

Integration Issues in Maturing Population Programs

**A Study of the Integration of Family Planning and Other Population
Activities with Health and Other Development Interventions**

Case Study of Indonesia

Case Study of Bangladesh

Comparison of Indonesia and Bangladesh

Informal Program Planning Checklist

Phase Two Report

James E. Kocher

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**Prepared for the Asia Office, Asia/Near East Bureau
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Introduction

In September 1993, USAID's Technical Resources Office/Asia of the Asia/Near East Bureau (ANE/Asia/TR) requested Research Triangle Institute (RTI) to examine the issues, experience, and lessons learned on population integration and to offer suggestions to the Bureau on future program strategies and design. Two types of integration were examined:

Type 1 -- integration of family planning and health in the provision of information and service delivery; and

Type 2 -- integration of family planning and population interventions with those in health and other development areas (for example, education, women-in-development, employment).

Phase One of the study focused on global trends and consisted of a brief literature review and interviews in Washington with USAID staff and members of the US-based international population and health community. The Phase One Report on population integration was submitted to the ANE Bureau in April 1994. That report provides more detail on terminology, approaches, and general trends in population integration.

Phase Two of the study consisted of case studies on Indonesia and Bangladesh. The Indonesia study included a two-week visit to Jakarta by the study team. The time period in which the team was available to visit Dhaka was inopportune for USAID/Bangladesh so, with the consent of the USAID/Bangladesh Population, Health, and Nutrition Officer, the team conducted the Bangladesh case study in the U.S.

This Phase Two Report includes the Indonesia and Bangladesh case studies, a short comparative paper on the two countries, and an informal program planning checklist for Mission staff and others concerned with health and population projects. Each of the country studies describes the general issues of strategy and program implementation emerging from the literature reviews and, in the case of Indonesia, a brief country visit. Given the short time frame for research, the reports focus on what appeared to be the main issues common to Indonesia and Bangladesh. At the request of USAID/Indonesia, we targeted some of our study efforts on specific Mission and Government of Indonesia program plans and ongoing projects. The Bangladesh study is based primarily on a review of recent literature and contains little Mission-specific information.

The comparative paper also contains some suggestions for USAID to consider as it implements the Agency's new initiatives in health and population. The checklist in the Annex was intended to put some of the team's experience, findings, and lessons learned in a framework that would be useful to Mission staffs and others involved in program design and planning. Based on an "open-systems" approach, the checklist is essentially a set of questions on internal program management and on some of the external factors that can affect the program. We welcome suggestions for improving the checklist.

Indonesia: Integration Issues in a Maturing Population Program

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The Team is especially grateful to the USAID/Jakarta staff for inviting us to Indonesia to share ideas and experiences on population, health, and related programs and on USAID's changing role in these vital development areas. The Indonesian site visit also provided our team with an important reality check on many of the general findings in our Phase One report on program and staff integration in population and health. We also greatly appreciate the effective Mission logistical support that permitted us to maximize the use of our short stay in Indonesia.

A list of general contacts is appended to the report.

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1. Executive Summary

A. Purpose and Scope of the Integration Study

In terms of global population issues, the Asia and Near East (ANE) countries are critical. Our two case study countries, Indonesia, and Bangladesh, have two of the ten largest populations in the world. Yet the ANE region also contains some of the richest experiences of governments and people trying to cope with such serious problems as disease, overpopulation, malnutrition, and women's status. Therefore, opportunities abound for learning from these experiences and applying relevant lessons in the design and execution of the Agency's new priority initiatives in health and population.

In September 1993, the USAID ANE Bureau requested that Research Triangle Institute (RTI) examine some of the issues of population integration and suggest future program strategies and design. To provide a quick inventory of global trends, Phase One of the study consisted of a literature review and interviews in Washington with government and private sector professionals concerned with population and health programs in developing countries. Phase Two consisted of case studies on Indonesia (including a two-week site visit) and Bangladesh (a one-week Washington-based study relying primarily on published materials). Phase Two products include the country case studies, a brief comparative report on the two countries, and an informal checklist to help USAID Mission staff concerned with designing health and population projects.

In particular, the RTI team was asked to see if some of the ideas from the global study are relevant to Indonesia. USAID/Indonesia also asked that the RTI team look at current GOI and USAID Mission planning and suggest potential opportunities for integrating health and population efforts. The Team urges readers to remember that:

1. examining a complex, dynamic program like Indonesia's is hardly possible in the two weeks we spent in Jakarta; and
2. achieving program goals may be specific to individual country conditions or the intra-country conditions existing at a particular time (including resource levels and competence of program leaders).

Through national development policy and a new five-year plan, Indonesia continues to give top priority to improving family health and wellbeing. Program managers are confident that, by addressing both supply and demand factors critical to increased contraceptive practice, Indonesia will achieve replacement level fertility (2.1 children) by 2005. Several sources point out, however, that overall contraceptive acceptance levels and the percentage of longer term method use seem to be plateauing. *It will be critical for USAID, the GOI and other donors to use data from the 1994 Indonesian Demographic and Health Survey (available in 1995) to assess the adequacy of current program efforts to achieve national goals and to revise policies and operations accordingly.*

Highlights of Indonesia's accomplishments, remaining challenges, and Team recommendations are discussed in the rest of this chapter. They are examined more thoroughly in other chapters issues relating to Type 1 and Type 2 as are interventions.

B. Accomplishments

During the past 25 years, Indonesia's health and population programs, aided by USAID and others, have made impressive progress. The country has increased contraceptive prevalence from under 10% to around 50%, reduced the total fertility rate from six children to three, and decreased infant mortality from over 130 per 1,000 births to below 70. The population's rate of natural increase is now estimated at 1.6% per year. With its success in reducing population growth, Indonesia has been able to invest resources in new development initiatives, including a new national effort to increase free compulsory education from six to nine years.

More specifically, through a new program, more women service providers are being prepared to reach clients and communities that have not been covered by existing service delivery networks. These nurse-midwives can have a positive impact on the use of long-term contraceptive methods if they are provided with adequate training, clear legal authority, and technical backup.

C. Challenges

Although Indonesia has received well-deserved accolades for its recent progress, our contacts pointed out that important policy and operational issues must be addressed if Indonesia is to achieve its national goal of replacement level fertility (2.1 children) by 2005. Most obstacles are related to political restrictions, to the service delivery system, and to the dissemination of information.

1. **Political restrictions.** Voluntary surgical contraception is not an official method under the government family planning program, partly, our contacts noted, because GOI program managers fear political backlash from religious leaders and others. Abortion is illegal. Menstrual regulation services are available from a few private sources, reportedly for clients who have had a contraceptive failure.
2. **Dissemination of information.** Family planning acceptance appears to be slowing down, partly because couples in poorer or more remote communities have yet to be reached. Also, women sometimes choose not to receive care from male service providers.
3. **Service providers.** Sensitive, skilled service providers are critical to the success of Indonesia's health and family planning services. Yet many service providers lack knowledge and skill to promote effective use of IUDs and implants. They also lack clear legal authority and technical backup to support clients' choices of certain long-term methods. Finally, many service outlets are understaffed.

The Government of Indonesia, thus, faces these challenges:

1. to expand and improve the quality of health and family planning information and services, including more effort to tailor these services to the actual needs of clients (representing Type 1 integration); and

2. to assess and address some of the broader economic, political, and social issues effecting fertility, health, and other aspects of population planning (representing Type 2 integration).

However, to verify whether our impressions are correct, USAID and the GOI should review available impartial data on current national trends as soon as they become available. For example, data from the 1994 Indonesian Demographic and Health Survey (IDHS) should be processed as quickly as possible. If they confirm that there has been a significant plateauing or decline in family planning acceptance and continuation rates, then the GOI and aid donors will need to quickly revise some current planning assumptions and action programs.

D. Recommendations

The Team feels that the mission's general population and health goals are consistent with the GOI development goals. Some of these goals reflect Type 1 integration issues. For example, GOI family planning and health activities are commonly integrated at the service delivery point. Therefore, more attention and resources should be given to the Ministry of Health, where various levels of cooperation need to merge.

In assessing new program investment opportunities, USAID should consider support for new integrated efforts in family planning, MCH, and reproductive health that focus on improving quality of care by (1) training or retraining doctors, midwives, and other service providers; and (2) improving the supervision and support of service providers at all levels of the system. Specific services might include all or part of the basic package of integrated health, population, and nutrition (HPN) services identified by the USAID/Washington Global/Population and Health working group.

USAID and the GOI should also focus on altering the reward and motivation factors that now cause service providers to favor short-term contraceptive methods (e.g., some short-term methods mean more income or recruitment credit for providers but are not necessarily the best methods for clients). Special efforts may also be needed to remove the barriers to expanding the role of private physicians and other private sector providers of family planning and health services.

The GOI is also addressing some of the broader issues of integrating fertility and family planning concerns with other development sectors; these efforts reflect Type 2 integration. Because the potential array of Type 2 integration activities could be quite broad in the GOI program, USAID should focus some resources on policy and operational studies to help the GOI identify options with the highest potential for payoff. For example, some attention might be given to assessing links between fertility and changes in female education levels, women's empowerment and labor force participation, and trends in reproductive health.

Finally, the Mission needs to place high priority on communication efforts with USAID/Washington and with the GOI to ensure that common goals and operations are agreed upon. For example, ranking of priorities regarding the new mission population and health goals would ensure that staff and financial resources are focused on key areas.

The Mission and USAID/Washington also need to ensure that the new priority being given to health and population programs is accompanied by appropriate shifts in the staffing pattern. Moreover, the newer integrated approaches in health and population may require some retraining of staff to perform new roles.

Since the Mission staff deals with GOI on a daily basis, it should play the critical role of ensuring that all USAID inputs (central and bilateral) are focused on the most significant and cost-effective interventions, whether for vertical or integrated efforts. Centrally-funded projects' and cooperating agencies' (CAs') staff must therefore be effectively assimilated into a focused joint venture at the country level.

With the GOI, the Mission may need to confirm that the GOI is still operationally committed to achieving replacement level fertility by 2005, and significantly expanding the role of the private sector (including more favorable allocations for private organizations under the USAID Services Delivery Expansion Support Project). Past acceptor targeting in the GOI program has reportedly been labeled as "coercive" by certain donors and other parties. This targeting may have stimulated a shift toward less precise approaches to measuring program progress (e.g., the extent to which the program will respond to regular surveys of the clients' expressed needs for specific contraceptive methods). In establishing joint priorities, we assume that the Mission will pursue its strategy of concentrating on efforts to influence key policies, develop cost-effective and client-centered service system prototypes, and leverage resources from other sources for expansion of successful trial efforts.

2. Accomplishments

Critics said "it couldn't be done." A country peopled largely by poor (\$50 per capita income), illiterate Muslim peasant farmers spread over thousands of islands, speaking many different languages and belonging to several hundred different cultural groups did not fit the pattern for the introduction and expansion of a family planning program. But Indonesia proved the critics wrong [Curtin, et al., 1992: 1].

A. A Remarkable Past Quarter Century

In 1970, Indonesia was one of the poorest countries in the world. Its population was about 116 million, growing at an annual rate of about 2.5%. Its TFR was nearly 6; the contraceptive prevalence rate (modern methods) was under 10%. The infant mortality rate was about 130 per 1000 births. Per capita income was about \$50. Nearly 50% of the population lived below the poverty line (defined as adults consuming less than 2,150 calories per day). Only about 40% of adults were literate.

By 1991, the contraceptive prevalence rate (modern methods) was 47%; the TFR had declined to about 3. Infant mortality had declined to about 70. The population had grown to about 183 million (it is now estimated to be about 199 million). During the period 1970 to 1991, real economic growth averaged about 6.7% per year. Between 1969 and 1984, when self-sufficiency in rice production was first achieved, annual production of milled rice more than doubled from 12.3 million tons to 25.9 million tons [Hobohm, 1993: 344]. By 1991, per capita income had risen to about \$660. The percent of the population living below the poverty line had declined to about 15. Nearly 80% of adults were literate, and over 90% of children now complete at least 6 years of schooling.

B. The National Family Planning Program

On August 17, 1967, President Soeharto announced that the government was committed to family planning as an official development program. The National Family Planning Coordinating Board (BKKBN) was established in 1970, independent of any cabinet ministry, reporting directly to the president. Over the years, BKKBN has been perhaps the world's most innovative national family planning organization. Its first major program initiative was village family planning: using village volunteers to promote the benefits of small families and to provide services in rural areas where over 80% of the population resided. In 1970 BKKBN introduced the family nutrition improvement program to provide basic health and nutrition information and services. In March 1984 the government initiated the integrated family planning and health services program (*posyandu*). *Posyandu* meetings are held at community centers once a month and consist of the following five components:

1. immunization of children under age 5 with BCG, DPT, polio, and measles, and immunization of pregnant women with tetanus toxoid vaccine;
2. prenatal care to identify and follow up high-risk pregnancies;
3. family planning information and services;

4. management of diarrhea (promoting home-based oral rehydration therapy [ORT]); and
5. nutrition education and services [BKKBN, 1989].

