assistance portfolio, with special attention to the several Agency-wide initiatives being addressed by the portfolio, and identify ways in which those activities might be enlisted to support a comprehensive, all-Mission response to the population crisis. Some illustrative examples include the following:

- Integrate Family Planning into the P.L. 480 Title II Program

USAID/Bangladesh manages the largest non-emergency Title II program in the world. The \$45 million/year program serves the country's poorest citizens in 61 of Bangladesh's 64 districts; most of these food recipients live in areas under-served by GOB services. The USAID Mission and the Food for Peace Office (FFPO) in USAID/Washington have prepared a new five-year Multiyear Action Plan (MYAP) that sets forth the parameters for a program scheduled to get under way in June of this year. The program will contain a maternal and child health component likely to reach between 4.3 and 7.2 million beneficiaries. The MYAP does not include any provision for the delivery of family planning information and services to participants in the MCH program, despite the fact that program participants are by definition married women of reproductive age. The directors of the USAID/Bangladesh PHNE Office and the Food Security Office both agree that this key FP component should be added to the MCH program. The precise procedure for incorporating FP into the Title II MCH program will be defined within USAID.

- Work with municipal leaders and elected officials

USAID/Bangladesh is supporting local governance activities in 200 municipalities throughout the country, many of which are responsible for providing health and/or sanitation services, and contraceptive supply support for NGOs within their jurisdictions. The PHNE and the local Democracy and Governance (DG) Offices should explore ways to engage municipal leaders as local champions for FP services via regional workshops, presentation of RAPID-style computer simulations to municipal leaders; and urging USAID-supported NGOs to involve local leaders fully in their planning and promotional efforts.

PHNE has shown strong interest in working with elected women to strengthen their FP awareness and involvement, and to encourage them to be effective FP advocates in Parliament. Specifically, PHNE plans to work with the 64 female members of Parliament and with the Health Subcommittee in Parliament to promote stronger support for the national FP program.

- The **PRICE** Project (Poverty Reduction by Increasing the Competitiveness of Enterprises), managed by the Mission's Office of Economic Growth, is stimulating job creation and investment in aquaculture, horticulture, and leather products, particularly for the benefit of women, young adults, and small business suppliers. While its impact on the CPR would be minimal, the project has the potential to reach the thousands of young and female project participants, many of whom may emerge as opinion leaders in their communities. USAID should encourage its NGO partners to meet with PRICE project managers to explore ways in which NGO promotional materials might be shared with PRICE beneficiaries, and possibly to position service-provider NGOs, such as the SSFP, as health and FP service providers for the employees of small businesses supported by the PRICE project.
- The **Madrasa Modernization Project**, managed by the Mission's Population, Health, Nutrition and Education Office, is working to improve primary education in 1,800 (with eventual expansion to 2,400) schools covering grades 1 through 8. Population studies—currently an optional module for grades 6 to 8—should be incorporated into the curriculum, thereby sensitizing the thousands of young people reached by the project to the consequences of rapid population growth on their own and their country's future. The project has the potential to enlist thousands of young advocates for responsible management of population growth.
- The Mission's work under the **Global Climate Change (GCC) Initiative** should include emphasis on the demographic consequences of the weather-induced changes facing

Bangladesh. These Bangladesh-specific issues can be incorporated into the population policy and advocacy efforts discussed earlier in this report.

## **IMPROVE THE DELIVERY OF FAMILY PLANNING SERVICES**

USAID efforts to create a more comprehensive population assistance program, i.e., one commensurate to the demographic crisis facing the country, will have only modest impact if couples do not have ready access to a delivery system (including public-sector, private-sector, and NGO providers) that can provide a full range of high-quality, affordable, and reliable contraceptive methods that match couples' needs and expectations. The current stalling in growth of contraceptive prevalence in Bangladesh—the unmet need is approximately 17%—strongly suggests that the delivery system for FP services is reaching the limits of its capacity, or that it has declined in its ability to deliver FP services. The assessment team has concluded that these limiting factors include:

1. Deterioration in field outreach and clinic-based services because of understaffing and overburdening of existing staff, particularly as FWAs decline in number and effectiveness.
2. The relatively modest reach of USAID-supported NGOs.
3. Pockets of under-served population groups, especially in urban slums.
4. Non-involvement of other potential partners in FP service delivery.
5. A lack of BCC support for the population/family planning program, and perhaps most fundamentally, a lack of communication to inform couples of their options and benefits from effective contraceptive use and smaller families.

The major consequences of these limiting factors include:

- Low contraceptive prevalence in sections of the country.
- Failure to respond to the needs of high-risk couples and prospective users of LAPM.
- High discontinuation rates for contraceptive use.

In the judgment of the assessment team, the limiting factors noted above are susceptible to USAID interventions that would be rapid, effective, and feasible within the bounds of the Mission's financial and management resources. The limiting factors, and proposed actions to address them, are discussed below.

### **Deterioration in Field Outreach and Clinic-Based Services**

Because of understaffing and overburdening of existing staff, the quality and coverage of the tradition home visit structure has declined. The problem is likely to get worse as FWAs decline in number and effectiveness.

#### *Decline in FWAs*

Service delivery in Bangladesh is facing many constraints. The GOB program is hindered by personnel shortages; lack of equipment, drugs, and other supplies; variable quality of technical and managerial leadership; poor use of data for decision-making and resource allocation; a weak in-service training regime; and poor attention to quality of care. In low-performing parts of the country, the lack of FWAs especially has been cited as a critical limiting factor to an increased CPR. The NGO sector is qualitatively in better condition, but has limited reach in the country, even while its potential—in the case of the SSFP, for example—is hindered by the training bottlenecks and funding limitations (e.g., sterilization reimbursements) described in Annex D.

Moreover, there is little, if any, comprehensive planning at the division or district level that attempts to identify the respective strengths, roles, or support functions of the various participants in the health/FP delivery system, including GOB providers, NGOs, private-sector providers, BRAC volunteers, Blue Star pharmacists, other vendors of SMC products, or participants in the P.L. 480 food assistance program.

Within this daunting array of constraints, the GOB program is being especially undermined by the declining number of domiciliary-level workers, i.e., FWAs.

The impact that domiciliary workers can have on contraceptive prevalence has been demonstrated by several studies over the past two decades. As noted by a researcher in Matlab several years ago, the introduction of FWAs in 1978 caused a dramatic shift in the CPR, with the presence of an FWA increasing by 54% the probability of a rural woman being a FP user.<sup>7</sup> Some years later, Cleland and others (1991) remarked: “There is unassailable evidence that routine household visits by family planning workers can have a lasting impact on reproductive behavior.” An ongoing health and fertility longitudinal study being conducted in two sub-districts of Sylhet by the Bloomberg School of Johns Hopkins University, Jhpiego, and the NGO Shimantik found that in households visited by FWA-type fieldworkers recruited for the study, the CPR increased from a baseline of 15% to a post-visit level of 56% after six months of project activity (data source: registers maintained by the fieldworkers). Several observers consulted by the assessment team noted that the role of FWAs is especially critical in low-performing parts of the country such as Sylhet and Chittagong (where there is a modern method CPR of 25% and 38% respectively) where domiciliary workers are the most effective way to reach less mobile women.<sup>8</sup>

Yet despite the key role FWAs have played in the success of the country’s FP program, their numbers have been allowed to decline dramatically over the past few years. Moreover, their departure from the MOHFW workforce is expected to accelerate in the near future, as the bulk of that workforce—recruited some 20–30 years ago—begins to retire. Significant numbers of FWAs will begin to retire in 2012–2013, and most of the current FWA workforce will be gone by 2014. Population growth and changes over the past several years in FWAs’ work responsibilities have further compounded problems caused by their declining numbers. FWAs who were recruited to serve 600 households are frequently responsible for double that number today, and these already over-extended workers are now responsible for delivering a significantly broader array of health information and services (supply of ORS, Vitamin A capsules, and health education on ANC, PNC, newborn care, EPI, nutrition, hygiene practices, adolescent health, etc.), detracting from their time and opportunity to provide FP counseling and services to their clients. Indeed, one of the key factors contributing to a reduction in the frequency and effectiveness of domiciliary visits by FWAs is the workers’ directed assumption of health-related tasks that more appropriately should be the responsibility of the MOHFW Directorate General of Health Services. DGHS staff, meanwhile, appear to be providing little, if any, family planning information or services as they undertake their responsibilities.

#### *Decline in FWA effectiveness*

As noted earlier, most of the country’s 23,000 FWAs were trained and deployed 20–30 years ago. The training they received did not prepare them to counsel patients effectively on contraceptive side effects, or to match successfully the reproductive life cycle needs of clients to appropriate FP methods. As a consequence, prospective clients who have special needs, such as

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<sup>7</sup> Kamal, Nashid. “Role of Government Family Planning Workers and Health Centres as Determinants of Contraceptive Use in Bangladesh.” *Asia-Pacific Population Journal* 9, No. 4, 1994.

<sup>8</sup> Mannan, Ishtiaq. Remarks made at working meeting of family planning program stakeholders, Sylhet, Bangladesh, March 2010.

young married couples, older multiparous women, limiters, spacers, discontinuers, women with absent spouses, women with a previous history of menstrual regulation, or women who use a traditional method are not adequately counseled by FP workers. Finally, this gap in fieldworker training may also be a factor in the very high rates of discontinuation in Bangladesh (57% in the first year of use and rising; in 2004 it was 49%).

The Director General of Family Planning (DGFP) has announced his intention to recruit 10,000 new fieldworkers over the next few years,<sup>9</sup> with some 1,270 of these staff to be recruited over the next year.<sup>10</sup> This recruitment drive is in addition to the recruitment of more Health Assistants (HAs)—thousands of whom will be recruited and/or reassigned to assist FWVs staff upwards of 18,000 Community Health Clinics that are being created and/or revitalized by the current Government.<sup>11</sup> Although the DGFP has reiterated the GOB's commitment to a clinic-based system for health care in Bangladesh, he has also acknowledged the need for a "hybrid" system—one that will combine domiciliary-based services and clinic-based services—in low-prevalence areas of the country. The DGFP's decision to proceed with this recruitment and deployment plan creates a significant opportunity for close and effective collaboration between USAID and the GOB to ensure the success of that initiative.

### *Recommendations*

#### *Near Term*

- Provide technical support for GOB recruitment and training of fieldworkers: Most donors and stakeholders interviewed in the course of this assessment applaud the Director General of Family Planning's decision to recruit upwards of 10,000 new FWAs, and his intention to deploy many of them in support of "hybrid" delivery systems in Sylhet and Chittagong. That enthusiasm is muted, however, by the realization that the initiative, if successful, will take considerable time to get under way, and years to complete. It may be instructive to note that the DGFP decided over a year ago to recruit 2,000 additional FWVs. To date, none has been recruited, the written qualification test has not been prepared, and no effort has been made to upgrade the twenty-year-old curriculum for their training program.
- With that caution in mind, the assessment team recommends that USAID work with the DGFP to develop a technical assistance initiative that would (1) expedite GOB action on the FWA recruitment plan, and (2) ensure that the training provided to the new FWAs is designed to prepare them to meet the needs of their clients. Specifically, the team recommends that USAID offer technical assistance to update/upgrade the GOB's training course for FWAs—a one-month training program that has not been substantively revised in about 30 years. That updated course would incorporate more recent best practices, WHO standards and protocols for health workers, and information gained from recommended research into the reasons for method discontinuation, in order to prepare FWAs to address the risk factors and side effects associated with method discontinuation, as well as other life-cycle-related needs of their clients. Clients having such needs include:
  - Women with a strong likelihood of high risk pregnancy (30.7% single risk and 30.4% multiple risk factors).
  - Women using less effective methods given their desire for no more children (three children: 44%; four or more children: 34%).

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<sup>9</sup> Public comments at the Population/Family Planning Roundtable Discussion, Hotel Lake Shore, Gulshan, Dhaka, March 21, 2010.

<sup>10</sup> *Daily Star*, April 2, 2010.

<sup>11</sup> FWAs are also required to staff the Community Health Clinics three days a week until sufficient numbers of FWVs and HAs are recruited, trained, and deployed to those facilities.

- Women wanting no more children and not using a contraceptive method (unmet need)—(6.6% spacing and 10.5% limiting).
- Women using traditional methods (8.4%).
- Women who have used menstrual regulation (5.7%).
- Women whose last pregnancy was not wanted (14.1%).
- Discontinuers (56%).
- Women not using contraception because of the absence of a partner (emergency contraception candidates).
- Women who are using a method incorrectly.

USAID’s participation in an effort to develop and install an updated training manual/course would have nationwide impact, as the 10,000 new FWAs are expected to be deployed throughout the country. The DGFP’s plan, moreover, creates a time-sensitive opportunity for USAID to produce significant long-term improvements in the service delivery system for a relatively modest investment in U.S. Government resources: These newly trained FWAs would be equipped with skills and tools not available to the cohort of FWAs that is gradually leaving Government service. Finally, USAID participation in this activity would closely reflect GHI directives urging Missions to collaborate with host countries in support of country-led initiatives.

- Promote dialogue between the leadership of the DGFP and the DGHS to rationalize the work assignments of FWAs (and other MOHFW) personnel and to secure greater cooperation from the DGHS on FP efforts: As noted above, FWAs, as well as other DGFP personnel, are frequently assigned to carry out non-FP tasks that do little to address FP needs, and frequently undermine the opportunity for DGFP workers to provide FP information and services to clients. Conversations between the leadership of the two directorates toward a more rational distribution of tasks have been hindered for several years by strong rivalries, even antipathy, between the staff of the two bodies. USAID supports the efforts of both directorates and is perceived within the MOHFW as a constructive and impartial organization. USAID should invest some of its political capital with the Ministry by urging/facilitating a meaningful dialogue between the two directors, possibly with the participation of the Health Secretary, toward a more rational distribution of health worker responsibilities. At a debriefing for GOB managers prior to the assessment team’s departure from Bangladesh, the DGHS representative stated that both DGFP and DGHS personnel should do FP and health work. USAID’s offer to help develop an updated training program for FWAs could serve as a point of departure for those discussions.

An additional focus of those discussions should be on the role that family planning plays in helping achieve national health objectives that are the nominal responsibility of the DGHS. Specifically, the DGFP should press for the involvement of DGHS resources in family planning, as consistent use of effective methods of contraception is one of the quickest, least expensive ways to decrease the current high rate of maternal mortality in Bangladesh, especially among segments of the population who are at highest risk of morbidity/mortality from pregnancy and childbirth. These include the too young, the too old, and older multiparous women. Moreover, an effective way to improve the rate of survival among children under age five is to increase the interval of time before the birth of a subsequent child (i.e., increased birth spacing through the use of effective contraceptive methods).

- Explore DGHS interest in USAID training assistance for Community Health Assistants (CHAs): The GOB has reaffirmed its intention to create a clinic-based health services

system, with some 18,000 community clinics forming the outermost, village-based component of that system. The DGHS-managed cadre of CHAs who will staff those health posts could play an important role in providing FP information and services, but, as noted earlier, DGHS-managed personnel have not generally viewed FP as falling within their range of responsibilities. USAID should build on the DGFP-DGHS dialogue mentioned above and offer to expand USAID’s training assistance to include the development of a new or refresher training program for the CHAs which would include a strong FP component.

- Explore mechanisms to ensure and support effective delivery of FP services at the community clinics.
- Improve NIPORT training capacity: The National Institute of Population Research and Training is the appropriate training provider for the training initiatives discussed herein. However, institutional rivalries within the MOHFW could be a factor in a Ministry decision to conduct FWA and CHA training under the sponsorship of one or both of the other two directorates. To the extent that USAID considers it appropriate—e.g., if the Mission, in consultation with the MOHFW, determined that an enhanced NIPORT training capacity were in the longer-term interests of the health/FP program—USAID should urge the Ministry to assign FWA and CHA training responsibilities to NIPORT.
- Facilitate certification of NGOs or private organizations as trainers of FP providers and support their capacity-building work. This can be for internal purposes, or as resources for others including government.
- Conduct research into the causes of high discontinuation rates:<sup>12</sup> The assessment team proposes an illustrative package of research activities (see Annex F) that would inform the implementation and management of the overall FP program. One of those research activities—into the causes of high discontinuation rates—should be designed and conducted quickly. Indeed, the immediate utility of its results will be to improve the content of the FWA training manual/course discussed above. The study would include secondary analysis of fertility history data in the 2007 BDHS, as well as qualitative and quantitative client follow-up studies. These client studies would be conducted at several sites around the country in order to capture both national and locality-specific factors behind discontinuation. Such analysis/client studies could be carried out quickly and at relatively low cost.

### **Modest Reach of USAID-Supported NGOs**

USAID-supported projects are playing a qualitatively important role in the service delivery program. But with the exception of the SMC program, these projects have not yet had a strategically significant impact on contraceptive use. The 2007 BDHS found that 5.2% of modern FP users report they obtained their services from the NGO sector (of which the SSFP is only a part). Anecdotal reports suggest that NGO-based FP services (again, with the exception of the SMC) reach approximately 15% of the population of Bangladesh; the “reach” of USAID-supported NGOs within that figure has not been calculated.

Mayer Hashi—This project is working with health care providers, the Government of Bangladesh, and NGOs to improve information about maternal health and family planning and to

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<sup>12</sup> Anecdotal reports suggest a number of reasons for discontinuation that include poor counseling, stock-outs, method-switching, and the absence of a husband. In fact, however, program managers have no actionable knowledge as to why discontinuation rates are so high in Bangladesh, especially for pills and injectables. Efforts to obtain a better explanation of the phenomenon are essential: Some observers of the FP program have estimated that a 33% reduction in the country’s high discontinuation rates would produce a 50% increase in the CPR (Streatfield, 2010).

train professionals to provide safe LAPM service in Sylhet, Chittagong, and Barisal. The activity has been underway less than a year, so its impact is still very modest. That said, the project's design calls for the nationwide expansion of best practices learned through the project, suggesting that it has significant potential to improve maternal health and increase the uptake of LAPM through public-sector and NGO providers.

MaMoni—The activity in 15 upazilas in Sylhet has demonstrated a potentially powerful model to increase community involvement in pregnancy-related care, support for safe delivery, and promoting the active participation of husbands in maternal health care. It is not clear to the assessment team, however, that this model has significant potential to be adopted and scaled up by the GOB in other parts of the country. Indeed, the GOB generally and the DGFP specifically have usually deferred to NGOs to conduct community mobilization activities in Bangladesh, suggesting that successful, nationwide replication of the MaMoni model will depend on the extent to which it is adopted by other NGOs in the country.

SSFP—The project is trying to increase the breadth and depth of its LAPM services by expanding its satellite sites, and by upgrading the capacity of its clinics to provide a fuller range of clinical FP services, including emergency obstetric care and LAPM. However, the project's efforts to deepen its clinical capacity in FP are hindered by the training bottlenecks and very limited access to reimbursement funds described in Annex D. Moreover, unlike the Mayer Hashi project which works closely with GOB partners, the SSFP is a stand-alone network that works essentially in parallel to the service delivery programs of other organizations, most notably the GOB. (In theory, the SSFP and other providers complement GOB services by being assigned to geographic areas that are not adequately covered by the GOB. In practice, that assignment process is driven more by DGFP logistics considerations than by any meaningful assessment of FP coverage in specific areas. See the discussion of “mapping” below). Until and unless the SSFP succeeds in its efforts to expand significantly its capacity to provide LAPM services, it risks being a very costly distribution mechanism for temporary FP methods.

SMC—The Social Marketing Company is Bangladesh's most extensive delivery system for non-clinical FP services, and will continue to figure prominently in any strategic response to the demographic crisis facing the country.

## *Recommendations*

### Near Term

- Continue support for key USAID Projects:<sup>13</sup> USAID should continue support for the Mayer Hashi and SSFP projects, while keeping in mind the somewhat modest contribution both activities are likely to make in effecting significant increases in the CPR. Mayer Hashi is a technical assistance activity the impact of which is conditional on the extent to which the GOB and other partners are able to incorporate and scale up the best practices being developed by the project. Allowing Mayer Hashi to provide more post-training followup TA and support should facilitate the dissemination and application of best practices. It is a new project, the effectiveness of which will not become apparent until 2011–2012.

The SSFP is meeting most of its contractual targets, despite delays in scaling up its clinic-based FP services for reasons mentioned earlier. Many of those targets, however, are being met by the project's provision of temporary FP methods—a service-delivery role that is not cost-effective in terms of the share of FP funding that USAID invests in the activity. In the immediate term, USAID should promote the SSFP's efforts to improve its LAPM, especially its sterilization

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<sup>13</sup> Annex D discusses each of USAID's key projects in support of family planning and offers recommendations for improvements in the projects' implementation.

capacity, by intervening on the SSFP's behalf with the DGFP to secure full SSFP participation in the DGFP sterilization reimbursement system.

The MaMoni project has demonstrated the feasibility and importance of community mobilization to support improved maternal health and, to a lesser extent, family planning activities. The assessment team understands that this community mobilization model is gaining traction elsewhere in the Bangladesh NGO community, and that other NGOs are incorporating elements of the MaMoni approach into their own programs. During the final phase of the project, USAID can help MaMoni disseminate that model to the broader NGO community.

As noted earlier, the SMC is a major partner in USAID's Population/FP program, and will continue to play a key role in any comprehensive plan to ensure contraceptive security and choice for Bangladeshi couples. The assessment team recommends that USAID work closely with the SMC, e.g., with the results of an upcoming project evaluation, to develop a long-term business and strategic plan for the organization.