BKKBN has also promoted an income-generating program (UPPKA) that consists of (1) providing coconut hybrid seedlings to family planning acceptors, (2) providing scholarships to children of low income, long-time acceptors, and (3) providing financial and technical assistance to communities for construction of physical facilities such as water sources and public roads. Two other major BKKBN initiatives in the 1980s were a major expansion in family planning in urban areas to meet the needs of rapidly growing urban populations and the introduction of Norplant into the national program (to date, there have been nearly 1.6 million Norplant acceptors representing over half the total Norplant acceptors in the world). In the late 1980s, BKKBN introduced the "Blue Circle" label of expanded services to primarily urban areas to include pills, IUDs, injectables, and Norplant. In 1992, BKKBN announced the introduction of "Gold Circle" contraceptives to be sold in rural areas and provide clients with more product choice and availability.

Another important BKKBN initiative in the late 1980s was the village nurse midwife (*bidan di desa*) program, implemented and funded by the MOH. This program rapidly trains and places nurse midwives in each of Indonesia's 66,000 villages through quadrupling the number of trained nurse midwives, from 16,000 in 1988 to 66,000 in 1996. To date, about 24,000 *bidan di desa* have been trained, and about 30,000 more are currently being trained (a four-year formal program commencing after completion of junior secondary school).

In 1993 a new Ministry of State for Population was created with Dr. Haryono Suyono as Minister. Dr. Haryono also continues as chairman of BKKBN. Within the past year, the Ministry has formulated a policy of "family wellbeing" (*Keluarga Sejahtera*). This represents a commitment by the GOI to look beyond family planning to all-important dimensions of family wellbeing (see Section 5 of this report for discussion of the new eight-point policy on families).

USAID has been the largest donor to the national family planning effort, providing about \$150 million since the late 1960s. The two major uses of USAID funds have been the expansion and improvement of family planning services and the strengthening of the institutional capabilities of BKKBN and other Indonesian organizations to organize, manage, and evaluate the family planning program [Curtin, et al., 1992: 15]. In recent years, USAID assistance has shifted from a bilateral Mission-managed effort to one that is largely funded out of USAID/Washington.

C. Reasons for Success in Family Planning and Fertility Decline

According to one recent study [Curtin, et al., 1992: 19-24], the most important nonprogram factors contributing to this success story have been sustained high-level political commitment to the program, political stability, a growing desire among families throughout the nation for fertility control to achieve small families, a sustained process of rapid socioeconomic development, and a cohesive village structure.

The most important program factors have been development of a strong, pervasive policy to promote the "small, happy, and prosperous family"; strategic vision and planning; creative BKKBN leadership; a strong and effective information, education, and communication (IEC)

program; enlisting Muslim leaders as allies in promoting family planning; and adequate program funding. Organizational strengths have also been crucially important: BKKBN as a strong, autonomous, coordinating institution; strong community involvement; and variety in service delivery.

Several other studies conclude that the remarkable accomplishments in family planning, fertility and mortality decline, rapid growth in per capita income, and significant reduction in poverty are the result of a critical combination of mutually-reinforcing policies and programs. The most important of these are policies and programs that have (1) achieved a stable political, social, and economic environment; (2) fostered sustained rapid economic growth (including growth in food production); (3) promoted rapid expansion of education at all levels including universal primary education (grades 1-6); and (4) aggressively promoted a small family norm ("small, prosperous, happy family") and made contraceptive services readily accessible throughout the nation. Indonesia's petroleum resources may have helped to protect its economy from the costly "oil shock" faced by some of its neighbors.

Between 1970 and 1980, the TFR declined about 27%, from 5.6 to 4.1. During the next five years, it declined another 22% to 3.2. The proportion of women using modern contraceptives increased from 27% in 1980 to 47% in 1987 [Gertler and Molyneaux, 1994: 36]. One recent report assesses the decline in fertility as follows:

Our results show that the dramatic fertility declines in Indonesia from 1982 to 1987 resulted from a large rise in contraceptive use which was motivated by increases in demand for contraception. In particular, improvements in females' educational attainment and in males' and females' wages were responsible for 45% to 60% of the decline; most of the impact acted through contraceptive use. More specifically, 75% of the decline was attributable to increases in contraceptive use, and 87% of the increase in contraceptive use was due to changes in education and wages. Therefore the educational and economic impacts, working strictly through increases in contraceptive use, accounted for 65% of fertility decline. In contrast, changes in measures of family planning program inputs were responsible for only 4% to 8% of the decline [Gertler and Molyneaux, 1994: 60].

3. Current Challenges

A. Achieving Replacement Level Fertility

Indonesia has the world's fourth largest population. In the past 90 years, the population of Indonesia has grown nearly five-fold, from an estimated 37 million in 1905 to nearly 200 million in 1994 (see Table 1).

Table 1. Size of the Indonesian Population, 1905 to 1994	
Year	Millions
1905	37.0
1930	60.1
1961	97.1
1971	119.2
1980	147.5
1990	179.3
1994 (estimate)	199.7
Sources: Haryono Suyono, August 1992; Population Reference Bureau, 1994 World Population Data Sheet	

The goal of Indonesia's national family planning program is to reach a two-child family size (replacement level fertility [RLF] with a TFR of approximately 2.1) by the year 2005. In 1991, TFR was 3.0 and desired family size was also about three. It is estimated that achievement of RLF will require a contraceptive prevalence rate (CPR) of between 63% and 70% in 2005 [Curtin, et al, 1992: 27]. This will require an increase in current users from 15.6 million in 1991 to 25.4 million in 2005. The annual number of new acceptors would have to increase from 4.6 million in 1991 to 7.2 million in 2005 [Curtin, et al., 1992: 28]. Over this period, approximately 85 million new acceptors will be required. This also assumes that long-term methods (IUD, implants, vasectomy, and tubectomy) will increase from 19.7% of all current users in 1991 to 24.9% of all users in 2005 [Curtin, et al., 1992: 27]. (However, since 1991, current users of long-term methods have declined as a proportion of all current users.) On the other hand, if users of long-term

methods *increased* as a proportion of all users, the number of new acceptors required to achieve RLF would be substantially smaller than 85 million. This would probably also be a considerably less costly method mix.

Even if RLF is achieved by the year 2005, the population will eventually grow to nearly 300 million. If RLF is not achieved until sometime after 2005, the ultimate population size could be well over 300 million.

B. Increasing the Use of Long-term Contraceptive Methods

For several years, increasing the proportion of contraceptive users who are using long-term methods has been a program objective. However, in the past few years, the number of IUD and sterilization acceptors has declined while the number of new Norplant acceptors has remained about constant. Table 2 illustrates the extent to which long-term methods can have a major impact on fertility. According to the 1991 IDHS, overall modern method prevalence was only slightly higher in East Java (53.0%) than in West Java (49.7%). However, prevalence of long-lasting methods was 2.3 times as high in East Java (29.8%) as in West Java (12.8%). By 1991, East Java had achieved RLF (a TFR of 2.13). However, the TFR in West Java was 58% higher (3.37).

Table 2. Comparison of East Java and West Java, 1991		
Indicator	East Java	West Java
TFR	2.13	3.37
% MWRA using modern methods	53.0%	49.7%
% MWRA using long-term methods	29.8%	12.8%
Total population (1990)	32,488,000	35,378,000
Source: Indonesia Demographic and Health Survey, 1991 MWRA = married women of reproductive age TFR = Total Fertility Rate		

Based on the 1991 IDHS, about 7 million women did not want any more children but were not using any method of contraception. In addition, a significant proportion of the 12.5 million women who were using spacing methods in 1991 did not want any more children (only 3.1 million women were using long-term methods). Long-term methods such as voluntary surgical contraception, the newer IUDs, and Norplant are among the most effective contraceptive methods and consequently may be preferable for couples who want to stop having children. Abortion is illegal in Indonesia except to save the life of the woman. Safe, legal abortions are unavailable to most women who want no more children but experience contraceptive failure and become pregnant. Reduction of illegal and unsafe abortions is another important reason for programs to encourage women to use effective, long-term contraceptive methods. Long-term methods are also generally the lowest cost on a "per year of protection" basis.

Typically, an Indonesian woman who already has two or three children and wants no more will be under age 30 at the time she has completed her "desired" childbearing and will need highly effective contraception for another 15 years or so. Women who use spacing methods instead of long-term methods are much more likely to have an unwanted pregnancy, thereby failing to meet women's and couples' needs and desires (demand fulfillment). Collectively, these women will cause national fertility to be higher than it would be otherwise. Moreover, such experiences can

be detrimental to the health and wellbeing of women and their families (*Keluarga Sejahtera*) and will impose greater financial burdens on the nation for education, health care, and other social services. Therefore, GOI and USAID should continue to give high priority to increasing significantly the use of long-term contraceptive methods.

Giving more attention to long-term methods will help to (1) improve the health and wellbeing of women and their families; (2) meet the needs and desires of couples (demand fulfillment); (3) reduce the financial burden of unwanted children on the nation, communities, and families; and (4) achieve the national goal of RLF. In addition, overall program costs will probably be lower if the use of long-term methods increases significantly (compared to costs of having users continue to rely primarily on spacing methods for limiting fertility). At present, long-term methods require that the couple make an immediate lump sum payment for the method that may be relatively large compared to their yearly income. However, the cost of a long term method may be quite low when amortized over the life of the method's effectiveness. Therefore, the GOI and NGOs should seek creative forms of helping clients to finance expenses for long-term methods. If the proportion of users of long term methods does not increase significantly in the next 10 years, it is highly unlikely that the national goal of RLF by 2005 will be achieved.

C. Achieving Universal Education through the Junior Secondary Level

For several years, Indonesia has had nearly universal primary education (grades 1-6) for girls as well as boys. On May 2, 1994, President Soeharto announced that it was GOI policy to achieve universal, free education through the junior secondary level (grades 1-9) within 10 years. The Ministry of Education and Culture (Depdikbud) estimates that over the next 10 years this will require an approximately three-fold increase in the public education system at the junior secondary level (grades 7-9). If the GOI achieves this goal, it is likely to contribute significantly to fertility decline in the coming years.

The rapid fertility decline of the past 20 years is an important reason for the achievement of universal primary education. The population of primary school age (ages 7-12) was about 15 million in 1970 and peaked at about 27 million in 1989/90. The population ages 13-15 (junior secondary school age) is still growing slowly, but it will peak at about 13.5 million in 1996/97 before declining slowly to about 12 million in 2008/09. (This projection can be made with considerable confidence because most of these children have already been born.) Had fertility not declined, the school age population would still be growing rapidly. It is unlikely that universal primary education would have been achieved, and achieving universal junior secondary education would be out of the question.

D. Continuing Economic Growth and Poverty Reduction

Due primarily to sustained rapid economic growth over the past 25 years, the proportion of people living in absolute poverty has been reduced significantly. However, it is estimated that nearly 30 million people still live below the poverty line, and an even greater number exist just above the poverty line. It is critically important that this lowest-income 30-45% of the population participate in the nation's economic growth in the years ahead if they too are to achieve the two-child family norm; low rates of infant, child, and maternal mortality and morbidity; and overall

family wellbeing. Therefore, the highest priority should be given to policies that promote sustained economic development together with promoting the participation of these low income households in employment opportunities and income growth. The extent to which substantial economic improvements occur among the lowest income populations may well be the most important factor in determining whether the national education, family planning, and health goals are achieved during the next 15-25 years.

E. Increasing the Number of Women Service Providers and Program Managers

Many of the service providers and NGO staff we interviewed indicated that Indonesian women prefer female health care providers. It is thus essential that a large cadre be established of women physicians and nurse midwives who are committed to women's reproductive health, including their health education, prenatal care, labor and delivery, postpartum care, and education and services relating to child spacing or limiting. To be effective, these appropriately-trained service providers must be regarded with trust and esteem. Increasing the number of women service providers will be one of the most important actions needed to achieve significant reductions in maternal mortality and morbidity [see PopTech, Mid-term Evaluation of Private Sector Family Planning Project, 1993]. Providers, as well as being female, should also be trained to be sensitive to their clients, particularly where ethnic and class differences exist between clients and providers. The activities being undertaken by the Indonesian Medical Society (IDI) should provide valuable opportunities for identifying, training, and fielding more female physicians.

The GOI needs to do more to increase opportunities for women to move into management and leadership roles in health and population programs. This will bring essential new perspectives to the design and execution of policies and programs that are primarily for female clients. In addition, USAID and other donors need to ensure that women are given equal opportunities to benefit from management and leadership training opportunities that are sponsored in Indonesia and abroad.

F. Addressing Emerging Issues in Adolescent Fertility and Reproductive Health

Some BKKBN and NGO staff informally expressed their concern about the effect of low fertility on adolescent behavior. There is an impression that teens in smaller families have more income and free time, so more may be engaging in less desirable behaviors (including unprotected intercourse). These sources report that the incidence of adolescent pregnancy is increasing and that sexually transmitted diseases (STDs) may become a problem for teens. Some NGOs have already organized programs for youths. USAID/Jakarta might consider supporting pilot projects in adolescent health through the HAPP and SDES projects in order to develop appropriate baseline data and interventions for Indonesia.

G. Focusing GOI and Donor Resources on Critical Priorities

The Indonesian program environment is complex, and there are many local and expatriate actors involved in the resource allocation process. The broad range of GOI goals reflected in the new national plans and strategies also presents a potential for resource scatteration unless there

is a clear action agenda and set of priorities. USAID's first concern must be to focus its own human and financial resources on key areas (whether the inputs come from central or bilateral sources). The ongoing PRISM and related planning operations can help staff to avoid duplication of effort and investments in low-return enterprises. In terms of better integrating health and population activities and groups, USAID and other interested parties should continue efforts to ensure that the regular meetings held for CAs and others include health and population issues on the agenda as well as including people from both of these fields. Many previous meetings have reportedly been organized along vertical lines.

Because the Mission's strategy also calls for it to leverage other resources, the USAID staff must be proactive in trying to influence the GOI and other aid donors in priority program areas. For example, formal GOI health and population pronouncements suggest that a high degree of interagency cooperation exists, but RTI Team interviews suggest that some serious gaps still impede integration and program implementation. While USAID may be unable to help resolve some of these issues, there is a need to continue efforts to concentrate resources and increase collaboration where key joint GOI-USAID goals are affected. Some contacts thus reported that improvements are needed in the quality of MOH services if fertility goals are to be achieved. Conversely, MOH employees reportedly complain that other GOI agencies propose new functions for MOH that they must perform without receiving additional staff or funding. The new village nurse-midwife (*bidan di desa*) program is cited as an area where better cooperation is essential if this critical outreach effort is to be viable over the long term.

GOI program coordination could be improved if various aid donors join together to logically divide development tasks and focus resources. Our impression is that different donors (World Bank, UNFPA, UNICEF, AIDAB, the Japanese) are funding projects either with the same target audiences (e.g., private health care providers, *bidan di desa*, potential condom users) or with similar activities (social marketing, training). Likewise, close cooperation among the organizations working in HIV/AIDS and population would better assure consistency of messages transmitted (e.g., about condoms) and avoid duplication of efforts.

A possible starting point for a systematic USAID donor coordination effort is to identify a few joint objectives and then work to get these on the action agendas of other donors and the GOI. The regular donor consortia meeting for Indonesia is one formal channel for achieving this. But such formal meetings must be preceded by considerable informal contacts between USAID and other donors at both the operational and executive levels. Such meetings should also help sort out who will take the lead on various initiatives. Such coordination should result in a better use of funds and less overlap of activities among donors and concerned GOI units.

In terms of program integration issues, USAID need not integrate all of its own population and health activities. Integration can also be achieved within specific regions of the country through close coordination of a USAID population or health activity with other donors' complementary activities. In other words, many different kinds of program modes and linkages can be used to achieve Type 1 or Type 2 integration objectives.

4. Type 1 Integration Issues

A. Definition

For purposes of this study, we have defined Type 1 population integration as the integration of family planning and health care in the provision of information and service delivery [see Kocher, Brady, and Krieger, April 1994].

B. Demand Fulfillment

The GOI has recently decided that, within its new approach of family wellbeing (*Keluarga Sejahtera*), provision of family planning information and services will be guided by the concept of demand fulfillment. Efforts will focus on women and couples who say they want no more children or want another child only after some time. According to the 1991 IDHS, 13% (slightly over four million) of married women of reproductive age (MWRA) have an unmet need for family planning. About half of these have unmet need for spacing and about half for limiting. According to the 1991 IDHS, women with little education (some primary school) or no education are most in need of family planning for limiting births while more educated women report more need for spacing. Therefore, within the context of overall MCH and reproductive health services, additional motivational and service delivery efforts should be directed toward the limiting needs of older and less educated women and to the spacing needs of younger and more educated women [IDHS, 1992: 79].

C. Health and Family Planning Service Delivery

Indonesia has developed a unique form of health care delivery that integrates not only health and family planning but also government and semigovernmental organizations. Each subvillage (an administrative unit that exists even in urban areas) maintains a *posyandu*. The *posyandu* provides health education, family planning education and motivation, supplies of oral contraceptives and condoms, nutrition education, food supplements for children, immunizations, simple health care, and simple medicines. The *posyandu* is built on the Indonesian concept of self-reliance (*mandiri*). The *posyandu* is held once a month in a woman's home or a government building. The *posyandu* is staffed by members of PKK, a women's organization that combines aspects of an NGO and a government agency. The head of each local chapter of PKK is always the wife of the village chief (the chief is a government civil servant who is appointed to this administrative post). Other members join out of personal interest and volunteer their time and energy.

At the *posyandu*, PKK members serve as health educators, teaching mothers about nutrition and use of oral rehydration solution (ORS), and teaching little children health education songs. PKK members organize and coordinate each *posyandu*. A nurse from the next higher level of health care facility, the *puskesmas*, attends the *posyandu* to administer immunizations, treat minor illnesses, and when necessary, refer to the *puskesmas*. BKKBN field workers also attend the *posyandu* to bring family planning acceptors in for supplies and to serve as family planning motivators and educators.

In addition, members of another women's semigovernment organization, *Dharma Wanita*, may help out at the posyandu. *Dharma Wanita* is composed of the wives of government employees who also donate their time to help with family planning, health, and other development issues.

The puskesmas is a polyclinic that delivers primary health services, family planning care, and (sometimes) dental services. Each village or urban subdistrict has a puskesmas. Each puskesmas is staffed by at least one nurse, one nurse-midwife, and one physician. However, the puskesmas may have a much larger staff. At the urban puskesmas visited by RTI team members, there were five physicians, six nurse-midwives, seven nurses, and four dentists. Urban puskesmas may be open six days a week, but at the puskesmas visited by team members, family planning care is delivered by the nurse-midwives (with physicians as back-up) only two days a week. This puskesmas also has outreach programs (e.g., a mobile van). In addition, two days a week this puskesmas holds a combination day care/old age club for elderly members of the community. The puskesmas refers patients or family planning clients, when necessary, to the next level of the health care system, the district hospital. Although vasectomies may be performed in a puskesmas (or even in a mobile clinic van, if equipped), by law tubal ligation may only be performed in a hospital. Only doctors may provide voluntary surgical contraception (VSC). Nurse-midwives may insert (but not remove) Norplant and intrauterine devices (IUDs), but only under a physician's supervision. They may also prescribe oral contraceptives and other contraceptive methods. However, in practice nurse-midwives remove IUDs as well as insert them and supervision by a physician may be very occasional.

D. Bidan di Desa (Village Nurse Midwives)

The bidan di desa (village nurse midwife) is a provider who literally embodies Type 1 integration. BKKBN and the MOH established an intensive training program for nurse midwives, partly funded by the World Bank, in order to upgrade and extend family planning and maternal health care. In a matter of a few years, the GOI is training around 50,000 nurse midwives and placing them in villages. BKKBN and the MOH have a joint stake in this program because the bidan di desa is expected to deliver health care to pregnant and parturient women, as well as to provide family planning care to all women.

In Indonesia an estimated 425 women die from pregnancy or childbirth-related causes for every 100,000 births. This is the highest maternal mortality ratio in the ASEAN region. The GOI plans to reduce this ratio and also to reach replacement level fertility by 2005. The bidan di desa, as the only trained medical professional in most villages, could be instrumental in the effort to achieve the goals of a 63-70% contraceptive prevalence rate by the year 2005, an infant mortality rate of 50, and a maternal mortality ratio of 225 per 100,000 births by 1999.

The bidan di desa must graduate from the equivalent of junior high school. She then receives three years of nurses' training. After graduating as a nurse, she completes one year of midwifery training. Each new bidan di desa is placed in a village that is supposed to provide a *polinda*, or community maternity care center, for the nurse midwife. The bidan di desa is a government employee for her first three years, but after the completion of this term she is expected to become a private practitioner.

The bidan di desa program has been criticized on a number of grounds: (1) the young nurse midwives' training is rapid, and their experience is negligible before they are placed alone in a village; they consequently lack confidence, and some are afraid to attempt even normal deliveries; (2) training does not equip them adequately in such areas as communication and culture brokering; (3) nurse midwives are trained in regional centers, but may be placed in districts or provinces' with which they are unfamiliar, requiring them to interface with a different culture and perhaps a different language; (4) the program did not take into account the existence of traditional birth attendants (TBAs) who deliver about 60% of the births in Indonesia, and made no provision for the new, young bidan di desa to work with the TBAs; (5) the shift to private practice was not well thought out, and there is no guarantee that the nurse midwives will be able to support themselves and remain in the villages; (6) the bidan di desa are severely underutilized; (7) supervision and refresher training are inadequate; and (8) BKKBN and MOH have each given the bidan di desa a job description that is equivalent to full-time employment. The bidan di desa, as a private provider, will also experience the lack of impetus to counsel or provide health education to clients who neither demand nor reimburse for these services.

Fortunately, there are hopeful signs. The MOH is aware of these problems and is taking some corrective action, including efforts to assign bidan di desa to the areas from which they come. Some bidan di desa, even when they are assigned to a province very different from their own, have successfully integrated themselves into the new culture. Some small pilot projects with bidan di desa have been very successful. For example, in order to integrate the bidan di desa into the village health care system in Lombok and Bali, the Program for Appropriate Technology in Health (PATH), with funds from the Australian International Development Assistance Bureau (AIDAB), is training bidan to provide key desired MCH services that are not provided by TBAs. Such services include immunizations for pregnant women as well as for children. The project also provides training in infection control, counseling, and family planning service provision.

The challenges in the bidan di desa program are probably not insurmountable, and the village nurse midwife's role is potentially crucial to achieving GOI and USAID goals in health and population. There should be better coordination of BKKBN and MOH efforts to (1) define a clear and manageable job description for the bidan di desa (including details on her role in achieving the GOI goals for reducing fertility and infant/maternal mortality); (2) provide adequate basic and refresher training in communication, counseling, and family planning; and (3) establish good supervision, logistical support, and technical back-up systems. As a public sector and future private sector health care provider, these nurse midwives will play a role within several USAID projects (MotherCare, Private Sector Family Planning project [PSFP], PROFIT, the Service Delivery and Expansion Support [SDES], and the HAAP project on HIV/AIDS). For example, on the HAPP project, in cooperation with project field workers in the demonstration areas, they can help disseminate the STDs/HIV/AIDS information developed by the project. The USAID population and health offices should collaborate to ensure that USAID-funded training and support activities are coordinated across all relevant USAID projects. USAID should also coordinate with other donors funding bidan di desa projects to ensure that the challenges to the program are met and that no significant duplication of effort occurs. If USAID chooses to design a new bilateral health and population program, it should include a component to improve the professional status and competence of the bidan di desa.

E. Providing Long-Term Methods: Role of Physicians and the Indonesian Medical Association

The Indonesian Medical Association (IDI) has 30,000 physician members and 196 branches nationwide. The GOI used to guarantee government employment of all physicians, whether they also had private practices or not. In a recent policy, the GOI stated that new medical graduates will only be employed by the government for three years after which they will have to rely on private practice for their income. Under the USAID-funded SDES project, IDI will help their members gain better skills in providing family planning services, with emphasis on long-term methods and quality assurance. Five training centers will be established in five major provinces and 240 doctors will participate. This activity with IDI is expected to result in substantial numbers of long-term method acceptors (an estimated 29,000 acceptors in the first year). It would be desirable to focus especially on training women physicians since women generally strongly prefer to receive family planning services, especially long-term methods, from female providers. This activity could also be the vehicle for conducting studies and clinical trials on the nonsurgical female sterilization method Quinacrine, which could be a less costly method.

This activity with IDI could be a supportive mechanism for PKMI in promoting voluntary sterilization. If doctors can provide a mix of long-term methods in their normal medical practice, especially with some material support from IDI, their cost for providing sterilization might become more affordable and closer to the subsidy rates. Thus, lower income clients could be better served by the medical community. A related issue is the unprofitability for private practitioners of providing family planning services, especially long-term methods. Numerous studies and demonstration projects show that unless health services and products are offered as well, the income from family planning services is not adequate for self-sustainability. It is therefore important that the IDI's upgrading of physician skills also emphasize other clinical and medical skills.