#### Intermediate Term

- Improve linkages between NGO, GOB, and SMC programs: As part of its training assistance for FWAs (see above), USAID should support the development of fieldworker tools (e.g., that guide the fieldworker to specific counseling advice depending on clients' age, parity, side effects, etc.). USAID should ensure that the same tool(s) are provided to all FWAs, SSFP counselors, and Blue Star providers, along with training in the use of the tools, to encourage use of consistent counseling messages across all components of the FP delivery system. In addition, Blue Star providers should be engaged as referral agents for LAPM services (using, for example, pre-printed referral cards) to the nearest SSFP or GOB clinic in their area.
- Provide technical assistance to the GOB to develop/implement "contracting out" procedures: The MOHFW has virtually no experience—and, some would say, little interest in—procedures whereby the Ministry or local-level elements of the Ministry could contract out to NGOs for provision of health and/or FP services. Meanwhile, several NGOs have excess clinical capacity and/or technical skills that complement gaps in the public sector. Contracting out to these NGO facilities would help equalize workloads, enable clients to exercise freer choice in their health-seeking behaviors, and contribute to the long-term financial sustainability of NGO networks. USAID should offer to provide technical assistance to the MOHFW to help develop the regulatory and, if necessary, legislative instruments needed to implement a contracting-out mechanism. This technical assistance should also help develop the specific administrative procedures to be followed by the MOHFW and NGOs that might choose to participate as contracted service providers.
- Map service providers: A wide variety of NGOs, private practitioners, and social marketing and GOB organizations work in the same or overlapping coverage areas; none of these parties is aware of the total number of organizations or programs working in any specific service area. Without this information, program managers and planners (the DGFP, donors, municipal governments, and the service providers) are not able effectively to "ration" roles and responsibilities, or to take advantage of the natural complementarities that may exist among the service providers.
  - It is not in USAID's interest to support a mapping exercise of the entire country. However, the Mission should consider sponsoring such an exercise in selected service areas where it proposes to implement (e.g., through an NGO) a specific service delivery program. The International Center for Diarrheal Disease Research, Bangladesh (ICDDR,B) and/or the Associates for Community and Population Research (ACPR)

could be contracted, or subcontracted through a USAID/Washington intermediary, to conduct such mapping exercises.

## **Under-served Population Groups, Especially in Urban Slums**

Rural-to-urban migration is fueling a rapid increase—estimated to be approximately 5% per year—in the size of urban areas in Bangladesh. This rapid growth is especially evident in the expansion of urban slums, some of which fall within cities’ administrative boundaries while others contribute to an expansion of metropolitan areas beyond the nominal jurisdiction of municipal authorities. The worst of these slums lack roads, infrastructure, water, electricity, and sanitation facilities. Such slums pose a huge ethical and development challenge to the country’s leaders. The slums also create an opportunity for FP program managers in that, to a significant extent, large numbers of people from rural, hard-to-reach areas are placing themselves at closer (and less costly) proximity to FP service delivery organizations when they move into urban areas.

The “2006 Bangladesh Urban Health Survey” conducted by the National Institute of Population Research and Training (NIPORT), the International Centre for Diarrheal Disease Research, Bangladesh (ICDDR,B), and ACPR, with assistance from the USAID MEASURE project, was the first study to disaggregate urban slum data as a distinct data set from hitherto more general “urban” data. The study shows that the poorest slum dwellers suffer from worse health and fertility indices than other urban residents. These indices include higher fertility, earlier onset of childbearing, earlier marriage, and lower contraceptive prevalence.

### *Recommendation*

#### Intermediate Term

- **Extend service delivery to urban slums:** USAID/Bangladesh and other donors have long recognized the need to extend health and FP services to urban populations, especially to the residents of urban slums. Urban populations are served neither by the DGFP nor the DGHS; they are the responsibility of municipal governments, which do not provide appropriate services. USAID’s Urban Family Health Initiative (UFHP) in the 1990s; the ongoing Urban Primary Health Care Project (UPHCP) supported by the Asian Development Bank (ADB), the United Nations Population Fund (UNFPA), the UK’s Department for International Development (DFID), the Swedish International Development Cooperation Agency, and others; the urban elements of the SSFP and SMC projects; and a Gates Foundation-funded project implemented by BRAC—all deliver significant health and FP services to urban populations in all six of the country’s city corporations. The assessment team’s examination of these projects indicates, however, that a relatively modest portion of project activity is directed to the worst of the country’s slums, i.e., those areas, many of them squatter settlements, that are destination sites for the poorest new arrivals in urban areas. One knowledgeable observer involved in the ADB/UNFPA-supported project suggested, for example, that the activity was probably reaching at most 10% of the population in those worst-case slums. The remaining 90% of slum dwellers may represent a key component of the under-served population in the country.

USAID could initiate services to some of these populations quickly, via an expansion of SSFP satellite sites into the country’s worst slum areas (assuming success in securing DGFP, Ministry of Local Government, and city corporations’ authorization to proceed). Sufficient approved “head room” currently exists in the project, which has USAID authorization to establish an additional 1,000 satellite sites throughout the country. Prior to taking that action, however, USAID (plus the GOB and other donors) needs a much better idea of the range and use of FP services in slum areas. The 2006 survey cited above was a useful start, but a more focused look at contraceptive knowledge, practice, and providers in the poorest slums is required in order to

inform expansion into those areas. The assessment team recommends that USAID consider sponsoring a second round of the 2006 survey to collect that information. If warranted by the study's findings, USAID should proceed quickly to support an expanded effort to deliver FP services in the country's worst slum areas. Should USAID decide to proceed in this direction, it is worth noting that experience suggests that municipal governments/city corporations do not seem to share the DGFP's reluctance to contract out services to NGOs.

### **Non-involvement of Other Potential Partners in FP Service Delivery**

FP services could become more widely available if a number of potential participants, now on the sidelines, entered the "market." Some of these prospective partners have been mentioned previously, including, for example, elements of the larger USAID/Bangladesh assistance program. A more significant and longer-term role in service delivery, however, could be played by the professional private sector, which at present is relatively sparse and focused largely on diagnostic services and provision of upscale obstetric and gynecological services. That arrangement is likely to change in the years ahead, as market forces and increasing client segmentation encourage more extensive participation of private-sector providers in the delivery of health and FP services. USAID can play a role in expediting that market transition.

#### *Recommendations*

##### Intermediate Term

- Engage professional organizations and private providers:<sup>14</sup> The fielding of new, better-trained GOB outreach workers will help ensure improved access to FP services. However, these new staff will not be working in a vacuum. Virtually all parts of the country, including hard-to-reach areas, are also served by traditional birth attendants, private practitioners (including physicians and trained midwives), and Blue Star outlets. The mapping exercise noted above will help to identify these providers and their location in key project areas, and will also provide a tool for USAID to begin the second phase of a longer-term effort more fully to mobilize non-government providers as full participants in the family planning program. This effort should include training of traditional midwives (a long-time focus of prior USAID programs in Bangladesh); outreach to private-sector nurses, midwives, and physicians through their respective professional associations; provision of business training to private-sector providers, especially midwives and Blue Star managers; examination of ways more actively to engage the 200,000 pharmacists and other retailers who sell SMC products;<sup>15</sup> and policy dialogue with the GOB to permit Government certification of private-sector practitioners. USAID should begin those overtures now with the professional associations and the GOB in order to lay the foundation for a more expansive future role for these parties.
- Facilitate private practitioners' provision of family planning services (e.g., include them in clinical and other training provided to NGO and public-sector practitioners and explore mechanisms through which private practitioners might gain access to necessary commodities at lower cost as is currently being done for Smiling Sun providers).

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<sup>14</sup> See Annex E, "Summary of the Role of the Private For-Profit Sector in Addressing the Impact of Population Growth on the Development Goals of Bangladesh," for a more complete discussion of a potential role for the private sector in service delivery and advocacy.

<sup>15</sup> Worldwide experience has demonstrated that contraceptive "training" for pharmacists does not generally result in meaningfully improved counseling for their clients. Bangladeshi pharmacies—generally small, crowded, and staffed by male pharmacists—do not appear suited to the counseling of women on contraceptive matters.

### Longer Term

- The curricula in Bangladesh’s medical, nursing, and midwifery schools lack any meaningful content, whether in the classroom or the clinic, on family planning. This gap places a heavy burden on the GOB—by far the largest employer of these schools’ graduates—to provide FP training to these personnel after they are recruited for Government service. Looking to the future, however, Bangladesh is likely to follow a trajectory similar to other developing countries, whereby Government services are increasingly targeted to segmented, i.e., the poorest, elements of the population, while the private sector moves forward to serve the rest. USAID should encourage and facilitate those trends by initiating efforts to introduce FP into the curricula of professional schools to hasten the day when these health professionals can play an important role in a comprehensive and sustainable FP delivery system.

## **LACK OF BCC SUPPORT FOR FAMILY PLANNING SERVICES**

Neither FP users (current or prospective) nor FP providers have been able to access timely, accurate, and relevant information from a coherent national BCC program that supports small-family norms, counters clients’ misinformation, provides information on where services may be obtained, or informs couples of their FP options. Moreover, quality of care is often poor, especially at GOB facilities, and clients have little awareness of their right to demand and expect better care from health service providers. Finally, the special needs of young people are generally acknowledged more in theory than in fact.

As a result of this lack of information:

- Basic knowledge of FP methods is low (e.g., women stop using orals when their husband leaves and start when he returns).
- Male involvement is low and unformed.
- Knowledge of the mortality and morbidity risk of unwanted pregnancies is low.
- The poor quality of service results in ineffective use of contraception, unwanted pregnancies, increased use of menstrual regulation and abortion, and increased maternal mortality.
- Younger cohorts are entering reproductive age without the benefit of an active BCC program to help them make informed decisions about their reproductive health.
- Provider knowledge is relatively low and undermines the role providers play.
- Widespread misinformation is not addressed.
- Traditional method use is relatively high.

Until a meaningful BCC effort is reestablished in Bangladesh, the absence of information that couples need to make informed decisions about their fertility will continue to depress the country’s CPR. Moreover, the continued absence of BCC efforts lowers the visibility of the FP program and undermines the political will needed to field a successful program. The essential task facing the GOB and its partners is to make BCC an ongoing part of the national (public, NGO, private) family planning program. This will require:

- Implementation of the GOB’s existing Communication Strategy.
- Harmonization of all programs’ BCC messages to maximize their impact.
- Formative research that refines audience segmentation and message content.

- Prioritization of targets for BCC to maximize impact on the CPR.
- Development of job aids to improve the interpersonal communication skills of field and clinic staff.

## **Current Media Environment**

In the media-poor environment of the 1970s and 1980s, the FWA was critical. The home-visiting role these women played gave them access to women in a safe environment, overcame the constraints of illiteracy, and provided the motivation to use and to keep using. As noted above, FWAs are still the GOB's primary channel for interpersonal communication with women and couples, but their declining numbers and outdated training impedes their effectiveness. FWA knowledge is not current; service delivery guidelines are out of date and cannot serve as a sanctioned reference; and women's specific knowledge of family planning is poor. The results of these problems include high discontinuation rates, use of less effective methods, and widespread misinformation affecting acceptance. The problem is exacerbated by widespread use of commercial sources (pharmacies and drug sellers) where counseling opportunities are rare.

The media have developed considerably and provide a wide range of possibilities. Exposure to electronic media is high, with 47% of ever-married women 15–49 watching TV once a week and 19% listening to the radio. Even among the poor, 17% watch TV and 8% listen to the radio. The problems with the electronic media in Bangladesh are the same as those in other countries: Media time is expensive; increasing production values raises costs further; impact is blunted by many messages; messages must be simple; and media design and placement takes sophisticated research to get messages right and to place them in the right spot for the desired audience. The reach and impact of electronic media are strong, however, so they are usually cost-effective. Print media have a reach, but not as large as the electronic media; nor do print media reach across social groups (BDHS-07).

Community mobilization is usually part of a strategic communication effort because it uses peer support to change norms and values for the larger group. It is not currently widely used in Bangladesh in family planning. It has been used in the past (Jiggasha) with some success, suggesting that it might play a role in future efforts. Currently the USAID Project MaMoni is using a community mobilization approach in parts of Sylhet Division, and it may provide some insights in how to use it on a larger scale. Community mobilization is used informally by FWAs to get satisfied users to promote family planning, but this is an individual effort and no training or materials have been provided to help FWAs leverage the power of the community of users.

## **Current Program<sup>16</sup>**

BCC works in Bangladesh. It has worked in the past for family planning and is currently working for an expanded program of immunization (EPI) and oral rehydration salts (ORS). Specifically, BCC works when it has the human resources, actionable responses, clear messages, coordination, and resources needed to reach the population. Unfortunately, that has not been the situation regarding family planning for several years.

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<sup>16</sup> This section is a synthesis of materials and ideas from BDHS-07, field observations, key informant interviews, and the following publications:

Bangladesh Center for Communication Programs. "BCC Issues in Bangladesh: An Overview." Dhaka, Bangladesh: October 2009. (Unpublished)

Bangladesh Ministry of Health and Family Welfare, Directorate General of Family Planning. The National Communication Strategy for Family Planning and Reproductive Health. November 2008.

Fox, Elizabeth. "Summary of Behavior Change Communication Roundtable and Assessment: Key Points from BCC Roundtable." Dhaka, Bangladesh: October 2009.

Current communication issues affecting the family planning program include:

- Failure to implement existing policies and strategies.
- Communication activities that are project-directed, with a narrow focus and no coordination or synergies for the large program issues.
- Lack of tools or job aids to facilitate quality interpersonal communication.
- Inadequate pretesting and formative research to ensure high-quality and culturally appropriate materials.<sup>17</sup>
- The fact that dramatic social changes have changed audiences, attitudes, and social norms, and will require new formative research and better evaluation.
- Lack of consistent messages and occasionally inconsistent messages.
- No systematic process for addressing new issues or innovations.
- Lack of communication materials and/or coordination by the GOB, diminishing the critical importance of population issues in the eyes of stakeholders.
- Limited interest among organizations in sharing lessons learned

On a positive note, the GOB has produced a “National Communication Strategy for Family Planning and Reproductive Health.” The Strategy is very good and comprehensive. The DGFP has recently expressed interest and has requested technical assistance to reactivate their BCC work. If and when the GOB and/or donors are interested in implementation, they will have a significant start on a high-impact strategic communication effort.

#### *Recommendations*

Media production and message design could begin quickly, using existing data to set priorities and define audiences. Below are some recommendations for communication initiatives that arise from existing data. They are listed roughly in order of priority based on their potential impact on family planning use and ease of implementation.

#### Near Term

- **Sensitize the Public to the Population Crisis and a Smaller Family Size Norm:** The new messages on family planning and small family norms will have to incorporate “why now” messages to explain their absence from the media over the last several years. These messages will have to deal with an already low ideal family size (2.3 children) and explain why this figure needs to go lower. The impact of reduced infant and child mortality will help explain some of the population growth. The problems, both national and personal, of excessive population growth will have to be articulated. These messages also need to “brand” the issue so that subsequent messages on multiple channels will link back to the problem statement and the consequences.
- **Build the Capacity to Design, Implement, Coordinate, and Evaluate BCC Interventions:** The substantial need for strategic BCC activities and coordination of those activities across stakeholders should be obvious. USAID has the predominant technical capacity in this area and the credibility to play a leadership role among the stakeholders. The Agency should

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<sup>17</sup> One of the hallmarks of good communication is a reliance on research to support audience analysis, message design, language, pretesting messages, media plans for maximum reach, and evaluation of results. The BDHS is an existing and critical tool for design, priority setting, and evaluation.

provide the technical support to build the institutional capacity to do BCC. There are two approaches—first, USAID should consider supporting expanded capacity within the MOHFW. The GOB will have an ongoing need for health communication beyond the existing reproductive health needs. A health communication structure already exists within the MOHFW, and improving its capacity to identify communication needs, identify basic communication interventions, and knowledgably contract for technical support (research, production, evaluation, media procurement, etc.) could institutionalize BCC. The second approach is to identify a host country group with a high level of technical expertise and sufficient manpower that will provide technical support to BCC activities in the OPHNE portfolio. Because the portfolio crosses the GOB, the private sector, and NGOs, the institution should be outside the Government. Supporting a single, technically capable organization would address the common criticism of current communication efforts—the lack of an overarching strategy, coordination, shared information, and consistency of messages (see Fox, BCCP). BCC is a critical part of the USAID agenda, and stability and consistency can only help increase the impact of BCC on desired family size, adoption of family planning, and use of more effective methods.

- Improve Contraceptive Continuation with an Effective Communication Intervention: There are two main reasons for discontinuation—contraceptive stock-outs and lack of information. Stock-outs are addressed elsewhere in this report. The team has recommended further study of causes of discontinuation, but there are already sufficient indicators from the BDHS and international experience to propose a set of communication activities for the most likely causes of discontinuation:
  - Fear of and misinformation on side effects.
  - Lack of information on temporary side effects (e.g., amenorrhea associated with implants).
  - Inadequate training of clients on effective use.
  - Lack of information on what to do if side effects occur.
  - Lack of information on backup methods if contraceptives are not available.
  - Lack of information on protection from unprotected intercourse (ECPs).
- Effective BCC requires effective audience segmentation, multiple channels for transmission of information, and sufficient exposure to the messages. The audience would include:
  - Health providers, including FWAs, FWVs, HAs, pharmacists (Blue Star is a logical channel), doctors, and clinic counselors.
  - Women currently using a method.
  - Women who have discontinued a method.
  - Women receiving menstrual regulation (MR) or abortion.
- Desired Behavior Change
  - Providers need to counsel clients better on side effects; the effective use of a method (e.g., the oral pill does not provide pregnancy protection immediately once a client begins to take it); what to do if the client has side effects; other method choices; and addressing misinformation.

- Providers in facilities providing MR or abortion need to counsel clients to determine the causes of unplanned pregnancy and provide information to prevent a recurrence.
- Husbands need to support effective use of their wife’s chosen method, encourage contact with a health professional if problems arise, and prepare a backup method (like condoms) if their partner discontinues use.
- Pharmacists need to provide more information to clients, both by counseling and through handouts, with special emphasis on side effects and effective use of contraceptives. (This intervention is especially important because pharmacists are a major provider of oral pills—the most important FP method—and they are may be the only health professional the client has contact with.)
- Contraceptive users need to choose more appropriate contraceptive methods; understand how to use these method effectively; be aware of side effects and seek help if bothered by them; combat rumors and misinformation in the community; and proactively seek information from providers.
- Channels of communication and appropriate message content could include:
  - Mass media—TV and radio can be used to promote ECPs as a backup if the regular method is discontinued. Print media can provide more detailed information on normal side effects, encourage consultations with health providers, and address misinformation.
  - Client educational materials.
  - Counseling job aids for providers.
  - Training for providers.
  - Community presentations to build a critical mass of knowledge in the community in order to combat rumors and provide peer support.
  - Clinic educational materials (e.g., Tiaht poster, handouts, videos).

The above framework of a communication intervention is often called a supply and demand model—the purpose being to create a supply of quality information and a demand for that information.

- Address and Reduce High-Risk Pregnancies: Messages to reduce high-risk pregnancies (women who are too young, older, multiparous, have a history of complications, brief birth intervals, a recent pregnancy termination, etc.) could be relatively simple and quickly impact the CPR, as well as integrate family planning and maternal health prevention of high-risk pregnancies. Such messages have also not been addressed in a communication program. The last measurement of maternal mortality ratio in 2001 was 324 per 100,000 live births. While this ratio has probably declined, the overall poor quality and limited availability of health services, the high percentage of home deliveries (85%), and the low percentage of deliveries assisted by a trained health provider (18%) all suggest that maternal death remains a common occurrence (BDHS-07). Preventing high-risk pregnancies with the use of effective contraception is an appropriate intervention for both a family planning and a maternal mortality prevention strategy. The desired behavior change is to get women with increased risks from pregnancy to use contraception and to use more effective methods, and to get high-risk women wanting the pregnancy to obtain prenatal care and delivery assistance. Interventions to reduce high-risk pregnancies should:

- Use mass media and health provider counseling to increase public awareness of risk factors.
- Improve health provider screenings to reduce pregnancy-related risks.
- Promote risk-appropriate methods.<sup>18</sup>
- Use targeted campaigns to promote male and female sterilization.
- Promote increased use of postpartum sterilization and IUDs (after regulatory changes).
- Promote the use of IUDs.
- Encourage women at risk and seeking pregnancy to learn the risks and the precautions (prenatal care, assisted delivery, access to emergency obstetric care).

Not all women at risk need contraception. Some may be using, and some may be infecund. But many are not using or are using less effective methods. Given the large numbers of women at risk and the obvious benefits of reducing that risk, a campaign focused on at-risk women could very quickly generate a jump in the CPR and save women’s lives.

- **Conduct Behavior Change Communication to Support Services in Low-Prevalence Areas:** The team has suggested activities to address the geographic disparities in the CPR. These areas can be characterized as having strong traditional values and a weaker service delivery structure. These activities would be intermediate, to allow project activities to start and to ensure that there is a supply when demand is generated. Based on the goal of affecting the CPR by responding to unmet need, interventions would first operate in Chittagong Division and Sylhet. Activities should start in Chittagong because it has a much larger population and has already shown a pattern of increasing the CPR. Activities associated with low-prevalence interventions could:
  - Conduct formative research better to address local cultures, languages, and associated constraints.
  - Select local champions to act as spokespersons.

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<sup>18</sup> Currently weaknesses in screening, counseling, and public education have resulted in clients making method choices that do not consider risk factors. As a result, many choose relatively less effective methods. For example, the risk of pregnancy complications and related mortality increases with age. Therefore, older women should be using an “age appropriate” method. Yet, among currently married women ages 40–44, 45% and 23% are using pills or injectables. Both pills and injectables have high rates of “perfect use” effectiveness, but lower rates of “typical use” effectiveness, especially in a stock-out and poor counseling environment like Bangladesh. Traditional methods (periodic abstinence, withdrawal, folk methods) are less effective than modern methods, and yet 8% of ALL married women (15% of currently married women aged 40–44, and 11% of women aged 45–49) are using them to prevent pregnancy. To minimize the risk of maternal mortality, a good method mix would have older women moving to more effective methods—IUDs, implants, sterilization.

High-parity women are also at greater risk from an unwanted pregnancy, and yet 27% of married women with five or more children are using pills and injectables. Only 13% are using “parity appropriate” methods. Couples who desire no more children are at greater risk because they are likely to be older and have higher parity, and they are also more likely to terminate the pregnancy with abortion. Despite the risk, 55% of injection users and 62% of pill users report that they want no more children. About 44% of currently married women use resupply methods. Shifting long-term users and high-risk women from resupply methods to sterilization, IUDs, or implants would reduce unwanted pregnancies, client costs, and problems with stock-outs and provider availability.

- Identify and prioritize constraints to contraceptive use and address those with the greatest impact.
- Develop local strategies that fit with the national-level communication strategy.
- Use a wide range of media to carry messages.
- Provide high-quality counseling to provide maximum behavior change.
- Support counseling with job aids and client education materials.
- USAID Should Support Advocacy Efforts to Improve the Quality of Care in GOB Family Planning Services: Such advocacy will be necessary to get the GOB to shift from an “increasing availability” strategy to a strategy that also addresses the poor quality of services currently hampering effective and efficient use of contraception. Advocacy support for quality could include providing empirical evidence of poor quality from BDHS and operations research or simple field assessments (see Research Agenda, Annex F); convening national policy workshops on quality; conducting study tours (e.g., Egypt Gold Star); and helping to mobilize civil society and women-serving NGOs on the issues of quality of care.
- USAID Should Advocate for More Active Roles in Meeting the Needs of Young People for Information and Services: Advocacy can focus on the issues of early marriage, greater parental support for delayed marriage, the consequences of dowry practices, and the role of employment for young women. The GOB should be leading the public debate on these issues and seeking ways for current policies and programs to support reproductive health for young adults. Advocacy should also be directed to local governments, which are closer to the consequences and possible solutions for addressing the youth issues that predominate in their communities.
- Support Existing Service Delivery Projects (the SSFP and Blue Star): Another communication intervention that could start very quickly would be the promotion of existing projects. The campaigns should have the following characteristics.
  - Blue Star has larger coverage areas, so the media can be national and local.
  - The SSFP has more limited coverage areas; promotion and education should support project services in the upazillas and communities where clinics are located.
  - Messages and media should be visually linked to the national program and objectives.
  - FWAs should be provided with promotional materials to make clients aware of alternate or backup sources of supply, and to promote self-reliance for clients able to afford a private-sector source.

#### Intermediate Term

- Educate Traditional Method Users to Shift to More Effective Methods: Bangladesh has an unusually large number (8.4%) of traditional method users (periodic abstinence, withdrawal, and others). These methods have very high pregnancy/failure rates (up to 27% per year). Interestingly, use of traditional methods is higher in the high-prevalence divisions where modern methods are clearly available. A campaign targeting these couples could impact the CPR quickly and prevent unwanted pregnancies and their associated health consequences. Interventions to transition users from less effective methods to modern methods could include:
  - Print media coverage to educate the public on the increased risks of unwanted pregnancies for traditional method users.

- Special efforts by FWAs and FWVs to identify and counsel clients who are using traditional methods.
- Involvement with traditional and religious leaders to counsel community members to use modern methods.
- Using the initiative to update FWA training (as proposed in the previous section of this report), which will play a major role in reducing these risk factors by preparing FWAs to address them more effectively in the course of their interpersonal communication with current and prospective clients.

### Longer Term

The above communication activities are based on empirical data and have priorities based on impact. There are other possible communication interventions available for a full-scale BCC strategy. Their priority will depend on selected interventions, how well the interventions support national program objectives, and the value of the benefits relative to the cost of the intervention. Longer-term initiatives for USAID consideration include:

- BCC to increase male involvement in family planning.
- BCC to empower young adults to make informed choices and reduce their risks.
- BCC to family planning providers to improve quality of care and respect client rights.
- BCC to generate demand for improved quality of care.

Finally, it is recommended that USAID create an organizational support structure for implementing its Behavior Change Communications Strategy. USAID should identify one host country group with high-level technical expertise and sufficient manpower that will provide technical support to BCC activities in the OPHNE portfolio. A common criticism of current communication efforts is the lack of an overarching strategy coordination, shared information, and consistency of message (see Fox, BCCP). BCC is a critical part of the USAID agenda, and stability and consistency can only help increase the impact of BCC on desired family size, adoption of family planning, and use of more effective methods.

## **CONTRACEPTIVE SECURITY**

Contraceptive security is fundamental to realization of the fertility choices of Bangladeshi couples, and to maintenance and expansion of the contraceptive prevalence rate. Ensuring contraceptive security should therefore be the foremost priority task of the DGFP, its donor partners, and family planning program stakeholders. Yet despite an impressive record of achievement over the years, the GOB family planning program remains beset by stock outages, gaps in the range of contraceptive methods available to users, unnecessary restrictions on method provision, and an overly narrow range of sources for contraceptive supply. As a result, the program is characterized by high contraceptive discontinuation rates, reliance on an inappropriate method mix, and unwanted/unintended pregnancies. Fortunately, most of these shortcomings can be addressed by USAID through policy dialogue and provision of technical assistance, as discussed below.

### **Consistent, Uninterrupted Supply of Contraceptives through the Government System**

During the past several years, a number of contraceptive stock outages have occurred within the Government system. Stocks of injectable, IUD, and implant contraceptives, for example, have fallen below levels of demand on several occasions, and contraceptive clients reportedly

have had to switch methods without warning or have discontinued contraceptive use. It is currently reported that unless concrete actions are taken immediately, there could be more stock-outs of injectables, IUDs, and condoms in the Government system within 12–15 months. By most accounts, the warehousing and distribution of contraceptive products run relatively smoothly within the Government system. However, several external analyses of recent stock-outages have revealed that failures in the implementation of the procurement process itself are the root cause of stock outages. (The current situation may be accounted for in part by USAID’s previous TA emphasis on logistics management, rather than on the procurement process.)

The Government of Bangladesh currently uses funds from SWAp-II for procurement of contraceptive and other health-related products. The contraceptives the GOB procures with these funds not only supply the needs of the public-sector outreach and clinic systems but also a significant part of the contraceptive needs of many of its NGO partners. Consequently, the success or lack of success with which the Government implements the procurement process has impact well beyond the Government’s own service delivery system.

Commodity procurement by the GOB with funds from SWAp-II is governed by the procurement rules of the World Bank. Many informants described to the team the cumbersome nature of the Bank’s procurement process, particularly the number of signatures required and the number of passes between Dhaka and New York that procurement documents must make. There is equal evidence, however, that local Bank staff are now working with DGFP procurement staff and their USAID-provided technical assistance support staff to help ensure the accuracy of procurement application paperwork prior to its formal submission for approval. There is also evidence that, despite awareness of the time-consuming and often difficult process for procurement approval, responsible DGFP staff are not ordering sufficient quantities to last through this lag time, or initiating the application process at a point in time that would allow for expected delays or required application revisions to be made, the process completed, and the product received in-country prior to a stock outage. In other words, DGFP staff are not ordering sufficient quantities to meet demand until the next order/shipment is received. In addition, procurement regulations of the Government of Bangladesh require that any commodity procurement whose value is US\$1.5 million or greater must be approved at the level of the Prime Minister.

The primary factors influencing the consistent, uninterrupted supply of contraceptives through the Government system appear to the assessment team to include the following:

- *Lack of accountability*—No one within the Government system appears to “get in trouble” when stock outages occur. Even at the upper levels of DGFP management, a belief that donor partners will provide “emergency” stocks when outages occur erodes a sense of accountability.
- *Lack of advocacy*—The link between contraceptive availability and use, and the achievement of national development goals, is not strongly perceived at the operational level. The vital importance of an uninterrupted supply of contraceptives does not appear to be truly and fully understood throughout the Government hierarchy.
- *Cumbersome procurement procedures*—Donor and GOB regulations and procedures governing commodity procurement are time-consuming and require multiple approvals up to the highest level of Government.
- *Inadequacies in procurement process scheduling*—Insufficient lead time is allowed to compensate for the possibility of required revision of paperwork and necessary approvals.

Everyone involved in the Government's contraceptive procurement knows that the procurement approval process has sometimes presented problems, but the procurement approval application process is not started within the DGFP far enough in advance to accommodate known possibilities for delay.

- *Inaccurate forecasting of needs*—Quantities ordered do not take into account the long lead time necessary for the procurement process and shipping of commodities.

The assessment team makes the following recommendations to address the factors cited above:

### *Recommendations*

#### *Near Term*

- A chain of accountability for timely procurement of contraceptives should be developed within the DGFP and published or otherwise communicated to all those involved in family planning program management. One person/office should be identified as accountable for reporting to the DGFP, program managers, and donor partners on a regular (monthly or quarterly) basis the status of contraceptive supply, by method or product type, vis à vis the status of the procurement approval process for resupply of each. USAID technical assistance through the Strengthening Pharmaceutical Services (SPS) Project within the DGFP should work to ensure that this accountability system operates.
- A high level of technical competence of DGFP procurement staff should be achieved.
- With the continuing help of SPS technical assistance, the DGFP should build the technical capacity of its staff so that they can develop realistic time lines for the procurement process. A revised calendar/time line should include sufficient lead time to allow for any application revisions required or likely delays in transmission through the approval hierarchy. The calendar/time line should not be based on a “best possible” scenario but instead on a “most likely” scenario.
- Accurate forecasting should be used that takes into account real needs and time lag until orders of commodities are processed and arrive in-country. All major stakeholders should be included in the planning process.
- USAID should continue to make clear to its DGFP counterparts that the Agency is not prepared to make emergency donations of contraceptive products when the shortfall is occasioned by mismanagement of the procurement process.
- USAID/Dhaka should resume its high-level advocacy within the Government of Bangladesh for family planning, and the importance of family planning to population and development goals. A consistent supply of contraceptives should be linked in this advocacy to the potential for success of the national family planning program, and ultimately to the achievement of national development goals.

#### *Intermediate Term*

- USAID should consider providing technical assistance (e.g., through the Health Policy Initiatives Project) for the development of a cadre of local influentials and family planning champions. The activities of these champions from within both government and civil society organizations can help to sustain understanding of the critical importance of an uninterrupted contraceptive supply to the national family planning program, and create demand for accountability for the availability of adequate supply.

- USAID should provide technical assistance to DGFP for multi-year procurement approval – thus alleviating the current annual need to implement time-consuming procurement approval applications.

#### Longer Term

- The team recommends that USAID and its donor partners provide the advocacy, policy, and TA support necessary to help the Government of Bangladesh prepare for that point in the future when the Government will have to accept financial responsibility for the public sector’s contraceptive supply from its revenue budget.

### **Availability of a Broad Range of Contraceptive Methods and Product Varieties within Methods**

Worldwide family planning experience has demonstrated that couples are most likely to use a contraceptive method when a broad range of contraceptive options is available to them. Family planning program managers also understand that a couple may use first one contraceptive method, then another as they move through their reproductive life cycle and/or their life circumstances change. Consequently, the availability of a broad range of contraceptive methods and product varieties is essential to overall contraceptive security in a national family planning program.

While many methods may be legally provided or are a stated part of the Bangladesh national family planning program, there is a somewhat restricted range of contraceptive methods actually available. Constraints on availability of contraceptive methods in Bangladesh include the following:

- Tubal ligation and no-scalpel vasectomy—A considerable shortage of trained providers currently hampers the widespread availability of surgical methods of contraception. Some NGOs that do have trained providers available for service delivery can only provide a limited number of procedures because they lack access to government-advanced funds for reimbursement of provider fees and acceptor travel expenses/lost wages. Eligibility criteria also limit the availability of these permanent methods of contraception. Tubal ligation, for example, can be offered only to women with two or more living children; and postpartum contraception cannot be provided, according to DGFP regulation, until at least 30 days after delivery.
- IUDs—Currently only female physicians and FWVs are allowed to insert IUDs. The shortage of physicians at post within the Government system, and the number of FWV positions standing vacant, limit the availability of this long-acting method. Product stock-outs in the Government system have also contributed to limited availability of IUDs.
- Emergency Contraceptive Pill (ECP)—In a market where not only do oral contraceptives account for over 50% of all modern method contraceptive use, but where the high discontinuation rate of approximately 54% within the first year of OC use (DHS 2007) implies considerable non-compliance, there is great need for a backup method of contraception. Husbands who return home from distant work with little or no notice to wives who have discontinued contraceptive use during their absence also contribute to the need for emergency contraception. Currently there is no ECP available in the Bangladeshi marketplace—which leaves MR and abortion as the only available backups for method/user failure. After an initial purchase of ECPs was not fully distributed through the public-sector system prior to its expiration date, the Government declined to purchase more. (The SMC purchased from the Government its remaining stock of ECPs and distributed it into the

SMC pipeline prior to product expiration. The SMC plans to reinstate sales of ECPs in 2011, although this depends on the availability of the product from a local producer.)

- Progestin-only Pill (POP)—Where lack of accurate knowledge of return to fertility after childbirth is high (forthcoming Bloomberg study, Sylhet), and where increased use of breastfeeding is a national health/nutrition priority, the absence of an oral contraceptive appropriate for nursing mothers represents a significant gap in the range of needed contraceptive methods. Additionally, when progestin-only injectables are unavailable due to stock-outs, adopters of that method are reportedly often advised to switch to OCs. To what degree any side effects from switching between a progestin-only method and a combined hormone method may contribute to client dissatisfaction and discontinuation is not known, but discontinuation rates are approximately 53% during the first year of use for injectable contraceptives, according to the 2007 DHS. SMC staff report that the company is on track to launch sales of a locally manufactured POP product in August 2010.
- Injectable contraceptives—Injectables are reportedly an increasingly popular method of contraception among Bangladeshi women, but Government stock-outs have limited their consistent availability. Household provision of injectables (particularly important in eastern regions where cultural norms are said to constrain female mobility) is limited to specially trained FWAs whose number and geographic distribution are not apparent to the team. Injectables are otherwise available in non-clinic settings only through the approximately 3,500 Blue Star providers of the SMC.
- Implants—Government stock-outs have limited the consistent availability of this long-term contraceptive method. The cost of procuring this product is said by some to have also limited the Government's purchase capability. Availability in the international market of a Chinese product, priced at about US\$7 per unit rather than US\$24 per unit for a Western-produced product, has ameliorated the cost constraint to some extent.
- Stock outages significantly limit the range of contraceptive methods available to Bangladeshi couples. The assessment team's recommendations for amelioration of stock outages appear above; the following are additional recommendations in response to limitations on method availability:

### *Recommendations*

#### Near Term

- USAID should work with its DGFP counterparts to demonstrate the need for POPs and ECPs in the public-sector family planning system.
- USAID should provide technical assistance, as necessary, to the Social Marketing Company to help it introduce and promote ECPs and POPs throughout its nationwide system. Useful TA could be provided through the centrally procured Strengthening Health Outcomes through the Private Sector (SHOPS) Project, for example, as part of a broader strategic planning and TA process.
- USAID should consider including within its financial assistance to the SMC funding for a reintroduction campaign in support of ECP and POP products. This campaign should be supportive of and compatible with any public-sector reintroduction strategy.
- USAID should continue to provide the SMC with free supplies of injectable contraceptives while providing TA to the SMC in identifying an appropriate-quality, affordably priced replacement for the donated product.

- USAID should ask its NGO partners to prepare a list of their service delivery outlets currently receiving advance funds from their local districts for reimbursement of tubal ligation (TL) and no-scalpel vasectomy (NSV) provider stipends and client travel costs/loss of wages. USAID should use this information to facilitate negotiations with the DGFP toward extending the GOB reimbursement arrangement to all NGOs that are authorized by the DGFP to deliver FP services in Bangladesh.

#### *Intermediate Term*

- USAID should work through its cooperating agencies and NGO counterparts to assist the DGFP in developing a comprehensive strategy for the reintroduction of POPs and ECPs into the national family planning program. Such a strategy should include a statement of the place of these products within the family planning program (target clients, indications for use, etc.); any necessary method refresher training for providers; development of information, education, and communication (IEC) and promotional messages for use with potential clients; and a plan for outreach and distribution of the products. Particular consideration should be given to the role that FWAs can play in the household distribution and promotion of ECPs and POPs.
- USAID should provide technical assistance, as necessary, to help the DGFP identify and evaluate potential domestic and international sources of lower-cost, high-quality IUDs, injectables, and implant products. Such technical assistance might be provided through an organization such as PATH, for example.
- USAID should discuss with the DGFP its policies regarding provider and client eligibility criteria for contraceptive methods. International standards, other countries' experiences, and medical norms should be shared within a context of policy dialogue—the desired outcome being a relaxation of requirements for provider type and client parity that now seem unnecessarily to limit the availability of injectables and long-term and permanent methods. This dialogue could follow a broad-based analysis of the legal and regulatory environment for family planning service delivery in the public, NGO, and commercial sectors (undertaken through SHOPS or the Health Policy Initiatives Project, for example), or it could stand alone.

### **Availability of Contraceptives through Multiple Sources**

Reliance on donors or on any one sector for provision of most of the national contraceptive supply makes a family planning program particularly vulnerable to adverse changes in policy and funding. Dependence on one sector as the principal source of contraceptive commodities may also increase program vulnerability to stock outages and short supply. Further, the exclusion of any sector from participation in supplying contraceptive method requirements may unnecessarily limit total resources available for addressing a critical service delivery need. (For further discussion of the role that the private for-profit sector can play in achieving the goals of the national population program, see Annex E.)

#### *Issues affecting the availability of contraceptives through multiple sources:*

- Dependence on donors—The Government currently uses SWAp-II funds to purchase contraceptives that it distributes both through its own DGFP service delivery system and to NGOs. Therefore, both the NGO and public sectors are almost completely dependent on donor funding of the contraceptive supply. While the SMC independently procures many of its contraceptive products, it relies on donor provision of both its injectable contraceptive—its product with the most current sales growth—and its highest-selling OC brand.

- Under-use of domestic manufacturing capacity—Donor-funded procurements under SWAp-II must follow World Bank regulations that require bidders to show G7 certification of their products. No domestic commercial-sector producer of contraceptives has such a certification for its products because no locally produced contraceptives are sold in a G7 country. The growing domestic pharmaceutical sector thus is largely untapped as a source of contraceptives for the national family planning program.
- Negligible commercial-sector participation—Sales of contraceptives by the international pharmaceutical sector in the commercial marketplace are negligible, perhaps due to consumer income distribution and commercial products' price in comparison with free public-sector and low-priced NGO-sector products. Consequently, commercial-sector investment in promotion of pharmaceutical contraceptive products is primarily limited to visits made by medical detailers to private practice OB/GYN specialists. Commercial-sector participation in the condom market, however, is a very different story. The SMC's promotion of condoms has created a commercially interesting market, and a large number of imported brands of condoms are now sold in Bangladesh. While the SMC's share of the total market has diminished, its unit sales have continued to increase.

The team's recommendations for increasing the availability of contraceptives through multiple sources include the following:

#### Near Term

- USAID should provide technical assistance to the Social Marketing Company in developing and implementing a financial and procurement plan that will allow it, over a period of time, to become less dependent on donor commodities yet retain its focus on low-income consumers. This technical assistance might be provided through the SHOPS Project, for example.

#### Intermediate Term

- USAID should engage the expertise of a source of technical assistance like PATH to provide an assessment of the capacity and product quality of local contraceptive manufacturers. USAID could provide technical assistance, if needed, in quality improvement and quality testing and could encourage technological transfer partnerships, similar to those undertaken in the PACT-CRH project in India, if they seem to promise capacity-strengthening among domestic contraceptive manufacturers.

#### Longer Term

- USAID should engage the public sector in a dialogue concerning public policies that constrain the operation of the commercial sector, both domestic and international, in the contraceptive market. This dialogue could begin with a legal and regulatory analysis of the environment for private-sector family planning service delivery that includes such topics as price controls, market segmentation, import tariffs, product registration requirements, other taxes, and the like.



## **IV. SUMMARY CONCLUSIONS AND RECOMMENDATIONS**

The foregoing discussion includes a large number of observations and recommendations across several facets of USAID's population assistance program. In the team's judgment, however, most of its key findings—and the steps needed to implement an improved program—can be summarized in relatively brief fashion. The team's essential findings and recommendations are as follows:

### **FINDINGS**

- USAID contributions have created a good foundation for a program that can have a significant impact on population growth.
- USAID is actively seeking ways to reinvigorate its population assistance program, and is asking itself the tough questions needed to inform the redesign process.
- USAID contractual emphasis on projects' financial sustainability may be limiting access to the poor, as well as prospects for program expansion.
- USAID's current response is not commensurate, in terms of the program's breadth and impact, to the demographic challenge facing the country.
- USAID-funded NGO projects are meeting their contractual objectives, but are limited in their coverage and impact (an exception is SMC contraceptive sales).
- The GOB is giving inadequate attention to contraceptive security, human resource requirements, and operational needs (supplies, equipment) of the FP delivery program and BCC.
- The capacity of the GOB family planning service delivery program is declining relative to the growing population.
- Neither the GOB, nor the several donors involved in the country's population program, are implementing a multi-sector response to the problem.