F. Integrating USAID/Jakarta's Portfolio: Type 1 and Related Activities

This section responds to a Mission request for suggestions on how the Mission's Human and Institutional Resource Development (HIRD) portfolio might be better integrated. Staffs, structures, and programs tend to be grouped around funding allocations, so the simplest response is that funding must be integrated. Since much of the USAID funding for health and population in Indonesia derive from USAID central sources, the Mission can be subject to the effects of conventional vertical programming where family planning/population and health activities are funded through discrete central projects and therefore cannot be effectively merged. Since there are not as many resources for education, fertility-related issues like female education are not adequately addressed. Thus, there can be a gap between Agency policy statements and what can be actionable under current USAID guidance on population funding. For example, in a November 1993 speech, Administrator Atwood stated:

"...Our concern must be to meet the unmet need for family planning, but to go beyond. Maternal health, pre-natal care, safe sex, and social education must be part of the picture. So must the empowerment of women. So must the education of girls. We cannot attack the crisis with a single arrow. We cannot go to war with a single weapon."

Of course, there is a danger of going too far afield from population concerns if one is considering enterprises like the "integrated rural development" programs of 10 to 20 years ago. However, we have encountered no one in USAID who is contemplating such a broad and amorphous approach. Rather the need is to link contraceptive services and information to other related and reinforcing efforts, especially in the areas of MCH. In the next section a few suggestions are also made on support for female education interventions (see sub-section 5.D).

In spite of a somewhat ambivalent climate for integration, the Mission should continue to work toward better integration of USAID health and population activities in Indonesia regardless of the funding sources or intermediaries. It might also be psychologically valuable to integrate the Mission structures and staff under one umbrella structure which connotes integration. We also suggest that the Mission consider having its own integrated health and population bilateral project. Some rudiments of such a project or program are outlined in Appendix 4.

G. Strengthening NGOs

Strengthening NGOs to contribute to health and family planning interventions is a natural part of Type I integration because some NGOs successfully deliver both health and family planning care. With current funding mechanisms, USAID addresses only NGO needs in either population or health, so the NGO must choose which kind of funding to request. For example, the Indonesian Planned Parenthood Association delivers MCH care as well as family planning care. However, only the family planning portion of its work is currently funded under USAID. Some of the Muslim NGOs that provide health care (e.g., Muhammadiyah) under SDES could be helped to provide both reproductive health and family planning care, although this might take some persuasion as well as training. A review of NGO activities could reveal areas in which the USAID/Washington Offices of Health and Population might consider joint funding in order to achieve a synergistic effect and increase the impact of both the NGO and the USAID funding. Some of the lessons learned from the Mission's private voluntary organization (PVO) co-financing and institutional strengthening program should be relevant for planning new NGO efforts in health and population.

H. Some Priority Training Needs

Training crosscuts family planning and health issues. Physicians, midwives, and pharmacists are usually involved in both areas. The USAID Health Strategy for Indonesia, 1994-2000, notes that counseling training provided by family planning programs is used by health care providers in addressing patients' health concerns. Common areas of training for nurses, midwives, and physicians (for delivering both appropriate MCH care and family planning care) include: (1) health communication and counseling; (2) infection control; (3) management of private practice (as relevant); (4) relevant supervisory skills; and (5) recordkeeping. Training workshops for MOH staff and private providers should have input from the USAID/Jakarta Offices of both Population and Health so that the providers' joint role as health and family planning caregivers is not compartmentalized by training. Funds can then be targeted so that training is not duplicated. Following are two suggestions for coordinating training:

- 1) A **training database** could be established in-country and its creation and maintenance incorporated into one of the CAs' scopes of work (e.g., through collaboration with the global database program managed by Development Associates, Inc.);
- 2) A **training coordinating committee** could be established to ensure that training is shared when appropriate and not duplicated. It should include representatives from CAs, GOI, and donors concerned with IEC, health, and/or family planning training.

I. Information, Education, and Communication

Depending on the project, IEC often compartmentalizes messages into health or family planning although the target audiences are the same. For example, the audience for messages on infant immunization (i.e., mothers of infants under 18 months) may be the same audience as that for messages on child-spacing. Joint IEC efforts could produce a similar look to messages that would cue the target audience that these messages are of interest to them. Coordination could also help avoid bombarding the target audience with too many health and family planning messages. Organizations producing IEC materials in MCH, HIV/AIDS, and family planning should be encouraged to coordinate their efforts and collaborate on joint interventions where relevant. USAID/Jakarta should encourage CAs and Indonesian agencies working in health and/or family planning IEC to establish a coordinating committee to meet periodically and discuss their activities, and to plan joint activities where appropriate and feasible.

J. Promoting Increased Private Sector Involvement

As noted elsewhere, the GOI has mandated that the private sector should become the major source of family planning services. However, some public agencies involved in family planning have an ambivalent position on privatization because they fear that their staffs and budgets may be cut if clients turn to the private sector for services and supplies. There is benefit in more clearly defining the respective roles of the public and private sectors in providing information and services. USAID should continue to promote the expansion of support for private sector activities that directly contribute to achievement of priority Mission health and population goals. It is thus important to expand the private sector's role in providing voluntary sterilization, both as a family planning and a maternal health measure. This expansion could include use of the SDES project (Pathfinder Cooperative Agreement) and other funds to train and support additional organizations that are able to promote high quality services for IUDs, implants, and sterilization. Continuing attention also needs to be given to finding new and cost-effective private channels for delivering affordable condoms/pills and other health supplies and information down to the household level (e.g., as part of the efforts needed to help the new village midwives become financially independent after completion of their three-year contract with the government).

5. Type 2 Integration Issues

A. Definition

For purposes of this study, we have defined Type 2 population integration as the integration of family planning and population interventions with interventions in other development activities (e.g., education, women-in-development, agriculture, employment programs) [see Kocher, Brady, and Krieger, April 1994].

B. Demand Creation

By 1991, the average desired family size in Indonesia had declined to three children. However, in order to achieve the national goal of RLF by 2005, the average desired family size will have to decline to two. Much of the decline in desired family size to three children is no doubt the result of aggressively promoting the ideal of a "small, prosperous, happy family." However, during the past 25 years Indonesia has also made enormous progress in development of a supportive environment for the small family norm. As described in Section 2 of this report, these include sustained economic growth, rising per capita incomes, poverty reduction, significant nutritional improvements, rising educational attainments (including for females), and significant increases in wage employment for both men and women.

In order to achieve the national population and health goals during the next 10-15 years (e.g., RLF by 2005; and reduce infant, child, and maternal mortality to about half their 1991 levels), the economic and social development of the past 25 years must be sustained in the years ahead. This includes maintaining a high rate of economic growth; while maintaining reasonable equity in the distribution of income; continuing significant reductions in the proportion of households living below the poverty line; achieving universal, free education through junior secondary school; and significantly increasing wage employment for both men and women.

Some new economic and social issues will emerge during the next 25 years. These include provision of preschool and other forms of child care, special needs of growing numbers of unmarried adolescents, and a growing need for formal systems for providing care for a rapidly growing elderly population. All of these will be increasingly important to family health and wellbeing.

It will also be important to continue to promote the ideal of a small family. All leaders need to set personal examples, and the popular media and other forms of IEC should encourage small families. One report suggests that continuing to promote the small family ideal and other demand factors could be as important as expansion of the service delivery system:

Family planning interventions that promote increases in demand seem to hold more promise than do policies that merely expand the distribution system, although some lagging areas may continue to require expanded distribution systems. Promotion of demand, through information, education, and communication programs, as well as through a complex political incentive system, has long been an important component of the BKKBN program, and should continue [Gertler and Molyneaux, 1994: 60].

BKKBN policy has always included some emphasis on demand creation and program integration. Recently the Ministry of Population and BKKBN have begun to look beyond family planning, both to creation of demand in hard-to-reach populations and to the time when Indonesia has actually achieved replacement level fertility. A proposed policy element in the National Development Plan (Repelita VI) identifies eight areas that should be the focus for family planning and development in order to promote human resources development, a proper balance between economic growth and population growth, and the wellbeing of the family. The areas (which the Team has interpreted in parentheses according to conversations with BKKBN staff) are: (1) religion; (2) protection (household promotion of health); (3) reproduction (planning ideal family size, spacing, and age at marriage); (4) economy (being productive); (5) culture (maintenance of cultural traditions in a period of potentially rapid culture change); (6) social (adherence to traditional norms and values and utilization of appropriate technologies); (7) love (maintenance of harmonious and "functional" families); and (8) environment (the family as a user and protector of the environment) [Source: USAID Mission, draft English extract of MOP/BKKBN, draft policy on family welfare, September 1993].

This new policy is being operationalized in several ways. Acceptors of contraception have long been organized into small (10-45 households) users' groups that meet monthly. These groups strive to maintain contraceptive continuation and create demand for contraception among those who are not users. They informally serve as a support network for women suffering from contraceptive side effects or other problems. They may also engage in economic activities, such as savings clubs (*arisan*) or operation of microenterprises with loans from BKKBN.

BKKBN has recently implemented a household survey that attempts, in a yes-no format, to elicit information on household economic status, family planning method use, health status, social affiliation, religiosity, education and literacy, and other socioeconomic variables that reflect the new eight-point policy outlined above. BKKBN field workers collect the data. The data are then analyzed and the geographic areas are mapped according to each household's needs for government services. BKKBN will then coordinate with other ministries to ensure that the required services are provided to the area. For example, in an area where many are illiterate, BKKBN will request the Ministry of Education to launch a literacy program. It is not yet clear how this new initiative will be implemented. It is intended to serve two functions: (1) to create demand for family planning, and (2) to assess family needs and help alleviate poverty. Furthermore, the GOI recognizes that the effects of a successful family planning program will be far-reaching, not only in terms of health, but in sociocultural, political, and economic terms. This program may permit the GOI to track sociocultural, economic, and political trends as they happen and to act as necessary.

C. Legal and Policy Factors Affecting Program Implementation

It is assumed that the USAID Mission will continue to play an important role in researching and fostering policy changes to improve program implementation. This section identifies a few areas where policy research and improvement could increase the quality and accessibility of health and family planning services. Some of the policy issues related to contraceptive demand creation and method mix identified by the RTI Team are already described in the April 12, 1994 memo from Katrina Galway to Ken Farr describing research that may be conducted under the Options II Project. Similarly, some of the research contemplated under the Family Health International (FHI)

Women's Studies Project should be useful in identifying needed policy changes. For example, it will be particularly important to get better information from clients on the methods they prefer as opposed to what is offered by providers.

Achieving current national fertility goals may require that policymakers better understand client and service provider views and other factors affecting the expansion of long-term and permanent contraceptive methods. In the legal and regulatory area, researchers might assess the options for changing some of the current administrative rules that restrict the availability of female sterilization services to hospitals with at least 20 beds. Since the RTI Team received conflicting information from different sources on the authority and responsibility of nurse midwives, there is a need to clarify and/or expand their authority to insert and remove IUDs and implants (and the extent to which they must be under a doctor's supervision to provide these and other services).

Research into the legal or administrative barriers to expanded private or commercial provision of services and supplies should also be worthwhile. The GOI has indicated a need to gradually shift costs to clients (who will purchase services and supplies from private sources). The Government has also indicated that the new village nurse midwives should become private practitioners at the end of their three-year contract with the government. Focused research could help to clarify the respective roles of government and private service providers and remove any outmoded rules or traditions that arbitrarily preclude a more cost-effective division of labor. If the GOI must improve and expand services within increasingly tight budgets, it must move from a policy of providing all services free to one based on market segmentation and ability to pay. If it expects the private sector to become the major provider of services and supplies, it must also help create an environment that motivates private organizations to play their role.

There may be a special need to look at the legal and other factors that will affect the ability of the new village nurse midwives to make the transition from government contractors to self-financed service providers in three years. Other tax, regulatory, and legal issues meriting assessment are spelled out in *Assessing Legal and Regulatory Reform in Family Planning* [Kenny, January 1993].

D. Girls' Education

USAID/Jakarta might also consider supporting policy studies of family planning, fertility, and health issues associated with extending compulsory education through grade nine. Research and pilot efforts on curricula at the junior secondary (grades 7-9) level might also be considered. Since the education sector is apparently not a high priority in the current Agency strategy, few Missions are likely to be able to make significant investments in education. However, USAID/Jakarta might explore the possibility of using operations research or pilot efforts in female education as a means of leveraging funds from other donors. These funds could then be used to replicate effective models for using education to improve the health and well-being of mothers and their children.

E. Integrating Health and Population Concerns into National Development Plans

Once joint USAID/GOI health and population priorities are agreed upon, the Mission needs to help ensure that these priorities are reflected in national development plans and in budget and staff allocations in the respective implementing agencies. The share of the national budget going to health activities is apparently not increasing and remains low compared to other Asian countries. Since there are so many national program initiatives competing for resources, key health or population programs could easily drop between the cracks in the resource allocation process. This possibility suggests that USAID program managers and senior GOI counterparts need to be actively involved in tracking and influencing resource allocation decisions in BAPPENAS, Ministry of Finance, Ministry of Interior (for provincial activities), etc. Given the small Mission staff, this activity requires a clear division of labor and teamwork among Mission staff (and among appropriate Indonesian and expatriate contractors and grantees).

6. Principal Recommendations

Our findings suggest that the following four areas will be especially important in efforts to achieve USAID and GOI population and health goals in Indonesia (we recognize that action is already being taken in areas such as infection control and efforts to increase the use of longer term contraceptive methods):

- A. Improve the **quality and availability of information and services** in family planning and reproductive health;
- B. Continue population and health **policy and program research** (including efforts to assess and remove legal, financial, and other barriers to improving client services and information);
- C. Support the **expansion of female education** and training (as an important variable affecting family fertility, health and well-being); and
- D. **Increase USAID's integration** of structures, staff, and operations in health and population (whether funded from central or bilateral sources).

Specific recommendations for each of these four areas follow.

A. Improve the quality and availability of family planning and other reproductive health services and information (to facilitate reaching the GOI goal of replacement-level fertility by the year 2005). Specific approaches include the following:

1. Improve contraceptive choice, including increasing knowledge of and providing easy access to long term and permanent contraceptive methods (thereby increasing the proportion of contraceptive users relying on long term methods).

This action supports the objectives of (1) meeting couples' needs for limiting fertility (demand fulfillment inferred from survey results) and (2) permitting and encouraging women who want no more children, but are currently using spacing methods, to switch to long term methods if they desire.

2. Improve the village nurse midwife program (bidan di desa).

Priority should be given to clarifying task descriptions and reporting channels, upgrading competency-based training and technical supervision, and identifying strategies for helping nurse midwives become profitable private practitioners after completing their three-year government contracts.

3. Support operations research, including testing of innovations, to improve the quality of family planning and health services. Illustrative activities include the following:
 - (a) Assessing women's needs through qualitative and other research and using the results to ensure that family planning services are client-centered rather than provider-centered;
 - (b) Establishing quality of care standards appropriate for Indonesia (addressing concerns of some GOI program leaders that foreign models may not be relevant to Indonesian program conditions);
 - (c) Providing problem-centered and quality-centered refresher training for other service providers (this would include increasing competence in client counseling and interpersonal communication);
 - (d) Improving supervision and technical support for service providers (including clarification of linkages between village nurse-midwives and area clinics and hospitals);
 - (e) Improving infection control standards, facilities and practices (e.g., to reduce re-use of needles, USAID and other donors should foster collaboration between HIV/AIDS, safe motherhood, and family planning activities to ensure sufficient supplies of disposable syringes); and
 - (f) Increasing the numbers of women service providers (including physicians) and women program managers.
4. Dialogue with the GOI on joint actions that might be taken to address emerging adolescent reproductive health issues.

B. Support and promote population and health policy and program analysis, specifically in the following areas:

1. Assess the feasibility and options for achieving national family planning and health goals (e.g., replacement-level fertility by 2005 and large reductions in infant, child, and maternal mortality and morbidity).
2. Support selected analyses of the 1993 Indonesian Family Life Survey (IFLS) and the 1994 DHS data to address questions related to current program and policy trends and issues (e.g., plateauing of acceptance; decline of long term methods; client-preferred sources of services and information; fertility and educational level; etc.).
3. Assess lessons learned from completed Mission projects and explore options for replication of successful elements (e.g., health care financing).

C. Support and promote efforts to improve girls' education. This is an important goal in its own right and is an effective long term intervention for achieving replacement-level fertility (through achieving a universal small-family norm) as well as for achieving low mortality and morbidity rates for women, infants and children. Actions might include the following:

1. Support educational policy studies on how best to achieve free, universal, compulsory education of acceptable quality through grade 9 (junior secondary);
2. Support studies and demonstration programs to test innovative approaches to encourage girls to stay in school for nine years; and
3. Support curriculum innovations to improve population/family life education, and health education, especially in junior secondary school (grades 7-9).

D. Improve coordination and integration within USAID's health and population program activities.

Actions might include:

1. Design and pursue an integrated health and population portfolio for Indonesia that targets critical and potentially critical program needs (e.g., increasing acceptance levels, improving quality of reproductive health care services and information, and increasing the role of private/commercial sectors). This portfolio could include both central and bilateral activities. We feel it should include a new bilateral effort (project or program assistance), provided that adequate staff are allocated to effectively manage a new program. This new effort would provide the Agency with a model program for integrated approaches that would be applicable to other priority countries covered under the new global health and population initiatives (see Appendix 4 for other ideas on this proposed program).
2. Encourage better communication, coordination and collaboration among both US CAs and Indonesian organizations engaged in population and health projects, to promote integrated activities and to enhance their working toward the same goals; for example, by organizing joint population and health CAs' meetings in Indonesia in common issues.

Appendix 1. Glossary

ADB	Asian Development Bank
AIDAB	Australian International Development Assistance Bureau
Arisan	Informal community savings clubs
ASEAN	Association of Southeast Asian Nations
BAPPENAS	<i>Badan Perencanaan Pembangunan Nasional</i> , National Planning Board, Government of Indonesia
Bidan	Nurse midwife
Bidan di Desa	Village nurse midwife
BKKBN	<i>Badan Koordinasi Keluarga Berencana Nasional</i> , National Family Planning Coordinating Board, Government of Indonesia
CAs	Cooperating Agencies (U.S. organizations that are carrying out USAID- sponsored projects)
CPR	Contraceptive prevalence rate
Dharma Wanita	A semi-government organization whose members are the wives of government employees and who donate their time to help with family planning, health, and other development issues.
DEPDIBUD	Ministry of Education and Culture, Government of Indonesia
DEPKES	Ministry of Health, Government of Indonesia
Desa	Village
DPT	Diphtheria, pertusis, and tetanus toxoid vaccine
FHI	Family Health International
GOI	Government of Indonesia
HIRD	USAID/Jakarta Office of Human and Institutional Resource Development
HIV	Human immunodeficiency virus
HPN	Health, population, and nutrition
IBI	Indonesian Nurse Midwives Association
IDI	Indonesian Physicians Association
IDHS	Indonesia Demographic and Health Survey (1991)
IEC	Information, education, and communication
IFLS	Indonesian Family Life Survey (fieldwork conducted in 1993-94)
IMR	Infant Mortality Rate, number of deaths to infants less than 12 months of age per 1000 live births
IPPF	International Planned Parenthood Federation
ITP	International Training Program
IUD	Intrauterine device
KB	<i>Keluarga Berencana</i> , family planning
KB Mandiri	Family planning self-reliance
KS	<i>Keluarga Sejahtera</i> , family wellbeing
MCH	Maternal and child health
MMR	Maternal mortality ratio, number of pregnancy-related deaths per 100,000 live births
MOH	Ministry of Health
MWRA	Married women of reproductive age
NGO	Nongovernmental organization

ORS	Oral rehydration solution [or salts]
ORT	Oral rehydration therapy
PATH	Program for Appropriate Technology in Health
PKBI	<i>Perkumpulan Keluarga Berencana Indonesia</i> , Indonesian Planned Parenthood Association (IPPA)
PKK	Women's family welfare movement. A national organization with branches down to the village level, to promote the role of women in family and community development. PKK members staff the monthly posyandu; the head of each local chapter of PKK is always the wife of the village chief (the chief is a government civil servant who is appointed to this administrative post).
PKMI	<i>Perkumpulan Keluarga Berencana Indonesia</i> , Indonesian Association for Secure Contraception
Polindes	Village or sub-village community maternity center
Posyandu	Post for integrated services (baby weighing, immunization, family planning, nutrition improvement, and diarrhea control) through a monthly community-operated event in each sub-village
Puskesmas	Community health center, under the Ministry of Health, located in each sub-district
PVO	Private voluntary organization
RLF	Replacement level fertility (representing a total fertility rate of approximately 2.1 if infant and child mortality have declined to relatively low levels)
RTI	Research Triangle Institute
SDES	Service Delivery Expansion Support Grant project (Cooperative Agreement between USAID/Washington and the Pathfinder Fund)
SOMARC	Social Marketing for Change project
TBA	Traditional birth attendant
TFR	Total fertility rate (the average number of lifetime births women will have based on current age-specific fertility rates)
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
VSC	Voluntary surgical contraception
WHO	World Health Organization
YKB	<i>Yayasan Kusuma Buana</i> , Foundation for Family Planning

Appendix 2. Persons Interviewed

USAID/Jakarta

Ms. Vivikka Molldrem, Deputy Mission Director
Mr. Virgil D. Miedema, Director, Office of Program and Project Support
Dr. Malcolm Purvis, Director, Office of Economic Policy Support
Dr. Joseph P. Carney, Director, Office of Human and Institutional Resource Development (HIRD)
Mr. Kenneth Farr, Director, Population Division, HIRD
Ms. Barbara Spaid, Director, Health Division, HIRD
Ms. Wilda Campbell, Michigan Fellow, HIRD
Mr. Stephen Grant, Director, Education and Training Division, HIRD
Mr. Diddy Sudarmadi, Population Officer, HIRD
Mr. Bambang Samekto, Population Officer, HIRD
Mr. Jurnalismukhtar, Health Officer, HIRD
Dr. (Ms.) Ratna Kurniawati, Health Officer, HIRD
Dr. Robert Aten, Advisor, Office of Economic Policy Support
Dr. (Ms.) Tin My Thien, Program Officer, Office of Community and Civic Participation

Government of Indonesia

BKKBN (National Family Planning Coordinating Board)

Dr. Pujo Rahardjo, Director, International Training Program (ITP) for Population and Family Planning, Training and Program Development Division
Dr. Rochadi Hardjanto, Director, Training and Development Center for Family Welfare, Training and Program Development Division
Professor Dr. Santoso S. Hamijoyo, Senior Advisor, ITP
Dr. Harun, Assistant Director, Bureau of Contraception, Department for Family Planning
Ms. Kasmiyati, Training and Development Center, Population and Family Planning
Dr. Donald Chauis, Senior Advisor, ITP

BAPPENAS (Ministry of Planning)

Dr. Edeng Abdurachman, Head, Bureau for Population, Family Planning, and Women's Affairs
Ms. Lenny N. Rosalin, Economist, Bureau for Population, Family Planning, and Women's Affairs
Dr. Fasli Djalal, Head, Bureau for Social Welfare, Health, and Nutrition

Ministry of Health

Dr. Soewarta Kosen, Director, Health Economics and Policy Analysis Unit, Center for Health Services and Development, National Institute for Health Research

Ministry of Education and Culture

Dr. Boediono, Director, Directorate of General Secondary Education (formerly Head of the Planning Bureau and Director General of Primary and Secondary Education)

Nongovernmental Organizations

Dr. H. Azrul Azwar, Executive Director, Perkumpulan Kontrasepsi Mantap Indonesia (PKMI) [Indonesian Association for Secure Contraception]

Sri (Ms.) Lestari Yuwono, Director, Perkumpulan Keluarga Berencana Indonesia (PKBI) [Indonesian Planned Parenthood Association]

Dr. Firman Lubis, Executive Director, Yayasan Kusuma Buana (YKB) [Family Planning Foundation]

Private Sector Family Planning Project

Dr. Jack Reynolds, URC

Ms. Patricia MacDonald, URC

Mr. Russ Vogel, URC

Mr. Kevin Kingfield, Futures Group

Others

Mr. Ali Ugur Tuncer, Country Director, UNFPA

Ms. Martha S. Ismail, Senior Program Officer, UNFPA

Dr. Rita Leavell, Asia Regional Director, SOMARC Project, The Futures Group

Dr. Does Sampoerno, Representative, Pathfinder International

Mr. Carl Serrato, Country Representative, RAND

Dr. Jayanti Tuladhar, Representative, The Population Council

Dr. Dipak Dasgupta, Economist, The World Bank

Mr. Donald Douglas, Director, PATH/Indonesia

Visit to an IPPA (PKBI) clinic

Visit to a Puskesmas (sub-district health center) and Posyandu (monthly sub-village-level integrated family planning, health, and nutrition community services program)

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Appendix 4. An Integrated Bilateral Health and Population Program (Some Basic Design Elements)

Following are some preliminary suggestions for general goals and components for a new bilateral assistance effort, if the Mission decides to pursue this avenue for better coordination and focusing of resources. It might take the form of project or non-project assistance or some combination thereof. Hopefully, the design work would benefit from the simplification of processes and documentation now being undertaken in USAID/Washington. However, successful implementation of this additional activity in the Mission portfolio will require additional experienced USDH and FSN professionals.