### **RECOMMENDATIONS**

- USAID should expand the depth and breadth of its population assistance program.
- USAID should advocate for increased GOB commitment to its FP service delivery program.
- USAID should seek opportunities to work collaboratively with GOB partners, i.e., to develop a more substantive partnership than is possible under the Mission's current NGO-focused approach.



# **ANNEX A: SCOPE OF WORK FOR THE ASSESSMENT TEAM**

## **USAID/Bangladesh Family Planning & Population Assessment March 14–April 6, 2010 SCOPE OF WORK**

### **I. TITLE**

Activity: **Bangladesh–Family Planning & Population Assessment**

Contract: Global Health Technical Assistance Project (GH Tech), Contract No. GHS-I-00-05-00005-00, Task Order No. 01

### **II. PERFORMANCE PERIOD**

It is anticipated that the period of performance of this assessment will be undertaken on/about March 14, 2010, to April 6, 2010. Total approximate time will be six weeks including preparation time in the United States, travel time, briefings and consultations, and time for finalizing draft products and reports.

### **III. FUNDING SOURCE**

The assessment will be funded from funds allocated by USAID/Bangladesh to GH Tech.

### **IV. OBJECTIVES**

The main objective of the assessment is to produce a diagnostic of the status of USAID Bangladesh's Family Planning (FP) program, and recommendations on what strategic objectives the program should pursue and possible approaches to achieve them. The key questions that will be asked are: 1) What is working in the FP/population programs supported by USAID in Bangladesh; 2) What is not working in USAID-supported FP/population programs in Bangladesh; 3) What are the gaps or missed opportunities to improve FP/population performance in USAID funded programs; and 4) What recommendations or actions should USAID take to support GOB efforts in repositioning family planning and increasing policy dialogue on population issues in Bangladesh. The FP/Population Assessment should also identify how population is impacting other sectors in which USAID works and suggest ways to ensure that population is included in other U.S. Government initiatives. For example, these should include discussions on linkages with Education, Food Security and Nutrition; Disaster and Humanitarian Assistance; Global Climate Change; and Global Engagement in the context of democracy and governance. Recommendations will feed into input for future investments for USAID and be included in a strategic planning process, which the mission is planning for early May.

### **V. BACKGROUND**

#### **Status of Family Planning in Bangladesh**

Bangladesh has a population of over 150 million, and a population density of over 1,000 inhabitants per square km, far more than any other country in the world except city-states. Family Planning was first introduced to Bangladesh in the early 1950s. Since the early 1970s national governments have reaffirmed the policy to reduce fertility rates.

Following a decline in fertility in the late 1970s and 1980s from 6.3 to 3.4 births per woman, TFR stalled at 3.3 for a decade. In recent years it has resumed declining and is now at 2.7. Objectives of the current Bangladesh Population Policy include attaining a net reproduction rate of one by the year 2010 in order to stabilize the size of the population by the year 2060. A recent publication emphasized the need for TFR to go significantly below replacement level. (Streatfield, 2008).

Fertility patterns are uneven, with high levels among the poor and on the eastern side of the country. Early marriage and childbearing are exceptional and persistent.

Use of FP has not increased much in the past decade, although it is equitable among most socioeconomic groups. It is still low in the eastern divisions and among newly married women who have not started childbearing. Actual TFR is above desired/ideal family size (0.4 children above nationally, 0.7 in Chittagong, and 1.0 in Sylhet).

Awareness/knowledge of FP has long been very high for all modern methods except vasectomy. But attitudes toward clinical and permanent methods have long been less than positive. There has been little BCC activity for a long time, and these misperceptions have not been successfully addressed.

The Bangladesh FP program relies heavily on temporary methods (28% of MWRA use pills, 8% traditional practices, 7% injectables, 5% condoms). Highly effective methods are the least used: vasectomy, implants, IUDs are each used by < 1% of MWRA, tubal ligation by 5%). Menstrual regulation (MVA) is legal; almost 6% of MWRA report having used it.

The public sector provides FP services and supplies to half of users, and to two-thirds of poor women. Public-sector services suffer from a marked shortage of skilled personnel; this will get worse in the near future as fieldworkers hired and trained in the 1980s and 1990s have retired. Procurement of FP commodities has been plagued by problems, and there have been stock-outs of supplies for several methods. Quality of care is frequently mentioned as a factor in low continuation rates and low uptake of clinical methods.

## **USAID's FP program in Bangladesh**

USAID had a very active FP program from the late 1970s through early 1990s. Key Bangladeshi and foreign stakeholders agree that USAID's FP program was largely responsible for the impressive increases in FP use and reductions in TFR during those years. The same stakeholders mention a perceived lack of political and technical leadership on the part of USAID in recent years.

Since early 2009, OPHNE has embarked on an effort to bring population issues to the forefront, and to reposition family planning as a strategic health and development issue. While family planning achievements have been remarkable and USAID has contributed substantially through its Social Marketing program, achievements have stagnated. While there is unmet demand for increased method mix, only one new program is focused on increasing long-acting and permanent methods (LAPM). The new Mayer Hashi program implemented by EngenderHealth is a four-year project that plans to assist the GOB to conduct approximately five million voluntary sterilizations to increase utilization of LAPM. The GH Tech Assessment team is to review the portfolio of USAID projects which currently are receiving population funds: In addition to the Social Marketing Program and Mayer Hashi, the Smiling Sun Franchise and the MaMoni MNCH Project are offering FP services within the context of other primary health care services. In addition, USAID is supporting capacity-building in procurement and contraceptive logistics through the Strengthening Pharmaceutical Services (SPS) Project through Management Sciences for Health. USAID also funds several important population surveys, such as the DHS and is now

helping in preparation for the 2011 Census. Finally, USAID purchases about \$6 million of contraceptives each year, which are used to subsidize FP supplies through the social marketing program. (See attachment which provides highlights of USAID projects in Bangladesh.)

## SCOPE OF WORK

The assessment should examine several key issues, including the following:

- Identify issues (including cultural, social, economic, religious, gender, education) affecting population dynamics and prioritize those to be addressed by the FP program and/or other USAID programs.
- Review the status of FP program progress indicators to determine to what extent the program is contributing to meet the unmet need for FP for key population subgroups, and of achieving a sustainable reduction of TFR below replacement level.
- Strategies: Assess if current strategies are likely to have an impact on unmet need and if they are appropriate to meet USAID's goals of increasing use of long-acting and permanent methods, and increasing use of FP by postpartum and post-abortion couples. Assess the program's strengths and gaps, and recommend ways in which elements can be reshaped to better contribute to meeting the unmet need.
- Current barriers: Review family planning performance over the past few years, identifying reasons for stagnation. Assess supply-side service delivery barriers underlying low performance, and which have been identified, such as dysfunctional procurement systems, lack of skilled personnel at all levels, and unavailability and poor quality of services. Examine demand-side barriers to increased use of FP, such as low continuation rates, very early age at first birth, and strong preference for boys. Assess if and how a reorganization of services can address these issues.
- Demand generation: Examine BCC strategies and activities, especially those targeting young married couples and couples who achieved desired family size and who have aimed at increasing the use of LAPMs.
- Coverage: Review the quality and reach of the public-sector and NGO systems, particularly for LAPMs, and how/if the USAID program complements other programs. Within the context of the overall FP program, assess whether the USAID program should attempt to expand overall coverage (to additional population groups and/or geographical areas), or if it should it focus on a few population groups and/or geographical areas for deeper but more localized impact.
- Sustainability: Address whether financial sustainability should be a priority given USAID's stated goals of 1) significantly increasing and improving FP activities, and 2) serving the poor in this very low-resource country. Assess program strategies and activities to achieve sustainability; determine how they can contribute to or deter from the above-mentioned goals; identify how sustainability strategies might be strengthened and broadened with respect to increased engagement with the GOB; assess the potential value of increasing the role and quality of private-sector services, strengthening health systems, and increasing community mobilization. When considering health systems strengthening, assess whether and to what extent health finance, governance, drug and commodity management, human resources, information and service delivery modes represent constraints on meeting the unmet need for FP. Recommend how to invest USAID resources to effectively address the most important health systems barriers amenable to change.

- Relationships with GOB and with other donors: Review USAID's relationships with the Government of Bangladesh across multiple sectors and with other donors to determine how these relationships can be strengthened and contribute to achieving strategic objectives.

Illustrative questions to assist in the assessment are provided below. Given USAID's goal of sustainably reducing TFR below replacement level, the assessment should address the following policy questions:

- What types of objectives should the USAID/Bangladesh FP program set for itself?
  - Which ones should be the priority?
  - What are ways in which these objectives can be truly synergistic?
  - Is there some degree of mutual exclusion between objectives?

*Illustrative Objectives:*

- Increasing overall CPR? Increasing CPR in specific population sub-groups?
- Increasing use of specific methods (e.g. LAPMs)
- Improving quality and diversity of FP/RH services
- Increasing coverage in specific geographic areas (ex: currently underperforming areas such as Sylhet and Chittagong)
- Achieving a high degree of sustainability for the overall program? For specific projects, organizations, or sectors?
- Which population sub-groups should be priority in USAID's strategies?
  - What strategies can meet the FP needs of all or most of these groups?
  - Or should strategies focus just on some of these groups?

*Illustrative target populations:*

- People more likely to adopt/continue FP
- People more likely to pay for services and/or products
- The poor in general
- The urban poor/slum inhabitants
- Rural
- Youth (e.g., for fp awareness activities)
- Young married couples
- Postpartum couples
- Couples who have achieved their desired family size

Should USAID strive to maintain a balance between support for different sectors? Or should USAID focus on one sector?

- NGOs
- Government

## **VI. METHODOLOGY**

The assessment team will decide on specific methodologies to be used for the different assessment activities proposed below. The team should start deciding on specific methodologies for the various activities during the Washington-based Team Planning Meeting before traveling to Bangladesh, and finalize selection of methodologies during the first full-team meetings in-country.

The following essential elements should be included in the methodology as well as the additional methods proposed by the team:

Review of background documentation: USAID/Bangladesh OPHNE will provide the Team Leader with a core list and/or copies of reports of recent relevant assessments and other key documentation before the assessment begins. The Team Leader will be responsible for expanding this background documentation as appropriate, and will review, prioritize, and distribute it to other team members for their review. All team members will review relevant documentation before their initial team meetings.

Planning meetings: The Team Leader and available team members will have a two-day team planning (TPM) meeting in Washington, D.C. They will meet with appropriate USAID officials in Washington, and should start planning the process during these initial meetings. The full team will meet upon arrival in Bangladesh (one day). The full team will finalize planning during their one day TPM in-country. The team planning meetings are essential in organizing the team's efforts. During the team planning meetings, the team should:

- Clarify all team members' roles and responsibilities, including drafting of report;
- Develop and review final assessment questions;
- Review and finalize the time line and share this with OPHNE;
- Develop and finalize data collection methods and instruments;
- Review and clarify any logistical and administrative procedures for the assignment;
- Establish a team atmosphere, share individual working styles, and agree on procedures resolving differences of opinion;
- Develop a preliminary draft outline of the team's report;
- Assign drafting responsibilities for the final report.

Initial Team briefing meetings with OPHNE: The full team will have an initial meeting with OPHNE officials in Bangladesh. During this meeting they will share an outline and explanation of the design of the assessment, and receive feedback from OPHNE. The full team and/or members will have follow up meetings with specific OPHNE staff at the outset of the process, and should remain available throughout the whole process as appropriate. OPHNE officials will also remain available for consultation as appropriate throughout the whole process. In addition, USAID/Bangladesh will provide a copy of the current Activity Approval Document, which gives an overview of the planned activities in the coming years.

Key informant interviews: The full team or team members as appropriate will have interviews with the following (not inclusive):

- Various USAID offices and other U.S. Government offices in Bangladesh
- Key Government of Bangladesh representatives across multiple sectors (health, FP, education, women’s affairs, religious affairs, other)
- Major donors involved in population/FP, MNCH, nutrition, development, education, and other sectors as appropriate
- All USAID implementing partner organizations
- Other implementing organizations
- Other key stakeholders e.g. professional associations, universities, other.

**Site visits:**

Team members as appropriate will visit selected sites in low-performing areas such as Sylhet and Chittagong. They should also visit sites in Khulna or Rajshahi, where CPR is higher and TFR is lower.

**VII. TEAM COMPOSITION, SKILLS, AND LEVEL OF EFFORT**

Level of effort for two (LOE) contractors will constitute XX days total. The following is a sample schedule.

Tasks/Deliverables	Team Leader (n=1)	Other Team Members (n=3)
Review of background documentation	3 days	3 days
Travel to Washington, D.C.	1 day	1 day
Team planning meeting in Washington	2 days	2 days
Travel to Bangladesh	2 days	2 days
In-country TPM	1 day	1 day
Briefing meetings with OPHNE	1 day	1 day
Field work (including key informant interviews and site visits)	12 days	12 days
Information review, discussions, analysis, draft report	5 days	5 days
Briefing(s) to USAID & others	1 day	1 day
First draft submission prior to team departing country (incorporate comments from briefings)	2 days	2 days
Travel from Bangladesh	2 days	2 days
Debrief to USAID/Washington	1 day	1 day
OPHNE provides comments on draft to team (within 10 days of submission of draft report)		
Final report review and submission to OPHNE by team	3 days	1 day

Tasks/Deliverables	Team Leader (n=1)	Other Team Members (n=3)
USAID/ECSA-HC review of final Draft (within 5 days of revision/finalization of report)		
GH Tech edits/formats report (one month)		
Total LOE	36 days	34 days

\*A six-day work week is approved while the team is working in country.

## Team Composition

The assessment team should include:

- **Gerard Bowers-** Team Leader & Family Planning & Population Specialist has in-depth understanding of population dynamics and their determinants, in addition to understanding FP programs. This specialist may have a demography, epidemiology, or social sciences background.
- **Gary Lewis-** Team Member & Family Planning Services & Behavior change Communication (BCC). Has experience and knowledge in design, management, and/or Monitoring & Evaluation of family planning programs and services. Will focus on demand for services issues and identify gaps in current FP BCC strategies.
- **Betty Ravenholt-** Team Member & Private-sector Specialist. Has experience and knowledge in the design and implementation of private-sector family planning service delivery programs.
- **Mohammed Alaudinn-** Team Member & Local Family Planning & Population Specialist. Has in-depth of experience on range of family planning and population issues in Bangladesh and is familiar with cultural norms and issues within the country.
- **Mahbub Shaheed-** Local Administrative & Logistical Support contracted through GH Tech and working directly with USAID/Bangladesh
- Additional Resource Persons:
  - **Marcos Arevalo-** USAID, FP Advisor and resource person to give advice on contraceptive supply, procurement logistics, and quality assurance issues.
  - **Zandra Andre-** BCC Specialist on Pandemic Diseases. Will help share lessons from successes in robust communication strategies for recent pandemic diseases and identify opportunities for similar processes for revamping family planning program.
  - **Mohaweza Khan-** Concerned Women for Family Planning & Development. NGO Service Delivery Specialist with over 25 years of work in USAID-funded FP and population sectors. Will provide insights to implementing integrated FP and development programs and travel with the team to field visits.
  - **OPHNE-** Team members will be available to assist as needed in addition to a select group to accompany the assessment team.

- **GOB participation-** Have extended an invitation for two representatives from the Ministry of Health & Family Welfare to attend the site visits to Chittagong, Sylhet, Dinajpur and Jessore to see low and better-performing divisions.

## VIII. LOGISTICS

USAID/Bangladesh will provide overall direction to the team, provide key documents and background materials for reading and help arrange the in-briefing and debriefing with Embassy and USAID, as required. USAID OPHNE staff will participate in key meetings with the Ministry of Health, other GOB Ministries, and other stakeholders as appropriate (in coordination with the assignment TL).

The GH Tech contractor will provide all logistical arrangements such as flight reservations, country cable clearance, in-country travel, airport pick-up, lodging, and interpreters, as necessary. A local support/logistics expert will be hired to assist with arranging key informant interviews and meetings, and arranging local travel. Cost for participation of NGO and GOB resource people will be included under the GH Tech contract.

## IX. DELIVERABLES AND PRODUCTS

Debriefings: The full team will debrief OPHNE on their findings, conclusions, and recommendations before leaving Bangladesh, using a PowerPoint presentation and any briefing materials required. OPHNE will provide feedback during the briefing meeting. The team will debrief other USAID Offices, U.S. Government, and/or Government of Bangladesh officials if requested by OPHNE.

Draft Assessment Report: The assessment team will provide OPHNE with a draft report that includes all the components of the final assessment report prior to their departure from country. OPHNE will provide comments on the draft report to the assessment team within 10 working days of receiving the draft report.

The synthesized draft report will include, at a minimum, the following: scope and methodology used; important findings (empirical facts collected by evaluators); conclusions (evaluators' interpretations and judgments based on the findings); recommendations (proposed actions for management based on the conclusions); and lessons learned (implications for future designs and for others to incorporate into similar programs). This draft report will be left in-country before departure of the team, as it will be immediately useful as inputs to another upcoming GH Assessment in April and USAID/Washington strategy development exercise in May.

Final Assessment: The final report will address the comments provided by OPHNE on the draft report. The team leader will revise the draft report and deliver an electronic copy of the final revised version to OPHNE within five days of receiving written comments from OPHNE Bangladesh.

GH Tech will provide the edited and formatted final document approximately 30 days after USAID/OPHNE provides final approval of the report. GH Tech will provide 10 printed copies and one electronic copy to USAID/OPHNE.

This report should be considered internal to USAID.

## **Proposed Outline for Assessment Report (to be Finalized During the TPM)**

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ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

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ANNEXES:

- Assessment Scope of Work
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- Persons Contacted

### **X. RELATIONSHIPS AND RESPONSIBILITIES**

The assessment team will work under the technical direction of USAID/Bangladesh OPHNE Khadijat Mojidi, and collaborate closely with other members of the OPHNE.

OPHNE Bangladesh will:

- Approve country clearances for travel
- Provide the team with a general list of suggested organizations and contact information
- Arrange for initial communication with appropriate government and other organizations at the outset of the process.

The assessment team will be responsible for expanding the list of organizations and persons, and for arranging meetings and appointments.

GH Tech will be responsible for all assignment-related expenses for their consultants incurred in carrying out this review, including travel, transportation, lodging, and communication costs, etc. Costs will also include support for local resource persons and GOB travel and per diem in order to facilitate the team's work.

## **XI. MISSION CONTACT PERSON**

Main contact person is:  
Marcos Arevalo  
Senior Family Planning Advisor  
[marevalo@usaid.gov](mailto:marevalo@usaid.gov)  
(88-02) 885- 5500 ext 2314  
(88-0171) 300-9880 cell

## **XII. COST ESTIMATE**

TBD

## **XIII. REFERENCES/MATERIALS FOR REVIEW**

- Bangladesh DHS 2007
- Streatfield PK, Karar ZA. Population Challenges for Bangladesh in the Coming Decades. *Journal of Health, Population and Nutrition*. 2008, 26(3): 261-272.
- Long-Term and Permanent Methods of Family Planning in Bangladesh. 2007, Carina Stover, William Jansen, et al through GH Tech.
- Government of Bangladesh Contraceptive Bottleneck Study. 2008, Todd Dickens, PATH.
- Preparation for Strengthening Pharmaceutical Systems (SPS) Activities in Bangladesh 2009, Francis Aboagye-Nyame, Beth Yeager, Kyle Duarte. (SPS/MSH Trip Report).
- A Case Study of Reproductive Health Supplies in Bangladesh. 2009, Leslie Patykewich, Elizabeth Leahy, (Population Action International).
- Bangladesh: Contraceptive Procurement in Transition. How Context Can Affect Outcome. 2008, Jim Bates (JSI/DELIVER).
- Addressing Gaps in the Existing USAID/Bangladesh Health Program. 2008, by Anuraddha Bhattacharjee, Wahiduzzaman Chowdury, Peter Connell, William Jansen, Judith Justice; through GH Tech. (THIS DOCUMENT IS INTERNAL TO USAID).
- USAID Bangladesh: Rebuilding Technical Leadership in Health. 2009, Al Bartlett, Karen Cavanaugh, Lily Kak, Kristina Yarrow.
- National Communication Strategy for Family Planning and Reproductive Health. 2008, Ministry of Health and Family Welfare – Directorate of Family Planning, Bangladesh.
- Summary of BCC assessment. (Notes by Elizabeth Fox GH/USAID/Washington).
- Trip Report. (2008) Beverly Johnston (GH/PRH). (Compliance issues in FP).
- Partnership Arrangements between the Government of Bangladesh and Development Partners Concerning Support for the Implementation of the Health, Nutrition and Population Support program (HNPSP).
- Building the Evidence Base to Support Decisions on a Future Health Sector Program in Bangladesh. World Bank, World Health Organization. (SOW for a consultancy).
- MAMONI Workplan 2009-10

- SSFP Workplan
- EngenderHealth Workplan
- ACQUIRE Final Report
- Bangladesh Population Policy 2004
- Bangladesh Population Policy 1976
- Bangladesh Media Reach by Channel and Sub-Populations for BCC
- Other key documents as identified

## ATTACHMENT

### USAID/Bangladesh Program Summary

*USAID projects in Bangladesh relevant to Population/FP*

#### Smiling Sun Franchise Program (SSFP) (Chemonics)

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 health goals 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 poor and rural communities. Currently, this project provides basic health care to approximately 1.8 million people per month, most of whom would otherwise have no access to health care at all. At the end of the four-year funding period, NGOs will no longer be dependent on USAID for recurrent costs while continuing to meet the family planning and health targets.

Prog. Element: MCH/FP & RH/TB  
Funding: \$46 million over 5 years  
Dates: October 2007–September 2011

#### Social Marketing Company (SMC)

SMC is a nonprofit 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, kiosks, and other outlets; and 3,500 Blue Star service centers. SMC opened an ORS factory in 2003 and is developing new products for family planning, health, and nutrition. Approximately 1/3 of all FP users in Bangladesh obtain their supplies through SMC's distribution network. A 10-year Cooperative Agreement with the Social Marketing Company ended December 2007, and a four-year follow-on project began January 2008.

Prog. Element: MCH/FP & RH/TB  
Funding: \$3 million over 4 years, plus approx \$7 million/year in commodities  
Dates: January 2008–September 2011

#### Strengthening Pharmaceutical Systems (MSH)

SPS 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.

Prog. Element: MCH/FP & RH  
Funding: \$900,000/year  
Dates: October 2009–September 2011

#### Mayer Hashi (EngenderHealth)

The project helps families achieve their reproductive health intentions by increasing families' knowledge of and access to long-acting and permanent methods (LAPM) of FP. Mayer Hashi supports the Government of Bangladesh efforts to improve access to LAPM in 21 low-performing districts of Sylhet, Barisal, and Chittagong Divisions. The project provides training, assists in strengthening the organization and management of long-term family planning service delivery, and works to improve the coordination of contraception service provision at the field level. The project also works to reduce cultural barriers to and increase demand for permanent

and long-term family planning methods in the country. Mayer Hashi also promotes safe motherhood through prevention and effective management of hemorrhage during and after child delivery.

Prog. Element: MCH/FP & RH  
Funding: \$12,000,000 (funding for 4 years)  
Dates: May 2009–March 2013

MaMoni (Jhpiego & Save the Children)

MaMoni is a follow-on project to ACCESS Safe Motherhood and Newborn Care Project. The project aims to decrease maternal and neonatal mortality in the program areas by increasing the practice of healthy maternal and neonatal behaviors during the prenatal, delivery, and postnatal periods; and increase use of family planning services. The project is implemented in 15 upazilas of Sylhet and Habiganj districts. The project will provide technical assistance to strengthen Bangladesh government systems at the upazila and union level facilities to improve service delivery effectiveness. Behavior Change Communications (BCC) and Community Mobilization are the core strategies of this project. MaMoni is also working with communities and religious leaders, government, and other stakeholders, and engaging and empowering community members to make sustainable improvements for mothers and newborns in their communities.

Prog. Element: MCH/FP & RH  
Funding: \$13 million over 4 years  
Dates: January 2009–September 2013

Modhumita (FHI)

Assists local NGOs to implement HIV activities with high-risk groups. The program works 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. Working with a local faith-based organization the program will train imams on HIV/AIDS and help spread messages on abstinence and faithfulness and reduce stigma and discrimination.

Prog. Element: HIV/AIDS/TB  
Funding: \$13 million over 4 years  
Dates: October 2009–September 2013

MEASURE DHS III (ORC-Macro)

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.

Prog. Element: HIV/AIDS/MCH/FP & RH  
Funding: \$600,000 (funding in FY 2009)  
Dates: September 2008–September 2013

MEASURE Evaluation III (Carolina Population Center, UNC Chapel Hill)

Designs and conducts population-based surveys to measure the performance of NGOs in providing the Essential Health Service Package. Findings will provide information on a number of programmatic indicators. Measure Evaluation is also planning to implement the Bangladesh Maternal Mortality and Use of Maternal Health Services Survey 2009 that will evaluate the impact of various maternal health programs on reducing maternal mortality.

Prog. Element: MCH/FP & RH  
Funding: \$1 million in FY 2009  
Dates: September 2008–September 2013

GH Tech (QED)

This Task Order field support mechanism is used by the Mission to enlist technical services from USAID/Washington for activity planning, design, monitoring and evaluation.

Funding: \$200,000 in FY 2009  
Dates: February 2005–February 2010

SUCCEED (Save the Children)

Works with the neglected lower grades of primary school. Supports the development of children's confidence, communication, cognitive and social skills before they enter school. Ensures 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. Trains pre-school instructors in interactive teaching methods; establishes home-based and school-based pre-schools. Most instructors are local women. Develops illustrated storybooks. Establishes "community learning corners" as after-school learning resource centers for children. Created a program to partner older children as learning mentors or "Reading Buddies." Works with members of School Management Committees to empower communities in the oversight of children's education, and to ensure that government resources are allocated responsibly.

Prog. Element: Basic Education  
Funding: \$12 million over 5 years  
Dates: August 2004–February 2010  
GOB Ministry: Ministry of Primary and Mass Education

Sesame Street Bangladesh ("Sisimpur") (Sesame Workshop)

Develops half-hour television shows in Bangla. Implements an outreach program which includes supplementary materials and modalities including teacher handbooks, children's books, and videos screened in mobile units or health clinics. Broadcast on state-owned BTV, *Sisimpur* has the potential to reach 70% of the population in Bangladesh.

Prog. Element: Basic Education  
Total: \$15 million over 8 years  
Dates: June 2003–September 2011  
GOB Ministry: Ministry of Women and Children's Affairs

Other donors supporting family planning include: UNFPA, JICA, and KfW.

*Suggested Organizations/Key Informants*

USAID Washington

Lily Kak  
Margaret Neuse  
Elizabeth Fox  
Carlyn Curtiss  
Maureen Norton  
Anthony Boni  
Allan Bornbusch  
Trish MacDonald  
Kristina Yarrow  
Al Bartlett

USAID/Dhaka

OPHNE  
Economic Growth  
Democracy and Governance  
Program

Government of Bangladesh

Ministry of Health and Family Welfare  
Director General of Family Planning  
Director General of Health  
Directors/Line Directors and/or Deputies, IEM/BCC, Services, Procurement and Logistics.  
Ministry of Education  
Ministry of Women's Affairs  
Ministry of Religious Affairs  
Other

Donors

UNFPA  
UNICEF  
World Bank  
JICA  
CIDA  
DFID  
KfW

Implementing organizations

MayerHashi/EngenderHealth  
SMC  
Smiling Sun  
MaMoni  
FHI

BRAC

FPAB

ICDDR,B

Pathfinder (Dr. Shabnan)

Pop Services Training Ctr. (Milan Bikash Pal)

Concerned Women for FP

Other stakeholders

Dhaka University, Population Sciences Dept. (Dr. Nara Nabi)

Professional associations

Mitra Associates

RTM (Research Training & Management)

Population Council (Dr. Obaitur Rob)

Measure (Ahmed Al-Sebir)

Dr. Alauddin (ex COP Pathfinder)

Abul Barkat (former Dhaka University, now Sonali Bank)

Ahmed Al-Kabir (formerly ICDDR,B, now with Rupali Bank)

## **ANNEX B: PERSONS CONTACTED**

### **U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT/WASHINGTON**

Scott Radloff–Chief, GH/Pop

Patricia MacDonald–Senior Technical Advisor, Service Delivery Improvement Div.

Lily Kak–Health Development Officer

Anthony Boni–Public Health Advisor

Allan Bornbusch–Public Health Advisor

Padmini Srinivasan–Health and Population Officer

### **U.S. EMBASSY, BANGLADESH**

James F. Moriarty–Ambassador

Jon Danilowicz–Acting Deputy Chief of Mission

### **U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT/BANGLADESH**

Denise Rollins–Mission Director

Carey N. Gordon–Deputy Mission Director

Khadijat Mojidi–Office Director, OPHNE

Marcos Arevalo–Senior Family Planning Advisor, OPHNE

Kanta Jamil–Deputy Office Director OPHNE

Kishan Chakravorty–Project Management Specialist, OPHNE

Umme Salma Mina–Project Management Specialist, OPHNE

Sharmina Sultana–Project Management Specialist, OPHNE

Md. Nasiruzzaman–Project Management Specialist, OPHNE

Sukumar Sarker–Senior Clinical Officer, OPHNE

Zandra Hollaway Andre–Senior Technical Advisor–Avian Influenza

Mark Visocky–Economic Growth Office

Jo Lesser-Oltheten–Office of Food, Disaster, and Human Assistance

Mohammad Shahidul Islam–Team Leader, Education Office

P. Adrianna Barel–Deputy Director, Program Office

Mahmuda Rahman Khan–Senior Program Development Specialist – Gender, Program Office

### **MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF BANGLADESH**

Shekh Altaf Ali–Secretary

Al-Azad Mandal–Director General, NIPORT

A.M.M. Anisul Awwal–Director, NIPORT (Research)

Nazrul Islam Sarker–Deputy Chief, Planning Cell

## **MINISTRY OF HEALTH AND FAMILY WELFARE, DIRECTORATE FAMILY PLANNING**

Mohammad Abdul Qayyum–Director General Family Planning  
Jafar Ahmed Hakim–Director, MCH Services and Line Director  
Abdullah al Mahsin Chowdhury–Director of Finance and Line Director, Field Services  
Delwar Hossain–Director, Administration  
Hossain Mollah–Director, Procurement and Logistics  
Mohammed Zearul Islam–Deputy Director, Information, Education and Motivation  
(accompanied Jessore Team)  
Momtaz Uddin–Deputy Director, Logistics (accompanied Chittagong team)  
M.M. Ershad–Deputy Director, Chittagong  
Dilip Kumar Brahma–Deputy Director, Jessore  
Rafiqul Alam Khan–Medical Officer, Maternal, Child Health and Family Planning,  
Jessore  
Abul Kalam–Assistant Director, Port Clearance, Regional Warehouse/Chittagong  
Shah Alam–Regional Supply Officer, Regional Warehouse/Chittagong  
Md. Siddiquir Rahman–FP Officer, Monirampur Upazila  
A. Kalam Azad–Health and FP Office, Monirampur Upazila  
Chandra Shekhar Kunda–MCH-FP Officer, Monirampur Upazila  
Rama Rani Das–Assistant Thana Family Planning Officer Monirampur Upazila  
Sufia Khatun–Assistant Family Welfare Officer Monirampur Upazila  
Mobashar Hossain–Family Planning Inspector Monirampur Upazila  
Sreeti Kana Mondal–Family Welfare Assistant Monirampur Upazila  
Amulla Mohan Das–FP Officer, Anowara Upazila  
Ram Prashad Mallik–SACMO, Upazila Family Welfare Centre, Buirag Union  
Dilip Kumar Burma–Deputy Director (in-charge), Maternity and Child Welfare  
Centre/Jessore  
Dr. Rafiqul Alam Khan–Maternity and Child Welfare Centre, Sadar Upazila, Jessore  
Gulshan Ara–Sacmo Union Family Welfare Centre, Khanpur  
Anjana Kunda–Family Welfare Assistant, Family Welfare Centre, Khanpur  
Sanjay Basu–Health Assistant, Community Clinic/Durbadanga Village  
Sabita Roy–Family Welfare Assistant, Community Clinic/Durbadanga Village

## **MINISTRY OF FINANCE**

Md. Shafiqul Azam–Additional Secretary, Economic Relations Division

## **WORLD BANK**

Tania Dmytraczenko–Senior Health Economist  
Bushra Binte Alam–Public Health Consultant

## **UNFPA**

Arthur Erken–Country Representative  
Tauhid Alam–Senior Program Officer  
Margub Aref Jahangir–Chief, UNFPA District Office, Sylhet

## **SMILING SUN FRANCHISE PROJECT**

Juan Carlos Negrette–Project Director  
Setara Rahman–Health Specialist  
Anwar Hossain–Business Planning Market Research Specialist  
Arefin Amal Islam–Clinical Quality Assurance Services Specialist  
Rehan Uddin Ahmed Raju–Marketing/Communication Specialist  
Md. Anwar Hossain–Business Planning & Marketing Research Specialist  
Md. Abdul Matin–Franchise Operations Officer  
Rafiqul Islam–Project Director, Swanirvar (NGO partner)  
Hasina Akhter–Clinic Manager, Swanirvar  
Adabar–Community Service Promoter, Shakertek Satellite Clinic, Swanirvar  
Salma Akhter–Paramedic, Shakertek Satellite Clinic, Swanirvar  
Sheikh Nazrul Islam–Project Director – FDSR, PATIA (NGO partner)  
Humayun Kabir–Clinic Manager –FDSR, PATIA  
Shah Alam–Senior Medical Officer – FDSR, PATIA  
Kamal Hossain–Consultant, Pediatric –FDSR, PATIA  
Belal Hossain–Medical Officer –FDSR, PATIA  
Oliva Chakma–Medical Officer – FDSR, PATIA

## **STRENGTHENING PHARMACEUTICAL SYSTEMS PROGRAM (SPS)**

Zubayer Hussain–Country Director  
Abdullah Imam Khan–Consultant

## **SOCIAL MARKETING COMPANY (SMC)**

Md. Ali Reza Khan–Managing Director  
Salah Uddin Ahmed–Manager, Blue Star Program  
Sayedur Rahman–Head of Sales  
Mahbubur Rahman–Head of Marketing  
Toslim Uddin Khan–Head Research and MIS  
Abul Hayat Kamal–Area Executive (Chittagong)  
Md. Mustafizur Rahman Khan–Senior Area Executive (Chittagong)  
Kamal U. Ahmed–Senior Sales Manager (Chittagong)  
Md. Monowar Hossain–Sales Promotion Executive (Chittagong)  
Mahbubur Rahman–Head of Marketing, Dhaka  
Sayedur Rahman–Head of Sales, Dhaka  
I.U.M. Ashfaque–Sales Manager – Khulna Division  
Md. Akhter Habib–Sales Manager, Dhaka

Kazi Humayun Kabir–Nasima Medical Hall/Mohammapur, Blue Star Provider  
Swapan Kumar Pa–Blue Star Provider, Jessore  
Abul Hossain–Blue Star Provider, Jessore  
Anjan Kumar–Blue Star Provider, Jessore  
Swapan Kumar–Biswas Blue Star Provider, Jessore  
Sah Abdul Kader–Blue Star Provider, Jessore  
Mosharaf Hossain–Blue Star Provider, Jessore

### **BANGLADESH CENTER FOR COMMUNICATION PROGRAMS (BCCP)**

Mohammad Shahjahan–Director

### **BRAC**

Faruque Ahmed–Director of Health

### **MAMONI PROJECT, SAVE THE CHILDREN & JHPIEGO**

Ishtiaq Mannan–Chief of Party

### **FAMILY PLANNING ASSOCIATION OF BANGLADESH**

Jahir Uddin Ahmed–Director General

### **ICDDR,B**

Peter Kim Streatfield–Head Population Programs

### **MOHAMMADPUR FERTILITY RESEARCH SERVICES & TRAINING CENTRE**

Rina Parveen–Director

Parveen Haque Chowdhury–Deputy Director

### **CHITTAGONG MEDICAL COLLEGE, FAMILY PLANNING MODEL CLINIC**

Setara Raihan Banu–Medical Officer

### **MARIE STOPES/CHITTAGONG**

Shahed Kamal–Clinic Manager

### **SECOND URBAN PRIMARY HEALTH CARE PROJECT**

Md. Faruque–Project Manager

Sabrina Siddiqui Abedin–Junior Consultant Doctor

Asma Chowdhury–Junior Consultant Doctor

### **IMAM TRAINING ACADEMY, CHITTAGONG**

Md. Selim Uddin–Deputy Director,

Moulana Isllahuddin–Master Trainer,

Monirul Islam Rafiq–Columnist, Presenter on TV & Khatib, Professor

## **MAYER HASHI PROJECT (ENGENDER HEALTH)**

Abu Jamil Faisal—Country Representative  
Sanjida Hasan—Senior Program Officer  
Ellen Themmen—Consultant, Technical Director  
Md. Liakat Ali—Senior Program Officer  
Fatema Shabnam—Team Leader, Service Delivery and Training  
Zeenat Sultana—Deputy Director, (BCCP assigned to Engender Health)  
Mahboob-E-Alam—Team Leader, Monitoring, Evaluation and Research  
S.M. Nizamul Haque—Team Leader, Policy and Advocacy  
Mizanur Rahman—Senior Technical Advisor  
Sharif Md. Ismail Hossain—Senior Program Officer

## **FAMILY PLANNING ASSOCIATION OF BANGLADESH**

Jahir Uddin Ahmed—Director General

## **JESSORE ROUNDTABLE MEETING**

Dilip Kumar Brahma—Deputy Director, MOHFW, Jessore, Khulna Division  
Rafiqul Alam Khan—Medical Officer, MCH-FP, Sadar Upazila, Jessore  
Ulfatun Nessa—Principal, Regional Training Centre, NIPORT  
Md. Sayeedur Rahman—Deputy Director, MOHFW Jessore (retired)  
Sazzadur Rahman—Executive Secretary, FPAB, Jessore (retired)  
M. Abu Sayeed—Assistant Secretary General, FPAB, Jessore  
Shahiduzzaman Laltu—Deputy Project Manager, Bangladesh Association for Voluntary Sterilization, Jessore  
Farida Tun Nahar—Project Director, Paribar Kallyan Samity (NGO partner)  
Sarbojit Anwar Kamal—Monitoring Officer, Paribar Kallyan Samity  
Mostak Uddin Ahmed—Program Coordinator, FPAB, Jessore  
Tarik Hasan Shahriar—Columnist, *The Daily Independent*  
Abu Sayed, Clinic Manager—Marie Stopes Clinic  
S. K. Nanda, Project Manager—The Salvation Army  
Md. Fazlul Haque—Deputy Director, Ad-din Hospital and Trust, Jessore  
Shabnam Momtaz Rosy—Upazila FP Officer, Jessore

## **AD-DIN HOSPITAL AND TRUST, JESSORE**

Moshiar Rahman—Deputy Director,  
Shila Poddar—Resident Medical Officer  
Subashi Biswas—Manager  
Uma Datta—Paramedic

## **OTHER**

Mufaweza Khan—Assessment Team Resource Person (accompanied Chittagong Team)  
Md. Abdul Halim—Private Practice Physician



## ANNEX C: REFERENCES

- Aboagye-Nyame, Francis, Beth Yeager, and Kyle Duarte. *Preparation for Strengthening Pharmaceutical Systems (SPS) Activities in Bangladesh 2009*. (SPS/MSH Trip Report)
- “ACQUIRE Project End of Project Report.” New York: EngenderHealth, 2009.
- Bangladesh Center for Communication Programs. “BCC Issues in Bangladesh: An Overview.” Dhaka, Bangladesh: October 2009. (Unpublished)
- “Bangladesh Media Reach by Channel and Sub-Populations for BCC.”
- Bangladesh Ministry of Health and Family Welfare, Directorate General of Family Planning. *The National Communication Strategy for Family Planning and Reproductive Health*. November 2008.
- “Bangladesh Population Policy 2004.”
- “Bangladesh Population Policy 1976.”
- Bartlett, Al, Karen Cavanaugh, Lily Kak, and Kristina Yarrow. *USAID Bangladesh: Rebuilding Technical Leadership in Health*. Washington, DC: USAID, 2009.
- Bates, Jim. *Bangladesh: Contraceptive Procurement in Transition. How Context Can Affect Outcome*. Boston, MA: John Snow, Inc./DELIVER, 2008.
- Bhattacharjee, Anuraddha, Wahiduzzaman Chowdury, Peter Connell, William Jansen, and Judith Justice. “Addressing Gaps in the Existing USAID/Bangladesh Health Program.” Washington, DC: GH Tech Project, 2008. (Internal USAID document)
- Bowers, Gerard, Frank Feeley, and Betty Ravenholt. *A Review of USAID’s Experience with the Private Sector in Health: 1968–2009*. Washington, DC: The QED Group, February 2010.
- Dickens, Todd. *Government of Bangladesh Contraceptive Bottleneck Study*. Seattle, WA: PATH, 2008.
- “EngenderHealth Workplan”
- Fox, Elizabeth. “Summary of Behavior Change Communication Roundtable and Assessment: Key Points from BCC Roundtable.” Dhaka, Bangladesh: October 2009.
- Johns Hopkins School of Public Health Center for Communication Programs, Asia Division. *Bangladesh Media Reach by Channel and Sub-Populations for BCC*. (Undated)
- Johnston, Beverly. “Trip Report.” 2008. (GH/PRH). (Compliance issues in FP).
- Kamal, Nashid. “Role of Government Family Planning Workers and Health Centres as Determinants of Contraceptive Use in Bangladesh.” *Asia-Pacific Population Journal*, 9:4, 1994.
- “MAMONI Workplan 2009–2010.”
- National Institute of Population Research and Training (NIPORT), Mitra & Associates, Macro International. *Bangladesh Demographic and Health Survey (BDHS) 2007*. March 2009.
- “Partnership Arrangements Between the Government of Bangladesh and Development Partners Concerning Support for the Implementation of the Health, Nutrition and Population Support Program (HNPPSP).”
- Patykewich, Leslie and Elizabeth Leahy. *A Case Study of Reproductive Health Supplies in Bangladesh*. Washington, DC: Population Action International, 2009.