1. Priority Goals:

This project/program will assist the public and private sectors in Indonesia to move toward the following national goals:

1.1 Reduce total fertility rate to 2.1 by the year 2005.

Based on data from the IDHS and other sources, the project should address specific constraints on reaching the TFR goal. It is assumed that priority would be given to the following kinds of objectives:

- 1.11 Increase the Contraceptive Prevalence Rate (modern methods).
- 1.12 Increase the use of long-term methods (IUD, implant, etc.).
- 1.13 Reduce client complaints, unintended pregnancies, and dropouts (due to dissatisfaction) by improving the quality of services, counseling, and provider-client relationship.

1.2 Reduce maternal mortality ratio from about 425 in 1994 to 200 by the year 2005 through a safe motherhood program and related interventions.

- 1.21 Increase prenatal and neonatal care visits to acceptable standards.
- 2.22 Provide each expectant mother with two immunizations for tetanus during the first pregnancy and one immunization during subsequent pregnancies.

1.3 Reduce infant and child mortality rates.

1.4 Provide support for pilot efforts to encourage girls to stay in school through Grade 9 (and assess implications of female educational attainment for fertility).

1.5 Increase the sustainability of family planning services by identifying new service channels and financing options.

- 1.51 Increase the percentage of acceptors using private sources.
- 1.52 Issue laws/policies removing constraints on provision of services by private sources and local governments.
- 1.53 Issue guidelines to restrict free distribution of GOI services and supplies in situations where clients can afford to buy these from private sources.

2. USAID Mission Implementation Strategies

- 2.1 ***Fund policy and operational studies*** on removing critical constraints to achieving above program goals (covering the areas of both Demand Satisfaction and Demand Creation).
- 2.2 Provide matching funds for national, provincial and/or private efforts to ***develop high-quality service delivery models*** and prototypes related to above program goals (using all types of public and private organizations as intermediaries for implementation).
 - 2.21 Support the design and testing of a provincial level model of a client service network which maximizes the professional preparation and performance of nurse-midwives (Bidan di desa) and related health service providers.
- 2.3 Sponsor training and information-exchange to ***improve interagency program cooperation and remove general environmental constraints*** to achieving program goals (e.g., political, legal, sociocultural, or financial constraints).
 - 2.31 Support integration of above program goals into macro development plans and various ministry action programs and budgets.
- 2.4 Develop mechanisms to ***leverage increased Indonesian and other donor investments*** in areas important to achieving above program goals.
 - 2.41 Ensure that Donor Consortia meetings give priority to above goals in allocating development aid.

Note: It is assumed that assistance on AIDS/HIV will be provided by centrally funded USAID projects and/or other donors (ADB, Germany, Japan, WHO).

Bangladesh: Integration Issues in a Maturing Population Program

**A Study of Integration of Family Planning and Other Population
Activities with Health and Other Development Interventions**

Phase Two Report

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Acknowledgments

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The original study design, similar to that for Indonesia, anticipated a field visit to Bangladesh by the study team. However, for the team to visit both Bangladesh and Indonesia, it would have been necessary to schedule visits to both countries back-to-back as part of a single trip. The late May-early June 1994 period, when all members of the team were available to travel, was an inopportune time for USAID/Bangladesh so, with the consent of the USAID/Bangladesh Population, Health, and Nutrition Officer, it was decided that the team would carry out the Bangladesh study in the U.S. Although the team therefore conducted a desk study, we fortunately had access to an extensive body of recent literature on Bangladesh, as reflected in the Bibliography (Appendix 2), and the amount of time the team spent on the Bangladesh case study was about the same as that spent by the team on the Indonesian case study.

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1. Executive Summary

A. Purpose and Scope of the Integration Study

In terms of global population issues, the Asia and Near East (ANE) countries are critical; our two case study countries, Bangladesh and Indonesia, have two of the ten largest populations in the world. Yet the ANE region also contains some of the richest experiences of governments and people trying to cope with such serious problems as high fertility, rapid population growth, malnutrition, disease, and women's status. Therefore, opportunities abound for learning from these experiences and applying relevant lessons in the design and execution of the Agency's new priority initiatives in health and population.

In September 1993, the USAID ANE Bureau asked Research Triangle Institute (RTI) to examine some of the issues of population integration and suggest future program strategies and design. To provide a quick inventory of global trends, Phase One of the study consisted of a literature review and interviews in Washington with government and private sector professionals concerned with population and health programs in developing countries. Phase Two consisted of case studies on Indonesia (including a two-week site visit) and Bangladesh (a U.S.-based study relying primarily on published materials). Phase Two products include the country case studies, a brief comparative report on the two countries, and an informal checklist to help USAID Mission staff concerned with designing health and population projects.

This desk study looks at the Bangladesh government's (BDG's) health and population goals and programs, and at some macro factors affecting program implementation. In particular, it focuses on current policy, program, and management issues facing Bangladesh as it expands and improves its health and family planning services.

The BDG continues to identify population growth as the country's greatest development constraint. The team surveyed and examined a host of the more current literature on the BDG's population program. While the literature acknowledges the program's impressive gains, it also identifies some problems with the BDG's performance in pursuing its population program.

Highlights of Bangladesh's accomplishments, obstacles and remaining challenges, and our recommendations are provided in the rest of this chapter. These are examined more thoroughly in the other chapters, as are issues relating to Type 1 and Type 2 interventions.

B. Accomplishments

Described as a "basket case" in the 1970s by international development officials, Bangladesh is now self-sufficient in rice production. Despite its inauspicious setting, in the last two decades it has achieved remarkable gains in family planning and child health. Contraceptive prevalence has increased more than tenfold from 4% in 1971 to 45% in 1994, and the total fertility rate has declined nearly 50% during this period. At the same time, the infant mortality rate has declined from about 140 to less than 90 per 1000 live births.

Unlike the experiences of most countries in Asia, Bangladesh's success in family planning was not preceded or accompanied by comparable progress in social and economic development. The proportion of the population living below the poverty line has not declined, and literacy, life expectancy, and employment have not improved much in the last decade.

The impressive gains in family planning have largely been attributed to the following:

1. **BDG concern and donor support.** The BDG sees rapid population growth as its greatest development constraint. International donors have maintained strong funding support to the population program over the last two decades.
2. **the government program's doorstep delivery of family planning services through an extensive community-based distribution (CBD) program as well as through clinics.** Female outreach workers motivate and follow up on women in their homes, supplying both information and contraceptives. They have been essential to the success of the program. While CBD has sometimes been criticized as labor-intensive and expensive, the cost/benefit ratio for averting births is favorable. In 1992-93, it cost \$62 to prevent one birth but saved \$615 in the social service costs that would have resulted from the birth of a child [Population Reference Bureau, February 1994].
3. **the variety of nongovernmental organizations (NGOs) involved in all aspects of the program and serving over 20% of family planning users.** NGOs also use community-based workers, and many NGOs link their family planning work with activities in health, women's micro-enterprise, and nutrition.
4. **the world's largest private social marketing project** [Population Reference Bureau, 1994]. The project sells condoms and oral contraceptives; oral contraception is currently the most popular contraceptive method in Bangladesh. In 1989, about 60% of condom users and 10% of oral contraceptive users relied on social marketing brands [Larson and Mitra, 1992: 124]. Increased employment opportunities for women in the social marketing of contraceptives have been another benefit of the project; many women are now community sales agents.

Despite existing socioeconomic development constraints, contraceptive prevalence is continuing to rise rapidly and fertility is continuing to decline rapidly in Bangladesh. Like other writers on Bangladesh, the RTI Team speculated on why so much progress has been made in family planning in spite of the negative economic and other macro factors that still exist. For example, women still face low status and low employment rates, as well as unsanitary clinic facilities and poor quality of care. As have several other analysts, the Team hypothesizes that much of the family planning success results from the perception by poor Bangladeshi couples that family planning is a means of economic survival for themselves and their families.

Women see themselves as particularly vulnerable. Underlying these reasons for success in family planning are women's concerns about the heavy work demands associated with closely-spaced births and the adverse impact of an additional birth on their household's economic situation [Nancy Stark, personal communication, June 15, 1994]. Clearly, women wish to control their fertility, as evidenced not only by contraceptive prevalence figures but also by the sad fact that abortions appear to be a leading cause of maternal mortality [Islam, 1992: 46; WHO, 1991].

C. Obstacles and Challenges

In spite of past family planning achievements, few observers believe that the BDG's goal of replacement level fertility by the year 2005 will be achieved. Most obstacles are related to socioeconomic conditions, women's legal and social status, the service delivery system, and the physical environment itself.

1. **Socioeconomic conditions.** The link between socioeconomic variables and fertility reduction is important. Family planning efforts over the last 20 years have been rewarded with a lower population growth rate that slowed the rate of increase of the school-age population and increased the per capita income. Despite these accomplishments, the actual buying power of wages may have decreased, and the distribution of income does not seem to have improved. Most analysts agree that achievement of replacement-level fertility is unlikely without significant, broad-based, social and economic improvements.
2. **Women's status.** The low status of women is a major impediment to achieving low fertility. Women's strong preference for sons to provide security in old age or widowhood is reflected in their desire for more than two children. Women's legal rights need to be improved. Girls need to be educated beyond the primary school level; and women need significantly more opportunities for wage employment.
3. **Service delivery system.** Although there has been significant progress in clinics and outreach delivery systems, access and quality of care in both the public and private sectors need improvement. Both supply of and demand for services need to be strengthened. A more integrated approach could improve both health services and family planning services.
4. **Physical environment.** Bangladesh's physical environment is often a serious liability. Because floods and cyclones are common, even accomplishments like self-sufficiency in rice are tenuous. Roads are often impassable; villages, isolated. These conditions exacerbate the difficulty that many women face in obtaining family planning and health services.

Because these obstacles are both severe and pervasive, the resulting challenges are readily identified. Moreover, because improvements in economic conditions and women's status are likely to come slowly, in the immediate future Bangladesh's best hope for progress in family planning lies in improving the access to and the quality of family planning and health services. The Ministry of Health and Family Welfare, thus, faces these challenges:

1. encouraging women to choose permanent or long-term contraceptive methods by offering more outlets for the service and by improving unsanitary conditions as well as the quality of care;
2. training fieldworkers to counsel and interact with clients more effectively and more often;
3. improving program management by ensuring that staff adapt to current program requirements;
4. increasing the number of women in management; and
5. further integrating the delivery of family planning and selected health care services.

Nongovernmental organizations (NGOs) are an important channel for improving services. Although NGOs have flourished since the government relaxed regulations affecting them, efforts of NGOs need to be coordinated better so that successes and lessons learned are disseminated more effectively.

D. Recommendations

To address the challenges described above, USAID should support a basic package of high quality, integrated health and family planning information and services (Type 1 integration) that is tailored to meet the needs of clients. It should make limited investments in Type 2 integration--the integration of policies and programs that go beyond family planning and health information and service delivery. (Type 1 and Type 2 integration are discussed fully in Phase One of this report.)

Type 1 Integration

Type 1 integration would generally bring contraceptives as well as important maternal and child health care closer to home, thereby linking highly valued services. Moreover, until the status of Bangladeshi women improves, it is imperative that as much health and family planning information and services as possible be delivered to their homes by female outreach workers in an integrated way. A more specific focus would include support by USAID and the BDG for the following reproductive health activities:

1. operations research on specific interventions to reduce the large numbers of abortion and maternal deaths;

2. integration of safe motherhood interventions with family planning;
3. policy and program changes to achieve significant improvements in diagnosis and treatment of STDs and in prevention of STDs and HIV/AIDs; and
4. better coordination of NGOs, particularly as they attempt to make long-term contraceptive methods more appealing and available and as they expand and replicate successful integration of health and family planning information and services.

Type 2 Integration

Although developing Type 2 initiatives is challenging, the results of successful Type 2 activities can be far reaching. Bangladesh's population problems are so critical that the BDG and donors should renew their efforts to work together successfully to promote Type 2 interventions. Specifically, they could invest in the following activities:

1. strengthen policies and programs that improve those social and economic conditions (e.g., reducing household poverty; empowering women and raising their status through education, wage employment, and legal reforms) that will contribute to a growing desire for small families and increasing use of effective contraceptives, thereby accelerating declines in fertility and population growth rates;
2. establish within the BDG a much more systematic and comprehensive approach to social sector policies and programs including, possibly, the creation of a social sector coordinating board to formulate and monitor the implementation of coordinated social sector policies; and
3. evaluate and support the replication of successful NGO Type 2 activities.