“Population/Family Planning Roundtable Discussion.” Notes taken at the Hotel Lake Shore, Gulshan, Dhaka, March 21, 2010.

Ravenholt, Betty, Angela Stene, Sara Sulzbach, Kathryn Banke, and Karen Finnegan. *Assessing the Commercial Viability of Long Acting and Permanent Contraceptive Methods*. Private Sector Partnerships-One Project: November 2009.

“SSFP Workplan”

Stover, Carina, William Jansen, et al. *Long-Term and Permanent Methods of Family Planning in Bangladesh*. Washington, DC: GH Tech Project, 2007.

Streatfield, Peter Kim, Carel van Mels, Abdur Razzaque, Karar Zunaid Ahsan, Abbas Bhuiya, Mehrab Ali Khan, Ahmed al-Sabir, John Cleland, and Nitai Chakraborty. *Plateauing of the Bangladesh Fertility Decline*. International Center for Diarrheal Disease Research, Bangladesh; Centre for Health and Population Research; National Institute of Population Research and Training, (NIPORT). London University, Dhaka University. (Undated)

Streatfield, P.K., S. Arifeen, A. Al Sabir, and K. Jamil. “Framework of the Next Health Sector Program (July 2011–June 2016).” (Draft)

Streatfield, P.K., S. Arifeen, T. Ahmed, and M.E. Chowdhury. *Bangladesh Demographic and Health Survey: Policy Briefs*. March 2009.

Streatfield, P.K. and Z.A. Karar. “Population Challenges for Bangladesh in the Coming Decades.” *Journal of Health, Population and Nutrition*, 26(3): 261–272, 2008.

USAID. *USAID Country Health Statistical Report: Bangladesh*. Washington, DC: USAID, December 2009.

USAID/Bangladesh. *Improving People’s Health in Bangladesh: Activity Approval Document 2008–2013*. Dhaka: October 2009.

USAID DELIVER Project. “Bangladesh: Contraceptive Procurement in Transition.” Task Order I. Washington, DC: USAID, August 2008.

World Bank, World Health Organization. “Building the Evidence Base to Support Decisions on a Future Health Sector Program in Bangladesh.” (Undated) (SOW for a consultancy)

World Bank, World Health Organization. *Health Systems Analysis: Building the Evidence-Base to Support Decisions on a Future Health Sector Program in Bangladesh*. Washington, DC: World Bank, WHO. (Undated)

Wright, Susan, Lily Kak, Kanta Jamil, and John Holley. *Program Sustainability Assessment*. Dhaka: USAID/Bangladesh, June 2006.

## **ANNEX D: USAID PROJECT REVIEW**

### **SOCIAL MARKETING COMPANY**

The Bangladesh Social Marketing Company (SMC) began operations in 1974 under the aegis of Population Services International (PSI) to expand the availability of condoms and oral contraceptives through the commercial marketplace at prices affordable to the poor. It is the largest contraceptive social marketing entity in the world and likely the longest-running contraceptive social marketing entity in the world. SMC is now a privately-managed, not-for-profit company, governed by a voluntary board of directors, that uses the techniques of social marketing to deliver products and services and promote behavior change in a number of health-related areas. Its primary areas of work are family planning, child survival, safe motherhood, and HIV/AIDS prevention.

Social Marketing Company complements public-sector distribution of contraceptives, oral rehydration salts (ORS), and other health-related products through a commercial-sector network that reaches 75,000 pharmacies, approximately 3,500 Blue Star service centers, and some 125,000 kiosks and other outlets. It also sells contraceptive products to some NGO clinics/networks, including the Smiling Sun Franchise Project. In addition to ten brands of condoms and three brands of oral contraceptives, the SMC currently markets an injectable contraceptive, two ORS products, two micro-nutrient products (zinc and iron), and a safe delivery kit. Social Marketing Company employs approximately 450 personnel in its headquarters and twelve area sales offices around the country.

Throughout its history, the SMC has received cash, technical assistance, and commodity support from USAID. Most recently, USAID implemented a ten-year cooperative agreement with the Social Marketing Company that ended December 31, 2007. A four-year follow-on project began January 1, 2008, and will extend to September 2011. Under the four-year agreement, SMC may receive up to \$3 million in cash of which \$2.44 million is already committed as well as supplies of injectable (approximately 4.75 million units of Depo-Provera/Pfizer) and low-dose combined oral contraceptives (approximately 104 million cycles of Femicon/Wyeth). By the end of the four-year follow-on agreement, the Social Marketing Company is expected to generate sufficient revenue through product sales and other enterprises to operate at 85% cost recovery.

### **Project Performance**

The Social Marketing Company is a major contributor to the use of contraceptives in Bangladesh. According to the 2007 Bangladesh Demographic and Health Survey (BDHS), users of SMC contraceptive products account for 35% of the total national modern method contraceptive prevalence rate. Approximately 57% of condom users, 45% of OC users, and 21% of injectable users surveyed in 2007 obtained their method from an SMC source. In FY 2009, the SMC sold 42 million cycles of oral contraceptives, 122 million condoms (units), and 940,000 vials of injectable contraceptive.

The Social Marketing Company is expected to use its revenue from product sales and other enterprises to support its operational, marketing, and commodity costs. SMC staff report that at the end of FY 2009 the organization had achieved a level of 82% cost recovery.

In effect, USAID during the four-year period of the current cooperative agreement is investing a total of \$3 million in cash and approximately \$7 million/year in contraceptive commodities in return for maintenance of 35% of national contraceptive prevalence.

## Implementation Issues

This is a time of special opportunity and challenge for the Social Marketing Company. Changes beginning to occur in the environment pose many significant questions for the future of the organization. The SMC has enjoyed considerable USAID funding over the past thirty years. However, USAID's commodity support of the SMC is decreasing and may further decline or end within the next five years. How will the SMC maintain, grow, or retool its position as the country's leading non-public sector provider of contraceptives when commodity donations end or are further diminished? Without donated commodities, how will the SMC most effectively maintain both its commitment to sell a range of selected products below cost, at a retail price accessible to the very poor, or at low profit and its own financial sustainability?

National contraceptive use is now heavily dependent on supply methods (OCs, condoms, and injectables) that the SMC sells. If the contraceptive method mix shifts toward LAPMs as a result of the government program's shifting emphasis, how may the SMC's current business and revenue stream change? What new lines of products or business or target consumers might best compensate for any major shifts in future method mix? Can SMC become an importer of IUDs or implants to supply the private market? How will the SMC maintain or grow its relevance to the contraceptive prevalence rate? How does the company remain managerially nimble and "ahead of the curve" of changing business conditions?

To what extent do the financial and human resources of the SMC allow it to be a significant and effective agent for behavior change within the marketplace? To what extent can the SMC be expected to successfully and profitably introduce health technologies that are largely new to Bangladeshi consumers—such as zinc, progestin-only pills, emergency contraceptive pills, and water purification tablets—without the aid of outside or additional financial and communications resources? What are the possible partnerships that could provide additional resources to the SMC for the introduction of new-to-the-Bangladeshi market technologies? What will be the opportunity costs and return on investment to the SMC of its integration of health services that are not connected to product sales—such as LAPM referrals, TB referrals, HIV/AIDS and antenatal counseling, for example—into the Blue Star program? Do these added services have demonstrable impact on clients' improved health and healthy behaviors? Does the extent of the Blue Star network allow for significant health impact? How can the SMC create partnerships with the public sector or with NGO and other private-sector players that will complement and supplement its service delivery resources—thus creating significant positive impact on the public health? To what extent does the Blue Star network enhance the SMC's role in supplying the contraceptive needs of a large segment of the population?

By the same token, this is an important time for USAID to ask itself significant questions in regard to the Social Marketing Company. What is the role in family planning and health services delivery that USAID expects the SMC, currently the second largest recipient of PHNE project support, to play? To what extent should it function as a provider of already established health and family planning products; as a referral agent for services and products available from other sources; as an agent for behavior change in the introduction of health technologies/products new to the Bangladeshi marketplace; as a promoter of new approaches/channels for already existing services/products; a promoter of behaviors complementary to the health goals sought by its products; or a promoter of behaviors consistent with its overall self-perceived mission as a major contributor to improving the health of Bangladeshis? What are the comparative advantages of the SMC in undertaking these tasks as opposed to those of other possible USAID partners? What are the financial self-sustainability expectations that USAID has for the SMC? Are those self-sustainability expectations compatible with the role in service delivery that USAID expects SMC to play? What role does the Government of Bangladesh most need the SMC to play for the advancement of the national family planning program? In what areas, if any,

does the SMC continue to need donor or other support in order to maximize its potential contribution to health and family planning services delivery?

None of the questions posed above can be answered meaningfully by the summary programmatic overview undertaken by the assessment team during this visit. They require a full-scale assessment of SMC operations, including at least the following elements: examination of the SMC's competitive environment; an assessment of the SMC's particular comparative advantages, strengths, and weaknesses as a health and family planning service provider; an analysis of existing financial plans and current and projected financial performance; a review of product sales data and consumer/client research; analysis of the SMC's domestic and international product procurement possibilities; and an analysis of the Blue Star network, its contributions to health and family planning services delivery, and its role in the business of the SMC. With such information in hand, there is then a more solid basis for the development of a long-term, strategic plan that is most likely to carry the SMC successfully through the next five years, a period that seems to promise considerable change. Nevertheless, there are several implementation issues implied in the questions posed above that the assessment team wishes to highlight and discuss briefly below.

### **Sustainability and Social Mission**

The SMC experiences tension between its social mission—i.e., serving the poor, creating behavior change, and delivering health services for the public good—and pressure for financial self-sustainability that many donor-supported social marketing and clinic franchise systems do worldwide.

The provider training, client counseling, and advertising/promotional support necessary to introduce new products and to create behavior change are expensive and labor-intensive. These behavior change interventions are also long-term—that is, they do not usually “pay off” in increased product sales in the immediate term, and they must be continued over time as new potential adopters/consumers enter the market. For example, SMC participates—primarily through Blue Star pharmacist training—in the national effort to identify and refer for treatment the large number of untreated TB cases, to promote and provide antenatal care, and to promote behaviors for the prevention of HIV/AIDS. While provision of these services by Blue Star pharmacists is expected to contribute to the public good and may enhance their standing and credibility in the community, this does not result in any direct financial return to the SMC on its investment in the required pharmacist training or to SMC providers themselves in the immediate term. It is unclear to the team what business decisions would need to be made by the SMC or what business directions taken to make effective behavior change interventions financially self-sustainable in a market like Bangladesh.

There does not appear to be available any current analysis of price elasticity or any recent test market experience to inform decisions relative to possible future SMC product price increases and their impact on SMC products' accessibility to lower-income segments of the population. There also does not seem to be readily available from either the 2007 BDHS or the SMC any current research that sheds light on the economic status of SMC consumers in general or on consumers' economic status and other relevant characteristics by SMC product/brand purchased.

### **Procurement and Expansion of Product Line**

The SMC currently procures for itself with revenue from product sales and its other business enterprises all the products in its line, with the exception of the injectable contraceptive (donated by USAID) and the low-dose combined oral contraceptive Femicon™ (now being

produced for the SMC by a local manufacturer but donated product also included in USAID's current year commodities budget).

Of particular concern to the assessment team is the ability of the SMC to continue to offer an injectable contraceptive at a price its target market is able and willing to pay. Currently, the SMC injectable is the only non-public sector brand available in the Bangladeshi market. USAID pays US\$1.01/vial for its large volume purchase of the injectable (Pfizer™), which is branded and sold by the SMC at a retail price of Tk. 28/vial (or approximately US\$ 0.40/vial). Before USAID discontinues donation of injectable contraceptives to the SMC, the organization needs to find a source/price for a high-quality injectable contraceptive that allows this product to continue to be offered outside the public-sector system.

Expansion of the SMC product line appears to be motivated both by the health and family planning needs of the population and by the company's need for increased revenues for financial self-sustainability. Each new product category introduced, however, needs significant advertising/promotional support, especially where the product or technology is unfamiliar to the consumer base—in cases, for example, like zinc, the nutritional additive moni-mix, the progestin-only pill, and the emergency contraceptive pill. Some new product introductions will also need considerable promotion to healthcare workers and providers whose support will be essential to behavior adoption and significant sales success. Mass media and other promotion at the levels likely needed for successful new product introduction are expensive even in Bangladesh. It would be difficult to achieve full cost-recovery on small margin products such as most of those mentioned above while making the investments in advertising, promotion, and training necessary to reach the level of sales success that donors and governments wish to see or that are necessary for real impact on the public health.

### **Expansion and Utilization of Blue Star Outlets**

The Social Marketing Company has created a network of Blue Star service providers that currently includes about 3,500 outlets. Each outlet is owned and operated by a community-level non-graduate medical provider who has received training in family planning and other areas of primary healthcare from the Social Marketing Company. Reportedly, many Blue Star providers were originally trained as rural medical practitioners, and 95% of the providers are male. Approximately 90% of Blue Star outlets are associated with drug shops/pharmacies, and 5% are associated with a provider's medical office.

Blue Star outlets are distributed throughout the six divisions of Bangladesh as follows: Dhaka (1,000); Rajshahi (850); Barisal (300); Chittagong (650); Sylhet (295); and Khulna (405). The degree to which this distribution is sufficient to create measurable improvements in service delivery and health outcomes to unserved or underserved populations does not appear to be well documented. There seem to be no particular synergies between the distribution and services offered by Blue Star outlets and by outlets of the USAID-funded Smiling Sun Franchise clinics that might create between them more measurable health/family planning impact and community-wide behavior change.

While the Social Marketing Company invests a significant portion of its advertising, promotional, and training budgets into support of Blue Star outlets and providers, these outlets account for approximately 6% of total annual revenue.

There are two aspects of the Blue Star network that appear unique in the Bangladeshi health and family planning service delivery environment. First, Blue Star providers and specially trained FWAs (domiciliary visitors employed by the public sector) are the only non-clinic sources of the injectable contraceptive in Bangladesh. Second, Blue Star outlets appear well situated—in market

areas with considerable surrounding consumer traffic and with 95% of its providers male—to serve as a channel for reaching men with targeted messages and services.

Approval for expansion of the Blue Star network must be given by the government. Currently, the SMC has approval for the addition of 300 new outlets—100 of which the government has said must be opened in Sylhet, Chittagong, or Barisal. Until now, SMC managers have felt that the network should be kept under a total of 4,000 outlets, due to the human resource requirements for adequate monitoring and supervision. With the current DGFP encouraging the SMC to open new outlets, however, the company is looking for ways to accommodate additional growth of the network.

### **Discontinuation Rates and Counseling**

According to the 2007 BDHS, more than half of all users of a modern contraceptive method are OC users, and 54% of oral contraceptive users discontinue method use during the first year. While there is no available analysis that illuminates the reasons for this discontinuation (Is it actually method switching? Is it due to husbands' departure from the household to work elsewhere? Is it due to perceived side effects? Is it due to faulty compliance?), such a high rate may greatly reduce method impact on fertility decline.

Since the SMC provides the oral contraceptives for 45% of OC users, according to the 2007 BDHS, the discontinuation rate is an issue of particular concern for the organization. To what extent, if any, does the fact that a large share of pill users obtain their method directly from a commercial pharmacy without other provider intervention or contact contribute to the reported high rate of discontinuation? Does the discontinuation rate for SMC oral contraceptive consumers differ in any significant way from the discontinuation rate for NGO or FWA oral contraceptive clients? There appears to be no research currently available that sheds light on these questions.

To ensure that pharmacists/drug shop owners have correct method information available, the SMC makes considerable investment in pharmacist training. The underlying assumptions are that this training will support SMC product sales within the trade and will also support pharmacists' promotion of the method and its correct use to consumers. The SMC has pre- and post-training research results that show increases in pharmacists' correct knowledge and positive attitudes toward the method. There has been, however, no research done on whether or not the newly acquired method information is transmitted by the trained pharmacists to their clients or on the impact, if any, of pharmacists' training on their clients' correct and continuing use of the method.

On the basis of scattered visits to non-Blue Star pharmacy/drug shops in several cities during its visit, the team is hard-pressed to see where the opportunity for OC client counseling might occur in a "normal" pharmacy setting. Shops are small, set close and open to very busy and crowded streets, staffed by men, and appear to have comparatively few female shoppers. Further, the assessment team has seen during its visit no particular community—or nationwide communications and IEC support for correct, continuing use of oral contraceptives that could supplement SMC training/educational efforts or contribute to more effective use of SMC and other sources' oral contraceptives.

### **Business Planning**

As the SMC product line expands and other sources of sustainable revenue streams are created—such as the ownership and expansion of product manufacturing facilities and the SMC Tower office building—business and financial analysis and planning will become increasingly complex. Return on investment and opportunity costs of each existing and potential new line of business should be carefully examined and compared. In particular, the cost to the SMC of its

manufacturing facility's operating at less than full capacity should be examined. There seems to have been some fairly recent activity-specific business/financial planning, but much of it was reportedly done prior to two years ago. Furthermore, it is not clear to the team that there is a current comprehensive plan for the company's business as a whole.

## **Marketing Support**

The Social Marketing Company has not been directly associated with an international social marketing organization for many years and does not now have through USAID a strong connection to any USAID cooperating agency working in support of the private sector in health. Consequently, the SMC appears somewhat isolated from current worldwide social marketing experience/lessons learned, especially related to the introduction and marketing of non-contraceptive health products, that it could perhaps adopt and use to its own advantage.

The next four to five years will be critical years in moving the SMC into fuller maturity as a private nonprofit company. It appears to the assessment team that the SMC cannot likely make this move with greatest potential for success without some carefully targeted technical assistance in strategic marketing and business planning.

## **Recommendations**

### *Sustainability and Social Mission*

- SMC is a key participant in the Bangladesh population/family planning program. Indeed, the organization's operational success and long-term institutional sustainability will be important contributing factors to the overall success of the USAID assistance program in the population sector. The assessment team therefore recommends that USAID renew/extend its cooperative agreement with the SMC for at least another four to five years after the current agreement expires in September 2011. Prior to the agreement design, emphasis should be given to providing the SMC with technical assistance in strategic planning, financial analysis, and business plan development. This analysis should help inform feasible expectations for SMC cost-recovery vis à vis its mission of serving the poor and promoting behavior change during the period of the new agreement. The agreement should include the opportunity for continuing technical assistance in the ongoing cycle of strategic plan development and management of long-range financial and business plans.
- If USAID plans to discontinue donation of any or all remaining donated commodities, then a phase-out plan should be developed, with particular emphasis on technical assistance to the SMC in its process of identification and procurement of an affordable, high-quality substitute injectable contraceptive product.
- Additionally, a new agreement should take into account the likely need for the SMC to have sources of complementary and/or supplementary funding (SMC, GOB, USAID, other donors, public-private partnerships) for the development and implementation of advertising, promotional, and provider training campaigns necessary for the successful introduction of strategically selected new products important both to the public health and to the cost-recovery prospects of the SMC.

### *Procurement and Expansion of Product Line*

- The team recommends that USAID provide technical assistance to the SMC in evaluation of the potential, if any, for export of products manufactured by Social Marketing Company-owned facilities.
- The team recommends that USAID provide technical assistance to the SMC in evaluation of and improvement in the cost-efficiencies of its current product manufacturing operation.

- The team recommends that USAID provide technical assistance to the SMC in evaluation of the business/profitability potential, managerial/monitoring requirements, and possible health impacts of new additions to the SMC product line such as, for example, Misoprostol, emergency contraceptive pills, IUDs, implants, sanitary napkins, and clean water tablets.

#### *Expansion and Utilization of Blue Star Outlets*

- The SMC should continue to build the value to outlet owners of participation in the Blue Star network. In particular, the team recommends that the company evaluate and—if feasible—develop a plan for volume purchases of selected pharmaceutical products that can be sold to Blue Star participants at a greater discount than they can obtain by purchasing on their own. (Smiling Sun does this now for its participating NGOs.) Some possibility for SMC profit within the negotiated discount should be realized—at least sufficient to cover the administrative costs of this activity.
- The team recommends that USAID provide technical assistance to the SMC in evaluating the potential for development and introduction of franchise agreements and franchise fees within its Blue Star network. The SHOPS Project is one possible source of such technical assistance.
- The team recommends that the SMC evaluate the costs-benefits of implementation—in conjunction with other relevant NGOs and the DGFP—of a strategy for using Blue Star providers as a special channel for reaching men with family planning and health-related information and products. Their location in heavily trafficked market areas and the presence of male providers in 95% of the outlets would seem to make Blue Star outlets especially useful in reaching men. Special consideration should be given to ways in which this service delivery strategy could contribute to increased SMC revenues.
- The team recommends that USAID work with managers of both the SMC and Smiling Sun to identify any possible synergies between the two networks that could add to their potential for having significant impact on targeted behavior change and effective contraceptive use. For example, the team recommends that USAID provide the technical assistance necessary to evaluate and implement, if found feasible, a possible referral relationship between Blue Star providers and SSFP clinics in which Blue Star providers might refer potential LAPM clients to nearby SSFP clinics in return for a referral fee paid by the SSFP clinic.
- The team recommends that USAID consider contributing to the SMC's funding of a promotional and advertising campaign for Blue Star outlets focused on the availability of injectable contraceptives there.

#### *Discontinuation Rates and Counseling*

- The team recommends that USAID commission a relatively small research project or analysis of already available data, if any, that will illuminate 1) reasons for the high rate of discontinuation of OC and injectable use, and 2) any patterns that may exist in discontinuation of OC and injectable use by source of method.
- The SMC should evaluate the costs-benefits of its large, continuing investment in pharmacist training. The SMC should undertake some type of research that sheds light on the effectiveness of pharmacist training as a mechanism for reaching OC users and affecting their correct and continuing use of oral contraceptives. The SMC should also evaluate the costs-benefits of pharmacist training on its OC and other product sales to those pharmacists.

- The SMC should seek to identify, if possible, other more effective and less expensive ways than pharmacist training to inform and influence OC users. Are there areas of possible collaboration with other NGOs that might be useful in this regard? Do other NGOs need to sell their own line of OC products, or can they provide the personal counseling/interpersonal communications needed to increase continuing, correct use of SMC brand oral contraceptives?

### *Business Planning*

The leadership of the SMC should be encouraged to conduct a comprehensive self-assessment and strategic planning exercise over the next several months, and to complete this exercise with the development of a five-year financial/business plan. As noted above, USAID should consult closely with the SMC regarding the implementation of these tasks, and should provide technical assistance, as needed, to ensure the success of those efforts. (Such assistance could likely be provided through the SHOPS Project, for example.) Individual product/activity plans that may exist should be integrated into one comprehensive strategic plan so that return on time/money investments of various business activities can be easily compared and evaluated.

### *Marketing Support*

The assessment team recommends that USAID provide the SMC with some tie-in with a USAID cooperating agency like the SHOPS Project that can provide linkages between the SMC and current worldwide social marketing business best practices/lessons learned.

## **SMILING SUN FRANCHISE PROGRAM**

The Bangladesh Smiling Sun Franchise Program (SSFP) is the latest version of a long-term effort by USAID/Bangladesh to deliver FP and health services through clinics administered by a network of NGOs. The initiative began in the early 1990s as two separate programs—the Urban Family Health Initiative (UFHP) and the Rural Service Delivery Partnership (RSDP). In 2000, USAID combined the two (urban and rural) activities into one program, the NGO Service Delivery Program (NSDP). NSDP clinics sought to establish a brand identity using a “Smiling Sun” logo; but the branding effort was not supported by a vigorous marketing/public education campaign.

The SSFP is the successor to the NSDP. Its essential mission remains unchanged from the earlier projects, i.e., to deliver a range of FP and health services through a facility-based (as opposed to door-to-door) model. SSFP has been organized, however, around a franchise model that is intended to improve the network’s ability to recover costs (e.g., by drawing on user fees), and thereby its prospects for eventual financial sustainability—while simultaneously ensuring delivery of services to the poor. The SSFP project also implements a far more intensive marketing effort to promote the “Smiling Sun” brand as a signal to clients that the branded site offers safe and affordable health services in a clean and courteous environment. SSFP is USAID’s largest health sector project in terms of its resource requirements (LOP funding will amount to approximately \$46.5 million).

The SSFP network currently includes 28 NGOs which are providing health and family planning services through 319 static and 8,500 satellite clinics in 61 districts of the country. The project recently began its third year (under its new franchise structure). By the fourth year of project operations, the project is expected to generate sufficient income to support approximately 70% of its operational costs.

### **Project Performance**

Relatively precise measures of the project’s service-delivery performance over time will be available in 2011–2012 following a second round of surveys of the knowledge and use of FP and

maternal and child health services among populations served by the SSFP program. The first, baseline survey was conducted in 2008 by Associates for Community and Population Research (ACPR), a research firm located in Dhaka, with technical support from the MEASURE project. Moreover, USAID/Bangladesh plans to conduct a mid-course evaluation of the project within the next few months.

Service statistics and financial data provided by SSFP personnel for the purposes of this assessment indicate that the project is generally on track in meeting its service and revenue (i.e., cost-recovery) targets. Service contacts are increasing year-over-year (from 27 million in FY 2008 to almost 28.5 million in FY 2009—though the past year’s performance was short of the targeted 32 million contacts); approximately 26% of these contacts were with the poor in both FY 2008 and FY 2009; and the project recovered roughly 40% of its operating costs—up from 26% in FY 2007. This latter indicator reflects the project’s increases in revenue: In FY 2008, the project realized earnings of \$1.8 million. Revenues as of the writing of this report (March 2010) are amounting to \$1.6 million per quarter and are projected to reach \$5 million for all of FY 2010.

## **Implementation Issues**

As explained earlier, the assessment team was not asked to evaluate the USAID Mission’s family planning projects; implementation issues identified herein are therefore limited to relatively few but seemingly important issues that emerged in the course of a quick review of those projects. With that disclaimer in mind, the assessment team noted a number of factors that SSFP has encountered, and continues to face, that could impede the ability of an otherwise successful program to respond to the service needs of increasing numbers of clients. These are summarized below.

### *Human Resource Constraints*

The current contractor for the SSFP project (Chemonics International) advised the assessment team that when they assumed responsibility for the SSFP activity in 2007, the contractor had expected to find some installed capacity to provide long-acting and permanent (LAPM) FP methods. Chemonics managers report, however, that upon closer examination of the NGO network in 2007, they found that the presumed capacity had largely evaporated. The project has therefore used much of the past 3½ years to reinstall that capacity—a task that was complicated by 1) a relatively high turnover rate of trained professional staff, and 2) delays in securing training slots for SSFP medical personnel in GOB training programs for LAPM.

SSFP has tried to improve the stability of its workforce by increasing compensation levels for its staff. SSFP management is attempting to address the second constraint through dialogue with the Dhaka-based Mohammadpur Training and Fertility Center, i.e., in an effort to increase the number of SSFP clinical personnel admitted to the Center’s training programs (102 SSFP doctors are awaiting training); and by seeking support from EngenderHealth in training SSFP personnel in LAPM. Pending success in these efforts, SSFP’s ability to provide LAPM services remains fairly modest. At present, some 50 SSFP clinics are capable of offering both tubal ligation and NSV services (94 can offer NSV only). SSFP hopes to offer both types of sterilization services through 102 clinics by the end of this year. The project’s success in meeting its LAPM goals is critical; alternatively, the project risks being a very costly delivery mechanism for mostly non-clinical, temporary FP methods.

Human resource constraints have also limited SSFP’s efforts to upgrade a number of its clinics from “vital” status—meaning they can provide the standard health package of health services defined by the GOB—to “ultra” status, indicating a clinic capable of providing those essential

services, plus emergency obstetrical care (EOC) and a full laboratory. Currently, 36 SSFP clinics are ultra facilities—a number that is projected to increase to 47 by the end of FY 2010.

#### *Inadequate funding for sterilization services*

As a USAID-funded partner subject to the provisions of USAID Policy Determination No. 3, SSFP cannot use U.S. Government funds to compensate sterilization clients for lost wages, transportation expenses, etc. SSFP is dependent on the GOB to provide these costs, along with reimbursement for provider (i.e., surgical team) costs.

Survey literature in Bangladesh does not indicate the extent to which client compensation, or the amount thereof, is a meaningful factor in prospective clients' decisions whether to seek a sterilization procedure. Virtually all GOB and NGO personnel interviewed in the course of this assessment believe, however, that client reimbursement is an extremely important factor in clients' decisions, and that the number of sterilization procedures in Bangladesh is driven to a large extent by the availability of those cost-reimbursements (putting aside the personnel constraints noted above). SSFP points to compelling clinical evidence of this link: SSFP clinics that requested full payment from patients for sterilizations averaged approximately 20 procedures per month. When those same clinics were able to participate in a pilot agreement with the GOB—whereby the clinics could draw down from an “imprest fund” (a special bank account established for SSFP by the GOB to provide funding for immediate reimbursement of patient expenses and provider costs), the number of sterilization procedures increased to 150 per clinic per month—an increase of 750%. The creation of such special accounts has not, however, been systematized on behalf of SSFPs (it was in fact an informal arrangement between local DGFP authorities and some SSFP clinic directors, worked out on a more or less personal basis).

This before-and-after performance differential strongly suggests that there is considerable excess capacity in SSFP facilities that has successfully addressed the human resources constraints noted above. Looking to the future, the creation of a workable, reliable, financially adequate GOB-funded reimbursement mechanism will be essential to ensuring the success of SSFP as a source of LAPM services.

The DGFP is supporting such imprest funds (for sterilization client and provider reimbursements) throughout the country. However, with the exception of the informal arrangements discussed above, these special accounts are used solely to reimburse public sector providers and their patients. The DGFP, moreover, lacks experience with, or administrative procedures in place, for contracting out service delivery responsibilities to NGOs—that is to say, the DGFP has no systematic way to pay for services provided outside their system.

#### *The Cost-Recovery Model*

USAID is applying sound project-management principles in its effort to promote a high degree of cost recovery within the SSFP program. Cost recovery and concomitant measures to contain costs are essential elements of a well-managed project, and are important to a donor's obligations to conserve scarce development resources, and to ensure that assisted entities/programs have a strong likelihood of enduring after the cessation of external assistance. That said, the assessment team believes that the cost-recovery/sustainability target (attainment of 70% cost recovery by EOP) that defines the SSFP project may be overly optimistic. Moreover, earnest attempts to achieve that target might impede the project's ability to meet its equity objectives and to increase delivery of FP services.

A search of the literature regarding USAID support for private-sector (including social franchise) programs in the health sector indicates that very few—if any—social franchises have achieved financial self-reliance, and virtually none have done so within the short timeframe allotted to the

SSFP project. Indeed, only three private-sector programs supported over the years by USAID can claim to be within close proximity to financial self-reliance: PROFAMILIA/Colombia; PROSALUD/Bolivia; and the Social Marketing Company (SMC)/Bangladesh. The first two, however, participate as health care providers in their host countries' national health insurance programs, earn income from USAID-established endowment funds, and still receive project-specific funding from various donors. The SMC is dependent on USAID for its supply of injectable contraceptives and for much of its current supply of Femicon (low-dose combined oral contraceptive). All three organizations, moreover, have had over 20 years of support from USAID, during which time they have been able to develop and refine their own sustainability models. The same literature describes many other USAID-sponsored initiatives that struggled to meet unrealistic temporal targets for financial sustainability, and which terminated operations (or severely contracted their programs) upon cessation of USAID assistance.

All of the SSFP clinic directors consulted by the assessment team noted the pressure they are facing to attain cost recovery targets; all claimed, moreover, that the project's efforts to achieve these targets are impeding the project's effectiveness in serving the poor, especially in rural areas, and to provide more FP services. While these sentiments no doubt reflect the discomfort of some "traditional" NGO managers with a new way of doing business, team observations suggest that they have a basis in fact: increases in demand for sterilization when client reimbursements are offered (see above); poor women unable to purchase more than one cycle at a time of the lowest-cost oral contraceptive (representing a possible factor in that method's high discontinuation rate); and a client "mix" that shows relatively low numbers of the "hard-core poor" being served, notwithstanding the availability of free or discounted services for those clients. Cross-subsidization of services—i.e., using revenues from diagnostic and elective services for higher-income clients to defray the costs of services for lowest-income clients—helps to some extent. But the bulk of FP services provided by SSFP, whether they are for the poor or the not-so-poor, are revenue-negative, even when they are provided at satellite sites. The cost of FP services increases dramatically when offered through the project's fixed clinics.

### *Network coverage*

SSFP's 319 fixed clinics and 8,500 satellite sites are more or less evenly divided between urban and rural areas—an echo of the project's roots in the UFHP and RSDP. SSFP managers estimate that this system is accessible to approximately 15% of the country's population. Project managers note, moreover, that an additional 1,000 satellite sites could be added to the current structure without adding any strain to the fixed facilities responsible for their oversight. Further expansion of the system has been postponed at USAID's request pending completion of the project's midterm evaluation later this year.

That evaluation is likely to identify some important cost considerations that will determine the direction of future expansion efforts. Expanding the number of fixed facilities will be expensive, but those facilities are also the major "profit centers" for the network. Each additional satellite site, on the other hand, is operated on a negative-revenue basis—yet increasing the number of those satellite sites represents the quickest and (for USAID) the least expensive way to increase the coverage of this largely successful but still relatively compact service delivery network.

## **Recommendations**

- **Address Human Resource Constraints:** GOB inability to train SSFP clinical staff has created a bottleneck that impedes the expansion of health and LAPM services through SSFP facilities. Specifically, the lack of adequate training funds compels the Mohammadpur Fertility Services and Training Center to give first priority to GOB trainees, and to admit SSFP trainees on a space-available basis. USAID should undertake any or all of the following tasks:
  - 1) authorize SSFP to use project funds to cover training costs of SSFP personnel at GOB

training facilities; 2) support the creation of a GOB-sanctioned private-sector training facility in Dhaka, and fund training therein for both NGO/private-sector and GOB personnel in LAPM; and 3) facilitate, in the interim, negotiations between SSFP and the Mohammadpur Fertility Services and Training Center toward the development of a systematic training plan for SSFP clinical personnel.

- **Funding for Sterilization Services:** USAID should facilitate negotiations between SSFP and DGFP toward the creation of imprest accounts that fund SSFP sterilization procedures in the same manner that such accounts are established and funded on behalf of GOB providers. Support for this negotiation process might be preceded by technical assistance to strengthen GOB policies and procedures supportive of contracting out for NGO services—an initiative that would serve longer-term strategic goals that go beyond support for sterilization activities.
- **Cost-Recovery:** Without abandoning its efforts to promote the project's recovery of a reasonable share of costs, and to start the SSFP along a pathway to improved sustainability, USAID should reassess the rigor with which it is applying those goals to the project. The upcoming mid-course evaluation of the project should include, as part of the scope of work for that evaluation, an in-depth assessment of the extent to which the existing contract's cost-recovery requirements are realistic, attainable by EOP, and whether they are indeed impeding attainment of the project's goal of extending services to the poorest elements of the population.
- **Network coverage:** The midterm evaluation to be conducted later this year will provide USAID with a sound basis for a decision regarding network expansion. As of this writing, however, there do not seem to be any substantive reasons why the project should not proceed to expand the number of its satellite sites to 9,500—a number that is within the management capacity of the project as currently configured. SSFP should probably focus on urban slums as the initial phase of this expansion; its network presence is currently very thin in the country's worst slum areas, and creation of satellite sites in such areas could precede relatively quickly. USAID should be prepared to 1) facilitate the needed approvals from DGFP and municipal authorities for this expansion, and 2) factor into its cost-recovery expectations the impact such an expansion would have on the attainment of the project's financial targets.

## **MAYER HASHI (SMILING MOTHER)**

Mayer Hashi is a four-year (May 2009–September 2013), US\$12 million project implemented by Engender Health under the aegis of USAID/Office of Global Health's centrally funded RESPOND Project.

Mayer Hashi has two primary objectives:

- To increase the use of high-quality family planning services with a focus on the informed and voluntary use of long-acting and permanent methods (LAPM);
- To prevent postpartum hemorrhage (PPH) through increasing proper practice of active management of the third stage of labor (AMTSL) by service providers at the facility level and increasing proper use of misoprostol at the community level.

Project objectives respond to the health and family planning environment of Bangladesh where 12,000 women die annually from complications related to pregnancy and childbirth, and where, of the 62% of MVRA who want no more children, only 7% use a long-acting or permanent contraceptive method.

The project is designed to work at the community, facility, and national levels. It seeks to achieve its objectives primarily through technical assistance to the Government of Bangladesh by providing training to providers of LAPM, assisting in strengthening the organization and management of long-term family planning service delivery, and working to improve coordination of contraception service provision at the field level. Additionally, Mayer Hashi seeks to reduce cultural barriers to and increase demand for permanent and long-term family planning methods. Finally, Mayer Hashi provides training to facility-level providers in AMTSL and mobilizes communities for proper use of Misoprostol during childbirth unattended by a trained provider.

Mayer Hashi is implemented in 21 low-performing districts of Sylhet, Chittagong, and Barisal Divisions where there is a catchment population of five million married couples.

## **Project Performance**

During the first ten months of the project, a variety of facility-level training and IEC materials have been developed and produced. These include a trainer's manual, training participant handout, community skilled birth attendant (CSBA) orientation handout, job aids, AMTSL poster, and Bangla dubbing of an AMTSL video for use in facilities. Eight hundred eighty-five DGFP, DGHS, NGO, and community leaders have so far been oriented to issues on maternal and newborn health.

At the community level, the first phase of a pilot project to test the correct provision and use of Misoprostol has been successfully completed in Tangail. A sufficiently high level of community acceptance and user satisfaction was reported through evaluation efforts that the second phase of the pilot was recently launched in Cox's Bazaar. Materials supporting the community-level trial of Misoprostol developed and produced by the project include flipcharts, stickers, and leaflets.

At the national level, the work of the project has supported formation of a National LAPM Advisory Committee that is headed by the Director General of Family Planning. Tools for mapping existing LAPM provider and trainer resources have been developed and disseminated for use in the field. A foundation has been laid on which further behavior change advocacy and communication can be built.

The project has reached 12 of the 21 districts planned.

## **Implementation Issues**

The assessment team has identified several implementation issues important to the future success of the Mayer Hashi project. These issues are discussed briefly below:

- **Inclusion of AMTSL in Government Operational Plans (OPs):** AMTSL is not currently included within the government's operational plans or included on the MIS forms used by the government for reporting, monitoring, and supervising delivery of government-provided services. Without inclusion in these two formats, the provision of AMTSL is not securely a part of the government's health services program and may not be consistently provided.
- **PPH management:** Managing PPH requires vigilance and preparedness on the part of the providers and their supervisor. The non-availability and occasional improper, i.e., non-refrigerated, storage of oxytocin were noted at some locations.
- **Vacancies and Transfers:** The Mayer Hashi Project works within the structure of the government's health services. Wide-ranging vacancies in sanctioned positions of doctors, nurses, paramedics, FWVs, SACMOs, HAs, and FWAs within the government health structure seriously impede the ability of the project to succeed in its tasks. Additionally, the

frequent transfer of government staff from one facility to another not only increases project costs by necessitating training of new incoming doctors but also represents a loss of project resources when outgoing trained doctors are transferred to districts outside the project area where his/her new skills cannot be used.

- Frequent transfer of trained providers also threatens the ability of Mayer Hashi to implement its plan for comprehensive family planning services, including LAPM, through DGHS facilities such as district hospitals, medical colleges, and UHCs. The success of a pilot project test of the comprehensive service delivery plan scheduled to begin in Barisal in April could be seriously hampered if provider transfers out of the project area continue at current rates.
- Design flaw: (above issue—vacancies and transfers, notwithstanding) Workplan and M&E plan encourage/allow Mayer Hashi’s capacity-building strategy to stop short: It focuses on training, without much followup guidance or support to ensure implementation.
- Regulatory Constraints on Provision of LAPMs: Client access to longer-term and permanent methods of contraception are unduly constrained by current government policy. For example, nurses are not allowed to insert IUDs. Only a relatively small number of specially trained FWAs are allowed to administer injectable contraceptives. A woman without at least two living children, the youngest of whom must be at least two years of age, is not eligible for tubal ligation. Even a woman undergoing a Caesarian section delivery is not eligible to receive a tubal ligation at the same time.

## Recommendations

The assessment team recommends the following actions in response to the implementation issues identified above:

- Inclusion of AMTSL in Government Operational Plans (OPs): The assessment team recommends that Mayer Hashi staff carefully track the timing of the next round of Operational Plan revisions so that AMTSL can be considered for inclusion in the revised OPs. The team further recommends that Mayer Hashi and relevant USAID/PHNE staff work with UNFPA (support for designing MIS software) and UNICEF (support for printing MIS forms) to ensure the inclusion of AMTSL in future revisions of the government’s MIS and reporting documents.
- Ensure Preparedness to deal with PPH: The team recommends that Mayer Hashi staff work closely with the heads of GOB facilities to ensure that providers maintain ready availability of oxytocin, and that it is properly stored in refrigerated conditions.
- Vacancies and Transfers: The team recommends that appropriate project and PHNE staff discuss with the DGFP and DGHS the problem of trained staff transfers from defined project areas in order to seek whatever resolution may be possible for that growing constraint on project performance and resources.
- Regulatory Constraints on Provision of LAPMs: The assessment team recommends that USAID engage the Ministry of Health and Family Welfare in policy dialogue related to the current eligibility requirements for both the provision and acceptance of longer-term and permanent methods of contraception. This dialogue could be initiated through a forum or presentation of WHO, IPPF, or other relevant agency service delivery standards and/or international best practices. The newly formed National LAPM Advisory Committee may be a useful partner in advocating for regulatory change.

- Follow-up TA and training: The project should develop procedures whereby Mayer Hashi can provide more post-training followup and support to trainees and their organizations, facilitating the actual use of newly learned skills (e.g., providing services or training others).

## **NEW MAMONI MCH PROJECT**

The goal of the MaMoni project is to improve maternal and neonatal outcomes in Sylhet and Habiganj. It is a four-year (April 2009–January 2014) project, implemented through the centrally funded ACCESS Project by Jhpiego and Save. MaMoni is building on the three-year ACCESS project, which focused on maternal and newborn health in seven upazillas of Sylhet. MaMoni is introducing family planning, hand washing, and newborn sepsis management into the MNH intervention package. It is also expanding geographic coverage to the Habiganj District.

Project objectives are:

- To increase knowledge, skills, and practices of healthy maternal and neonatal behaviors in the home.
- To increase appropriate and timely utilization of home and facility-based essential MNH and FP services.
- To increase acceptance of FP methods and advance understanding of FP as a preventive health intervention for mothers and newborns.
- To improve key systems for effective service delivery, community mobilization, and advocacy.
- To mobilize community action, support, and demand for the practice of healthy MNH behaviors.
- To increase key stakeholder leadership, commitment, and action for these MNH approaches.