Generally, Type 2 integration at the *policy and planning* levels is more feasible for governments, and thus more likely to be successful, than is the implementation and management of large multisectoral Type 2 *programs*.

2. Accomplishments

A. Fertility Decline Despite a Difficult Socioeconomic Environment

A recent World Bank report notes that: "Bangladesh is an inauspicious setting for family planning programs. Extreme poverty ... and environmental adversity are rooted in constraints to increasing agricultural productivity, enhancing women's status, improving health conditions, and reducing fertility" [World Bank, 1992a: 97]. One of the world's most impoverished nations, Bangladesh is also a patriarchal society in which most women are in *pardah* (isolation), and they are dependent on their fathers, brothers, and sons for sustenance, economic support, legal and social protection, and social class status [World Bank, 1992a].

However, in the early 1970s, Bangladesh was also characterized as a most unlikely setting for any significant family planning progress. At that time, both fertility and mortality were among the highest in the world. The total fertility rate (TFR) was still about 7; the infant mortality rate (IMR) exceeded 130 deaths per 1000 live births, and over 20% of children died before reaching age 5. The maternal mortality ratio (MMR) exceeded 1,000 (i.e., over 1,000 pregnancy-related maternal deaths for every 100,000 live births), a rate more than 100 times higher than in North America and Europe. The people of Bangladesh had also just suffered through the 1971 Liberation War and were experiencing pervasive food shortages and economic chaos. Moreover, the nutritional status of the population had apparently been deteriorating since at least the mid-1930s [Larson and Mitra, 1992: 123]. The female literacy rate was less than 10%. Over 90% of the population lived in rural areas. Communication and transportation systems were extremely poor. For much of the year, rural Bangladesh was (and still is) basically a group of tens of thousands of villages, each surrounded by water.

Despite all of these problems, in the past 20 years Bangladesh has experienced one of the world's most successful family planning programs. As one report notes:

The vast majority of married women below age 50 know about contraceptive methods, nearly half have ever used them, and two-fifths currently use them. Analysis of trends indicates that contraceptive use in rural areas, pill use, fieldworker visitation and fieldworker source of supply have registered the greatest gains over time. These trends suggest that the community-based delivery system accounts for a large share of recent program success [Mitra, et al., July 1992: 26].

As shown in Table 1, between 1972 and 1994, the contraceptive prevalence rate (CPR) increased from 4% to 45% (the rate in 1994 was 36% for modern contraceptive methods). Fertility had declined nearly 50% to an estimated TFR of 3.44 in 1994. About 80% of this fertility decline was attributed to increased contraceptive use; the remaining 20% was attributed to rising age at marriage. (Average female age at first marriage was 14.4 years in 1951, 16.3 years in 1974, and 17.7 years in 1989.) Infant and child mortality has also declined. The IMR was estimated to be about 116 per 1000 births in 1991 and perhaps as low as 90 in 1994 [personal communication, Charles Lerman, July 1994].

Unlike the experiences of most countries in East and Southeast Asia (e.g., South Korea, Taiwan, Indonesia, and Thailand), Bangladesh's success in family planning and fertility decline was

Table 1. Contraceptive Prevalence Rate (CPR) in Bangladesh, 1972, 1981, 1991, and 1994.

	1972	1981	1991	1994
Overall CPR	4%	18.6%	39.9%	44.6%
Modern method CPR		10.9%	31.2%	36.2%
Pills			13.9%	17.4%
Condoms			2.5%	2.2%
Injectables			2.6%	4.5%
IUDs			1.8%	3.0%
Tubectomies			9.1%	8.1%
Vasectomies			1.2%	1.1%
Traditional Methods		7.7%	8.7%	8.4%

Sources: Mitra, Lerman, and Islam, July 1992; Gov't. of Bangladesh et al., July 1994.

neither preceded nor accompanied by comparable progress in social and economic development. Rural landlessness in Bangladesh increased from 33% in 1960 to 37% in 1982. Between 1972 and 1987, per capita income increased at an average annual rate of only 1.6%. (In contrast, in Indonesia from 1970 to 1990, per capita income increased at an average annual rate of about 4.5%.) In 1963/64, 44% of the population lived below the poverty line; it was still 43% in 1988/89. (In Indonesia, the proportion of the population living below the poverty line declined from about 50% in 1970 to 15% in 1991.)

There have also been significant social and cultural barriers to increasing contraceptive prevalence rates. For example, low levels of female education are usually associated with low levels of contraceptive practice. Female educational attainment in Bangladesh is among the lowest in Asia. However, as shown in Table 2, contraceptive prevalence in 1991 was relatively high even among women with little or no formal education. Several authors describing results for rural samples conclude that education has no influence on contraceptive use. Koenig et al. [1992] and Tin Myaing Thein, Kabir, and Islam [1988] found that education level was not a motivating factor in family planning use. Data presented by Rahman [1994] indicate that there is no significant difference in contraceptive use between women who had no education and women who had some primary schooling or who had completed primary school.

In her recent research, Nancy Stark found that women with no education were more likely to use family planning without their husband's knowledge. First, women who have little or no formal education are also likely to live in poorer households than are women with some formal education. Because of their more impoverished circumstances, they are probably less able to

Table 2. Contraceptive Prevalence Rate by Woman's Level of Formal Schooling, 1991.

Level of Formal School Achievement	CPR
No Formal School	37.0%
Less than Primary School	40.7%
Completed Primary School	40.8%
Completed Lower Secondary School	48.1%
Completed Secondary School	60.9%

Source: Mitra, Lerman, and Islam, 1992.

attain or aspire to the behavioral ideals set for women--those of remaining at home (many must work in the fields), obeying their husbands, etc. Thus, they are more likely than educated women to disobey their husbands in order to further their economic and reproductive goals. Second, in rural areas, fewer women possess higher education or have access to employment opportunities that would derive from higher education. As a result, factors associated with traditional attitudes about the proper role and contribution of women (e.g., achieving increased status and authority through raising sons) exert greater influence on a woman's position within the household than does education because whatever education she might have achieved has such little impact on her economic and social circumstances [Stark, personal communication, June 15, 1994].

During the past twenty years, Bangladesh was able to achieve relatively high CPRs in spite of the low status of women. However, since rapid population growth is still seen as the most serious constraint on development, even more urgent action is needed to increase women's status, improve health and

family planning services, and increase contraceptive prevalence levels.

There appears to be significant latent demand for family planning services, but more women must be empowered to act to receive services. The USAID Mission is supporting an activity with Johns Hopkins University promoting the jiggasha concept to encourage husbands and wives to talk more openly about family planning. Under the Local Initiatives Project (LIP) which promotes sustainable, decentralized family planning services at the thana level, 11,000 female community volunteers are involved in project activities in 79 thanas. The Social Marketing Company is pilot-testing a scheme using women as community sales agents to simultaneously expand women's access to contraceptives, increase the paying customers' market, and open employment opportunities for women in the program. These and related activities to enhance women's status will be critical to the future success of the health and family planning program.

B. Family Planning Success Despite Serious Structural Obstacles

A recent World Bank report on case studies of country population programs notes the impact of a "diffuse" social structure on providing services in Bangladesh:

Of the Bangladeshi social characteristics with ramifications for organizing human services, the most striking is the 'diffuse social structure' of rural Bangladesh.

Village government does not exist. This lack of structure permeates all social systems in Bangladesh. Models for community-based service systems that have been developed effectively in East Asia do not transfer well to Bangladesh [World Bank, 1992a: 97].

Another review of population and development in Bangladesh reaches similar conclusions:

... The natural village (gram) is socially defined, and residents have a clear perception of its territorial boundaries; but these units tend to have no corporate features, little cohesive identity, and only a residual degree of solidarity [Arthur and McNicoll, 1978: 39].

Moreover, the structural rigidity and bifurcation within the Ministry of Health and Family Welfare (MOHFW) is often cited as an obstacle to effective program implementation. Communication among headquarters units and between headquarters and field units is deficient. Changes in the family planning program's focus, content, and structure are often promulgated without field trial or phased implementation. A recent World Bank report suggests that the MOHFW management could be the most serious single deficiency of the Bangladesh program [World Bank, 1992a: 103,105]. The same report notes that the BDG has also consistently set unrealistic national family planning and fertility goals:

The First Five-year Plan specified cautious demographic targets, but when their implication for future growth was cause for alarm, they were revised in 1976. Working from the premise that sustaining population growth below the level of 120 million in the year 2000 was a matter of economic necessity [it is currently projected that in 2000 the population will be about 132 million], it was concluded that replacement fertility was required by 1985, implying a decline in the crude birth rate from 40 to 17 in nine years--an unprecedented change in reproductive behavior with no empirical justification [World Bank, 1992a: 107].

The BDG's current idealistic goal is to achieve replacement-level fertility by the year 2005. The failure to achieve past unrealistic goals has reportedly undermined service provider morale and the public credibility of the national program.

However, despite these management, structural, and other shortcomings, a relatively innovative and successful family planning program was developed over the past 20 years. Most modern contraceptive methods are available through three delivery systems: clinics, community-based distribution (using paid women fieldworkers), and retail outlets. According to the 1991 Contraceptive Prevalence Survey (CPS), 43% of users of modern methods received their supplies from clinics, 38% received them from fieldworkers, and 13% purchased their supplies from pharmacies and shops [Mitra et al., 1992]. Government facilities are the primary source of clinical contraceptive services in rural areas. Nearly all of the nation's 397 subdistricts have 31-bed health centers equipped to provide sterilizations, IUD insertions, and other outpatient family planning services.

About two-thirds of the 4,325 unions have health and family welfare centers, headed by a medical assistant and a family welfare visitor (FWV) who inserts IUDs and provides follow-up care to family planning clients. FWVs also conduct outreach clinics twice monthly at which

women can receive IUDs, injectable contraceptives, and follow-up care [Larson and Mitra, 1992]. Because many rural women are unable to travel to health clinics alone, paid female fieldworkers who distribute contraceptives during house-to-house visits are perhaps the single most important part of the program. In rural areas, fieldworkers supplied over two-thirds of the pills and condoms [Mitra et al., July 1992]. Female workers may also escort women to health/family planning facilities.

Finally, while the usual governmental structures may not exist at the village level, indigenous political forms and groups have been used successfully by many family planning groups. Political and economic interactions are based on patron-client relations. Groups that have been referred to as "solidarity" groups coalesce around powerful patrons. A woman's membership in a solidarity group is often dependent upon her father, husband, or sons. Some family planning programs thus try to appoint female outreach workers from influential families belonging to a powerful solidarity group since they have higher status and are more acceptable.

C. Success of Female Outreach Workers Despite Cultural Obstacles

Early outreach workers were largely male health workers left over from programs begun when Bangladesh was part of Pakistan. The Family Welfare Assistant (FWA) outreach program began shortly after independence in 1976 [Population Reference Bureau, February 1994]. Based on survey results indicating that FWAs visited only nearby families, the BDG increased the number of FWAs from 13,500 in 1985 to 23,000 in 1991 (with funding largely from the World Bank). All FWAs are female. One report says that a home visit by a female worker is associated with a corresponding 45-day adoption rate of 2.6% while the corresponding rate for male workers' contacts is 0.5% [Phillips et al., 1993: 332].

The increase in national family planning practice levels over time suggests that, in spite of problems at the central ministry offices, service outlets and field workers were performing reasonably well. In fact, many authors attribute the success of family planning in Bangladesh to the efforts of female outreach workers, both governmental and NGO. Phillips, Hossain, Simmons, and Koenig [1993] studied the government's FWA program and concluded that the outreach workers' visits not only led people who already wanted to use family planning to begin using a method, but FWAs also successfully encouraged contraceptive use among those who had never thought of using family planning before. Similarly, Larson and Mitra report: "Research has demonstrated that contact with a fieldworker is the most important predictor of contraceptive adoption, regardless of preexisting demand for controlling fertility" [Larson and Mitra, 1992].

Fears that outreach workers were visiting only those homes where members had already accepted contraception have not been borne out by at least one study. "The [1989] CPS ... revealed that 53% of the women visited by fieldworkers were not current users and that visits to new or continuing pill or condom users constituted only 26% of all visits" [Larson and Mitra, 1992]. Other reports indicate that women usually hold female outreach workers in high esteem; their counsel is highly regarded, and to some extent they are seen as role models. Some of these women are even permitted to work in union parishads.