## **Project Performance**

MaMoni is in the start-up phase and has yet to report performance. Planned family planning activities include: increased household counseling of pregnant women to promote, and development of community norms to support, postpartum family planning. Observation suggests the community mobilization model is successful in getting clients to use health services including postpartum family planning.

## **Implementation Issues**

- Regulatory issues are constraining access to post partum contraceptives.
- Little interest is exhibited by GOB partners in scaling up lessons learned.

## **Recommendations**

- Regulatory Constraints on Provision of LAPMs: The team recommends that USAID engage the Ministry of Health and Family Welfare in policy dialogue related to the current eligibility requirements for both the provision and acceptance of longer-term and permanent methods of contraception.
- The MaMoni project has demonstrated the feasibility of community mobilization to support improved maternal health and, to a lesser extent, family planning activities. The team understands that elements of the model are being adopted by other NGOs. When the

testing of the model is complete, and best practices have been identified, the tools, approaches, and evidence should be packaged and disseminated to the NGO community.

- MaMoni has demonstrated in 15 upazilas in Sylhet a potentially powerful model to increase community involvement in family planning. It is not clear what the potential is for adoption and scale-up by the GOB. The DGFP usually defer to NGOs to conduct community mobilization activities, suggesting that successful replication of the MaMoni model will depend on the extent to which it is adopted by other NGOs in the country.
- USAID should consider a cost-benefit analysis of the community mobilization activities of MaMoni. Generally, community mobilization is slow and labor-intensive. There are sufficient other service delivery models in the USAID portfolio to make a comparison of the costs and impacts of the different service delivery strategies. It should also be noted that MaMoni is piloting service delivery models, and this is generally more expensive.

## **DEMOGRAPHIC AND HEALTH SURVEY—MEASURE DHS**

The DHS has provided technical support to the implementation of five BDHSs, the last in 2007. There is currently a follow-on activity to disseminate and utilize the survey data—Bringing Health Information to Communities Project. The project is designed to educate stakeholders nationwide about major health indicators and support evidence-based decision-making.

Project objectives:

- Increase knowledge of the Bangladesh DHS (BDHS) results among national and upazilla policy and decision makers.
- Promote evidence-based actions derived from BDHS and other research results.
- To achieve these objectives in the most cost-effective way the following strategic approaches have been adopted:
  - Focus on the USAID priority health areas for Bangladesh: high fertility, safe motherhood, neonatal practices, and childhood under-nutrition.
  - Integrate BDHS findings into ongoing projects.
  - Collaborate with both government and non-governmental organizations and activities.
  - Channel activities to geographic areas of greatest need.
  - Target several key audiences for maximum impact.

The National Institute for Population Research and Training (NIPORT) is the principal local partner for this project. NIPORT oversees and coordinates the project activities and serves as the local expert organization on the BDHS.

### **Project Performance**

- PowerPoint presentation: To ensure that each local partner is disseminating the same results and key messages/recommended actions, representatives from about 15 organizations developed and are using the presentation.
- Journalists' Training: This activity will focus on improving local journalists' skills in health reporting and their ability to use of the BDHS and other research. Two three-day workshops were held for 40 journalists. To follow up there will be continuing activities with the Health Journalists' Forum.

- **Informing Sylhet and Upazilla Decisionmakers:** Workshops in all upazillas and the four municipal areas of Sylhet are scheduled. Local leaders and family planning officials will participate. BDHS results for Bangladesh as a whole and for Sylhet specifically, and recommended action points, will generate group discussions on fertility, safe motherhood, nutrition, and neonatal care.
- **Reaching Health Care Providers:** Social Marketing Company (SMC) trainers will include the BDHS results in their regular workshops with these health care providers. The next version of the SMC's *Alap* newsletter will be distributed to 60,000+ health care providers nationwide. The SMC will also convene a series of BDHS workshops at the medical training schools in Sylhet and Chittagong.
- **Reaching Religious Leaders:** The Asia Foundation will distribute a specially prepared booklet on the BDHS results presented within the context of family health and Quranic teachings.
- **Nutrition Advocacy Package:** A Nutrition Advocacy Package featuring BDHS data is under development. The package will be widely disseminated.
- **Advocating for Safe Motherhood:** DHS, White Ribbon Alliance, EngenderHealth, NIPORT, and the MOHFW are preparing a short booklet and PowerPoint presentation for use by USAID-funded projects and the media to support reduced maternal and neonatal illness and death.
- **Activities in the planning stages:** Reaching parliamentarians and Chittagong decision makers workshops.

### **Implementation Issues**

None identified.

### **Recommendations**

USAID has supported the monitoring of the performance of the family planning program since 1975. It is safe to say these surveys have created awareness of the population problems of Bangladesh, and that they have helped identify solutions. The BDHS is clearly a necessary activity. USAID is very proactive in supporting the use of the data at all levels of program management and decision-making. USAID also supports media use of the data, making the BDHS a public education tool and an advocacy tool. The team's assessment is that the BDHS is a good investment for USAID and should be continued. The secondary analysis and policy utilization is a model for other countries and also should be continued.



## **ANNEX E: SUMMARY OF THE ROLE OF THE PRIVATE FOR-PROFIT SECTOR IN ADDRESSING THE IMPACT OF POPULATION GROWTH ON THE DEVELOPMENT GOALS OF BANGLADESH**

The impact of population on development in Bangladesh is fundamental. Population growth affects not only the public health but also education and thus the work force, job requirements, waste management, water supply, climate change, food production, energy, land use, political stability and governance, transportation, the environment, and housing—to name only the most obvious.

Recognition of the fundamental importance of the issue of population growth on development is, however, not enough. Population growth itself must be addressed, and the most effective and efficient means of diminishing population growth is the widespread availability and use of family planning. A clear understanding of the direct connection between the impact of population growth on national social and economic development and the availability and use of family planning services must be established throughout all levels of society and government. This task requires the engagement of resources from all sectors—including the active involvement of the private/for-profit sector.

There are **four primary avenues** through which the resources of the private sector can be engaged in affecting the impact of population on development in Bangladesh: **advocacy and leadership, financial resources, human resources, and service delivery.**

### **ADVOCACY AND LEADERSHIP**

Leaders of business and industry are influential in any society. They have impact on government policy as well as on the actions of their business colleagues and the opinions and life choices of their employees. Before business leaders can become champions for population and family planning, however, they must themselves be convinced of the importance of these issues. Consequently, any USAID-supported population advocacy program should be sure to include members of the business community in the fora and presentations where population issues are demonstrated and discussed. These leaders exist not only on the national level but also at the regional and local level and can be accessed, for example, through trade associations, chambers of commerce, professional associations, and service clubs such as Rotary International. Many media are themselves part of the private for-profit sector, and journalists and broadcasters should be signal targets of any population advocacy effort.

Once convinced of the significance of population growth on development, and of the importance of family planning as a tool with which to address population growth, private-sector leaders may need guidance in how best to become effective advocates for these issues. USAID should consider provision of technical assistance to facilitate the development and effectiveness of issue champions recruited from the private sector. This technical assistance could include guidance in such areas as prioritization of advocacy tasks and messages, identification of effective channels for advocacy messages, formation of private-private or private-public partnerships for synergy in advocacy, and the like.

### **FINANCIAL RESOURCES**

Efforts around the world to develop among business owners a sense of “corporate social responsibility”—where companies invest their own financial resources in public service communications campaigns, health services delivery to employees, school improvements, and

support of NGO service delivery to the poor, for example—have often met with mixed results at best. In relatively few instances have USAID-initiated project outcomes aimed at developing and harnessing corporate social responsibility been effectively sustained beyond the life of the donor’s project involvement. Nevertheless, in a setting like Bangladesh where the momentum of population growth and its impact on society are so great, it may be worthwhile to evaluate the prospects for private-sector participation in financial support for population education and advocacy and for expanded access to family planning services. The presence in Bangladesh of garment factories producing products for international design and retail firms presents the possibility of linkages with these international companies—which may perhaps have more public relations needs and other reasons for participation in pro bono activities than do domestic firms—for private-sector support of enhanced behavior change communications and service delivery.

In particular, the potential for mutually beneficial private-public or private-NGO partnerships should be explored. USAID has developed considerable experience in the cultivation and implementation of these partnerships, and that experience should be examined for its applicability to the Bangladeshi environment. One example of a private-NGO partnership that is already established at least in small measure in Bangladesh is the contracting out by a garment manufacturing firm to an NGO clinic system (Marie Stopes) for healthcare services provision to its employees. Family planning and other reproductive health services can easily be included in such a partnership.

Partnerships are also quite common worldwide between service organizations like Rotary International and local NGO or other service delivery groups. These types of partnerships have worked well in Bangladesh for issues related to water, hygiene, and prevention of diarrheal disease, and could also work well for issues related to population and family planning.

## **HUMAN RESOURCES**

The number of Bangladeshi couples in their fertile years is growing and will reach a historic peak in five years. There does not exist within the public sector a sufficient level of trained providers to meet this near-term need for family planning services. Additionally, the population will continue to grow, because of existing momentum, likely until 2050. The family planning service delivery infrastructure required to service this growing population adequately is not sustainable by the public sector alone. Private-sector service providers, however, are not optimally prepared or in some cases allowed to contribute effectively to the family planning service delivery needs of the Bangladeshi population.

USAID can address the issue of increased participation of the private sector in service delivery with the Government of Bangladesh in several significant ways:

- Provide technical assistance in the development of curricula for medical (physicians, nurses, midwives) colleges that include up-to-date knowledge and best practices in family planning and contraceptive use as well as opportunities for clinical practice;
- Provide technical assistance in analysis of the regulatory environment for private-practice delivery of family planning services;
- Provide technical assistance in advocacy for and preparation of any necessary revisions in policies related to the private-sector provision of family planning services; and
- Provide technical assistance to the Government of Bangladesh in the development of appropriate regulations regarding the certification, relicensing, and continuing education requirements for private-practice service providers.

Private-sector specialist physicians such as OB/GYNs usually serve the upper, financially able segments of a population and are not often regarded as important channels for reaching underserved or unserved segments. However, specialist physicians are frequently important opinion leaders and change agents within their medical communities, and can play a significant role in, for example, increasing acceptance of the relevance of family planning to women's health and in disseminating best practices to providers who do serve lower-income segments of the population.

## **SERVICE DELIVERY**

A variety of healthcare providers exists that is affordable to lower-income segments of the general population and can complement the service delivery capacity of the public sector. These providers include general medical practitioners, non-graduate providers, midwives, and nurses, among others. They are often limited in the extent to which they can provide services, however, by their lack of appropriate and updated clinical skills, by governmental restrictions on their ability to practice in the private sector or on the kinds of services they are allowed to provide. While many of these restrictive regulations may protect the safety of the public, some may unduly constrain access to needed services from affordable, conveniently located service delivery outlets. USAID support for an analysis of the legal and regulatory environment for private-sector family planning service provision could inform policy dialogue designed to eliminate or lessen any unnecessary restrictions on private-sector service provision that may exist in Bangladesh.

The sustainability of service delivery in the private sector, especially service delivery by midwives and lower-level healthcare providers, is often limited by the lack of business training and experience that these providers have received and by their access to FP commodities. USAID should consider including in any curricula it collaborates with relevant professional associations to develop at least some business training—especially training related to management of a private practice, accounts and record keeping, purchasing and supplies, and application for loans and credit that may be necessary to establish or expand a private practice.

Quality of care in private-sector service provision is an issue of great importance and should be addressed to the extent possible prior to the extensive expansion of the private sector into provision of family planning services. USAID/Global Health and its cooperating agencies have worldwide experience in issues related to quality of care, and USAID/Bangladesh should consider drawing on that expertise to inform possible quality of care strategies for the Bangladeshi private sector. Requirements for licensing and certification, periodic re-licensing, and continuing education are some of the tools that have been used in many countries to ensure appropriate quality of care in the private sector. Behavior change communications campaigns that educate consumers to the issue of quality of care and to their right to receive quality services have also proved effective in many countries in improving and sustaining quality of care in both the public and private sectors.

Private-sector family planning service delivery may also be said to include the distribution and sale of contraceptive products through outlets in the commercial marketplace. There is currently a relatively small commercial market for pharmaceutical contraceptives in Bangladesh. (The commercial market for condoms, however, is expanding due largely to the market growing activities of the Social Marketing Company.) The reasons for the commercial market's lack of vigor as a source of contraceptive supply may include product price, the availability of free products in the public sector, income distribution among the consumer public, or a variety of other reasons. An analysis of the legal and regulatory environment for private-sector family planning service delivery, as recommended above, can provide information on factors that may be constraining the availability of contraceptives through commercial channels. Constraints may

include such things as high import tariffs on pharmaceuticals (OCs and injectables) or medical devices (IUDs), other taxes, price controls, and the process for registration of products, and obtaining import licenses, for example.

## ANNEX F: ILLUSTRATIVE RESEARCH AGENDA

### UNDERSTANDING DISCONTINUATION

Rates of discontinuation in Bangladesh are high (57% in the first year of use), and are rising (in 2004 it was 49%). These rates are disturbing and compromise the efforts at recruitment and fertility control. There are a variety of reasons for discontinuing given to the team: stock-outs, method change, absence of husband, poor counseling on side effects, and improper provider treatment of side effects. Discontinuation increases the chances of gaps in protection, side effects, use of less effective methods, and improper use of a method. It is recommended that further study be done to identify impacts, causes, and solutions to method discontinuation. This would include analysis of the fertility history in the BDHS-07, and qualitative and quantitative client followup studies.

**Implant discontinuation**—Discussion with providers reported strong demand, but a high rate of discontinuation for the implant. Since implants generally have few side effects, the question is, are drop-out rates high, and why are clients discontinuing? Since lower cost implants will be entering the program soon and there is a shift to LAPM, a study is recommended to determine causes and solutions to the wasting of an expensive and scarce contraceptive method.

**Quality of Care**—Research in quality of care is necessary as an advocacy tool (awareness of the problem and the associated consequences—discontinuation, method failure, use of inappropriate methods, unaddressed rumors, and misinformation); to help better understand the situation to design high and rapid-impact interventions; and to provide a baseline measure for evaluating interventions and impacts. Activities could include (in order of timeliness):

- A secondary analysis of the quality-related data in the BDHS (e.g., appropriateness of method mix to the life cycle, contacts with FP workers, contraceptive knowledge, discontinuation, reasons for not using, source of supply [likelihood of counseling and motivation], spousal communication).
- A rapid field assessment of quality of clinical care (IUD, implant, injection) and counseling (ability to use, possible side effects, actions if problems, method choices, fit of method to client characteristics and life style, etc.) should be conducted on public and private providers. These data would be used to frame discussions, prioritize settings, and help design interventions in current and new service delivery activities.<sup>19</sup>
- Focus groups to help define perceptions, importance, and consequences of quality of care or the lack thereof.
- Put mechanisms in facilities to give feedback on quality (suggestion boxes, post-service interviews).
- The next round of BDHS should include the quality of care module and additional questions on method knowledge, ability to use effectively, contact with provider, etc.
- Build monitoring of quality of care into the current service delivery projects.
- More refined measures and monitoring of quality as the quality becomes a program agenda.

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<sup>19</sup> Generally assessments of quality test compliance against the standards of service. Since current standards are out of date, an assessment should use very basic international standards (e.g., Measure Evaluation's "Quick Inventory of Quality" and/or one of the many job aids on "facilitative supervision").

## **COST-BENEFIT STUDY**

The Marie Stopes program in Chittagong has a “Health Card” program to serve garment workers. Employers pay for services (site-based services and referral). A cost-benefit study could be used to make the program more efficient and to advocate other employers to participate.

## **MAPPING OF FP SERVICES**

A number of factors (e.g., increased NGO activity, private practitioners, social marketing, and GOB expansion of health infrastructure and field staff vacancies) have resulted in confusion over coverage of family planning services. To reduce overlapping coverage, provide coverage where missing, and to help plan future interventions, it is recommended that a mapping exercise of service sites, FWA coverage areas, and private-sector outlets be carried out in collaboration with the GOB.

## **LOCAL CONTRACEPTIVE PRODUCTION CAPACITY**

Some of Bangladesh’s contraceptive security problems could be met by increased local production. An assessment of local capacity, interest, and constraints is a necessary first step in using the thriving local pharmaceutical industry.

## **COST-BENEFIT OF VASECTOMY VS. TUBAL LIGATION**

FWAs give a higher priority to recruiting NVS clients. As a result they will spend multiple visits and several months motivating the husband. While NSV is easier and safer, there are additional costs for recruitment and the risks of an unwanted pregnancy. A small study to look at the costs and risks of delaying sterilization in order to get an NSV client is proposed to provide field workers with guidance on the break-even point between NSV and tubal ligation.

## **ANNEX G: CASE STUDIES: HIGH-PREVALENCE AREA (JESSORE) AND LOW-PREVALENCE AREAS (CHITTAGONG AND SYLHET)**

### **HIGH-PREVALENCE AREA—JESSORE DISTRICT IN KHULNA DIVISION**

There are significant geographic differences in contraceptive use and fertility. This difference generally refers to divisions in the East (low prevalence) and the West (high prevalence). Khulna Division has a CPR of 53% as compared to Sylhet with 25% (BDHS-07). The assessment team visited Jessore District, the highest-performing district in Khulna, to help identify some of the FP program factors associated with their relatively high performance. Jessore's success in family planning has resulted in a reported below-replacement total fertility rate of 1.44 (local data). The factors as identified by GOB managers and NGO partners in a roundtable discussion with the team are described below.

- **Cross-sectoral coordination**—There is close cooperation between NGOs, the Government program, and private-sector providers. There was a strong sense that Jessore is the best in family planning and that everybody who helped maintain that status was a partner. Sectors shared sterilization capacity, data, training, and coverage planning.
- **Dedicated staff**—Both government and NGO staff seemed highly motivated and committed. Retention rates are high, and recognition is freely given.
- **Few vacancies**—Jessore seems to be one of the few districts where the government staff operates at close to the sanction levels. Only 10% of the medical officer positions are vacant. Out of 463 FWA sanction positions, only 54 were vacant. Out of 106 FWV positions, 11 were vacant.
- **Political support**—Local leaders are proud of the status the family planning program brings to Jessore and are very supportive. Support is maintained by regular meetings and involvement in the program.
- **Local-level planning**—In the 1990s, Jessore, with help from the USAID-funded FPMD Project, instituted a unique local-level planning system. Planning is still done at the upazila, union, and worker levels, and then shared and reconciled.
- **Monitoring**—The local Government family planning office designed an ongoing monitoring system that is used to drive supportive supervision and constant improvement in services. Recognition and competition among FWAs also contribute to staff morale.
- **Volunteer network**—Manirampur Upazila is the largest upazila in Jessore District. On its own, it initiated a network of 500 volunteers to support satellite clinics and to promote family planning.
- **Reputation of field staff**—The highly respected FWAs and FWVs provide a range of related health services in the 592 satellite clinics held each month. They are seen by their clients as family planning workers who provide other health services, and not the other way around. This brings considerable credibility to the family planning program.
- **Women's education**—Jessore women are better educated and less conservative, so dialogue, mobility, home visits, and recruitment for family planning are all easier.

- **Travel**—It is relatively easy to get around in Jessore. It is flat, and there are lots of roads, making home visits, supervision, and logistics easier. It is also easier for clients to get to services.
- **Male participation**—Jessore has an unusually large number of male sterilizations due to active recruitment of men and promotion by satisfied users.
- **Community participation**—The satellite clinics require active participation from the benefiting community. Local officials provide their house, and community leaders organize and promote.
- **Hindu population**—Jessore has a large Hindu population, and some sub-districts are majority Hindu. The Hindu community tends to be better educated, and women have greater freedom of movement. This makes it easier for them to get services and to give services—many of the FWAs and FWVs are Hindu. Hindus also travel to India around Bangladesh and so have been exposed to modern urban cultures (Kolkata is closer to Jessore than Dhaka, and there is considerable cross-border trade).

Early on, Jessore became goal-oriented and proactive in its implementation of the family planning program. Family planners in Jessore also were willing to experiment and innovate. These practices led to early successes and recognition. The adage, “Success breeds success,” is reflected in the lower fertility and higher prevalence of Jessore.

## **LOW-PREVALENCE DISTRICTS (CHITTAGONG AND SYLHET)**

- **Late arrival of the family planning program**—The GOB started family planning, including facilities construction, staff recruitment, and demand creation later than in most other divisions.
- **Religion**—The Islamic community is considered to be conservative on a range of issues related to family planning.
- **Staffing**—There are a large number of vacancies, and recruitment of additional staff has been “pending” for 25 years.
- **Home visits**—Family planning was established originally by home visits, and couples still see it as an in-home activity rather than a clinic service.
- **Fieldworker overload**—FWAs and FWVs get pulled off family planning responsibilities to support other health services, such as EPI, arsenic testing, measles campaign, nutrition education, and so on. This is frustrating for staff and management, especially since health workers “never ever!!!” are called on to provide family planning services.
- **Implants**—Implants were widely promoted and are very popular, but there is and has not been any stock.
- **Quality of care**—Indicators and practices suggest a lack of quality of care. For example, high dropout rates from implants suggests poor counseling and screening. A lack of postpartum services suggests a passive role in provision of services.

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