Several applied research projects have also led to improvements in outreach efforts. For example, the Bangladesh Rural Advancement Committee (BRAC) initiated a combined education,

community-based health, and family planning program. BRAC found that the FWAs get very little support and their contraceptive supplies are often erratic. BRAC workers provided various forms of assistance and showed the FWAs how to conduct baseline studies and prepare action plans. In the areas where BRAC worked with FWAs, contraceptive prevalence rose from 24% to at least 44% [WHO/HRP, 1994]. To prevent the possibility that the government's FWAs visited only those women who lived near them, the government hired more FWAs and reduced their territories. This has been successful: "Upazilas in which the new [FWAs] have been recruited have had improved visitation rates from both new and veteran family welfare assistants and, more important, have experienced a concomitant rise in contraceptive use" [Larson and Mitra, 1992].

FWAs use a cafeteria approach and distribute oral contraceptives, condoms, and vaginal foaming tablets. However, the family planning program tries to impose method targets on FWAs: "Family welfare assistants are required to attract a certain number of sterilization clients and new pill, condom and IUD acceptors per month, and risk having their salaries withheld or reduced if they do not meet the targets" [Larson and Mitra, 1992: 127]. Despite this pressure to draw couples to permanent or long-term methods, oral contraceptives (OCs) are still by far the most popular method. One reason may be the easier access to OCs provided by CBD programs and other sources. The poor quality of service associated with clinic-based methods may also have deterred clients from pursuing other forms of contraception.

D. The Role of NGOs

NGOs have always been an important part of the national program. In fact, family planning in Bangladesh was first introduced in 1953 by an NGO (the Family Planning Association of Bangladesh, known then as the East Pakistan Family Planning Association) [WHO/HRP, 1994: 31]. "Some [NGOs] have specialized in training workers or in operating information, education and communication projects or in maintaining clinics for sterilizations, but most are involved in community-based delivery of contraceptives" [Larson and Mitra, 1992: 124]. Although estimates of the number of NGOs providing family planning services range from 120 to 400, most sources agree that at least 20% of family planning services are provided through NGOs. NGOs have traditionally been located in urban areas. However, with the relaxing of government restrictions on NGOs, they have proliferated and expanded or begun operations in rural areas as well [Larson and Mitra, 1994].

The BDG is now emphasizing closer cooperation with NGOs. NGOs pilot-test innovations and, if they work, the Government tries to incorporate the results into its national program [WHO/HRP, 1994: 31]. The government has thus used some findings from the ICDDR/B's (International Centre for Diarrhoeal Disease Research-Bangladesh) Matlab field area to improve its program. For example, the finding that FWAs visited only women in the vicinity of their homes led to the hiring of thousands of additional FWAs [Phillips, Hossain, Simmons, and Koenig, 1993]. NGO outreach programs, which commonly use more intensive training, supervision, etc., than government outreach efforts, have achieved contraceptive prevalence rates of 60% in some areas. As the national program faces new challenges, there is a need for the NGO experiences and lessons learned to be more systematically assessed to see if some of the more promising approaches can be replicated by other NGOs or the government.

3. Current Challenges

A. Focusing on the Problems of Rapid Population Growth

Bangladesh is now one of the most densely-populated countries in the world (with 2,300 people per square mile). However, the area that is now Bangladesh has been contending with a large and rapidly growing population for a long time. Table 3 uses World Bank sources to present actual and projected population sizes during the 150-year period 1901 to 2050. The projections for the years 2000, 2025, and 2050 are based on the assumption that Bangladesh will achieve replacement-level fertility in 2015. Bangladesh is thus expected to experience a seven-fold increase in its population over a period of about six generations. Even with this rather optimistic projection (e.g., UN projections for Bangladesh do not anticipate the achievement of replacement-level fertility as early as 2015), it is daunting to contemplate the human and environmental conditions that will result from population pressures in Bangladesh during the next 25 to 50 years.

B. Pursuing Economic Growth and Poverty Reduction

The interaction between socioeconomic variables and fertility reduction will continue to be critical. As noted above, per capita income in Bangladesh is among the lowest in the world, and little progress has been made in improving the economic status of the rural poor. Wage labor is pursued by increasing numbers of rural Bangladeshis, but real wages have declined. Educational levels, already low, have not significantly improved. Literacy among women--at 20%--is among the lowest in Asia and is less than half the level for men [Population Action International, 1993]. Moreover, there are few opportunities for wage employment for women in rural areas.

Several analysts have concluded that, if significant further improvements are made in family planning and health care services, the CPR could perhaps rise further to around 50% or so, and the TFR could decline to around 3.5 [e.g., Cieland, 1993; World Bank, 1992b: 96]. However, few experienced analysts think that replacement-level fertility (a TFR of about 2.1-2.3, depending on the level of infant and child mortality) is achievable without significant social and economic improvements.

In 1991, the average desired number of children was 2.9 [Mitra et al., 1993], but this number comprised two sons and one daughter, which implies a TFR of around 4 (on average, two sons and two daughters, and also allowing for infant and child mortality). With so much of

Table 3. Actual and Projected Population Size of Bangladesh, 1901 to 2050.

Year	Millions	Source of Data
1901	32	census
1972	73	census
1990	107	1989 census
1994	117	PRB, 1994
2000	128	World Bank
2025	176	World Bank
2050	211	World Bank

For World Bank projections, see Bos et al., 1992

women's welfare affected by high infant mortality rates and the presence of adult sons, there is little likelihood that the vast majority of women will soon want to risk having only two births.

This assessment is reinforced by some findings from the 1991 CPS [Mitra, Lerman, and Islam, 1992]. Contraceptive use by the extremely small group of women with at least secondary education has leveled off (though it is still 20-30% higher than for women with primary education or less). The level of contraceptives supplied through shops and pharmacies in urban areas has also leveled off. These developments, with a desired family size that implies a TFR of nearly 4, reinforce the assessment that it will be very difficult to achieve a CPR much above 50% and a TFR well below 4 unless gains are made on other social and economic fronts. Again, the status of women needs to be significantly enhanced, including education of girls to beyond primary school level and significant growth in wage employment of women outside the household.

On the other hand, the prospects for achieving needed social and economic progress have been improved by the family planning accomplishments of the past 20 years. As a result of the decline in the TFR from 7 to below 4, the annual population growth rate in recent years has been below 2.5% instead of about 3.5%. This has increased the rate of growth of per capita income. (During the past 15 years, per capita income has increased about 1.5-2% annually; about half of this growth is attributed to the decline in the population growth rate.) However, the actual buying power of wages may have decreased, and the distribution of income does not seem to have improved. The decline in fertility has also slowed the rate of increase of the school-age population, which will make it possible to achieve higher levels of school enrollments with more years of schooling for a given level of national educational expenditure. Moreover, the lower population growth rate has significantly improved the per capita availability of domestically produced food. In short, government and donors must continue to pursue progress on both fronts (broad-based socioeconomic development and family planning) to achieve the goals of continued rapid fertility decline and replacement-level fertility in the near future.

C. Raising Women's Low Status

The low status of women in Bangladesh is a major impediment to achieving high levels of contraceptive prevalence. Most rural Bangladeshi women observe *purdah*, a form of isolation that restricts women's movements and dress in public. Women's low status is reflected in some of the norms for women, e.g., women and girls must eat last and should eat little; a woman must not disagree with her husband or use a loud voice when speaking to him. Female children suffer from more malnutrition than male children and, when ill, are far less likely to receive medical care than their brothers [WHO/HRP, 1994]. There are few employment opportunities for women in rural areas and women's status is dependent on their fathers, husbands, or sons. Urban areas may provide more opportunity for women to use their education in wage labor so that sons may not be quite as important. Students of women's status find that status is complex and not readily amenable to change [Balk, 1994; WHO/HRP, 1994; Cain, Khanam, Nahar, 1979].

For example, women's status in Bangladesh has not increased appreciably so that, even when women are educated, some aspects of their status do not increase significantly. Balk [1994] found that educated rural women tended to be less mobile than less educated women (perhaps due to greater wealth resulting in stricter *purdah*); nor does education necessarily encourage women to use family planning. Cain et al. [1979] found that women's social class was

dependent on the status of her husband, or if she were a widow, on the status of her adult sons; if the widow of even a wealthy man had no adult sons to support her, she was reduced to abject poverty.

Some NGOs are making special efforts to raise women's status. The results of their attempts should shed light on which aspects of women's status are most amenable to change and which result in the freedom and desire to use contraception. Marty Chen describes one such effort by BRAC:

Currently BRAC operates on the assumptions that (1) programs designed for the whole community deliver most of their benefits to the rich and tend to by-pass the very poor; and (2) programs designed for the poor must challenge the rural power structure which keeps not only power but also resources in the hands of the few. Today, BRAC seeks to organize the poor and powerless (both men and women) in the village into cooperative groups who then plan and manage their own group activities. The groups receive support from BRAC in the form of training, extension, credit, and logistics assistance as needed [Chen, 1984: 3].

D. Improving Family Planning and Health Services

While Bangladesh has made significant progress in establishing outreach and service delivery systems, there is still an urgent need to improve the quality of family planning and health services in both the public and private sectors. Some aspects of the NGOs' successes in service expansion and improvement are relevant to the government's programs. In any case, increasing the CPR and improving the contraceptive method mix must be priority BDG policy and operational concerns if the population growth rate is to be reduced over the coming years. Larson and Mitra conclude that:

The national family planning program is unlikely to achieve, in the near future, the level of success found in Matlab or the non-governmental organizational sites. However, if the present is any guide, program input, rather than socioeconomic development or declining family-size ideals, will be the catalyst to further fertility decline [Larson and Mitra, 1992: 129].

Improving the quality and accessibility of services is critical, but Bangladesh needs to work on both supply and demand factors. And, since support for health has reportedly lagged behind that for family planning, future programs should take a more integrated and balanced approach.

Specific suggestions for improving the services delivery system include the following:

1. Realism in goals and targeting: More realistic population planning goals would provide a more logical base for designing action programs. However, for political and other reasons, top government leaders and managers in Bangladesh reportedly prefer unwarranted optimism to more realistic and achievable goals. One option is for donors and others concerned with sound baselines to establish their own "estimates" or "benchmarks" to complement the official BDG goalsetting exercise. On the other hand, setting targets to achieve specific contraceptive method mixes may not be desirable or productive. Setting method-specific targets can cause service providers to

push the client to accept methods that may not meet his or her need. Some research on Bangladesh suggests that method-specific targeting has had little impact on the actual method mix [Larson and Mitra, 1992:127].

2. More effective implementing structures and personnel: The central bureaucratic structures are considered ineffective by World Bank and other observers. Some reports suggest that the only solution may be to wait for older staff members to retire so that younger and more innovative talent will be recruited. However, such assumptions do not square with research findings on the enduring conservatism of large bureaucratic organizations. The process of converting enthusiastic newcomers into good risk-averse bureaucrats is labeled "role socialization." Promoting more innovative and service-oriented public organizations usually requires strong and sustained outside pressure for change from political leaders and/or influential citizens groups (sometimes called "rebels"). Another option is to create new alternative temporary structures to replace or bypass existing bureaucratic units to achieve specific priority goals. Again, strong political support is required to get the competent staff and other resources needed by these alternative organizations (sometimes called task forces, project organizations, special commissions, etc.) [Brady, 1993: 304].

Some observers believe that the recruitment of more women as service providers, field supervisors, and program managers will improve program effectiveness and the quality of client services. Women represent a very small percentage of the management corps in MOHFW in Dhaka and the field (only 10% of the managers at the subdistrict level are women). The percentage of female service providers has been increasing, especially as some of the older male workers retire. For example, retiring male field workers in the health division of MOHFW are reportedly being replaced with women who will be trained to provide both health and family planning care. Female outreach workers were first hired in the course of the First (World Bank) Project. USAID and other sources have also supported the training and use of women health volunteers to extend services in rural and urban areas. While having more women managers in the MOHFW system will have some positive effect, their impact will be limited until other aspects of the organizational culture are changed.

3. Training and organizational development: Continued support for technical and managerial training is essential to (1) prepare new employees for effective job performance, (2) update and expand skills of existing staff, and (3) support critical actors in the design and implementation of innovation and quality improvement. Organizational development (OD) includes training but also focuses consultant and internal staff resources on removing impediments to effective organizational communication, interaction, and performance. In short, OD can be another tool to create more flexible and innovative structures. Some pilot efforts are already underway to transfer new management practices from demonstration programs or test projects to larger governmental programs and structures. However, in order to improve the quality of inservice training, it may also be necessary to invest in upgrading the training institutions themselves. For example, a 1992 US-MOHFW team noted that the quality of training in clinical methods had suffered because training institutions were encountering serious problems of staff attrition and turnover [Ahmed, Jahiruddin, et al., 1992]. Training and retraining is needed for supervisors and service providers at all levels of the system. Priorities for staff training include client counseling skills, infection control, and IUD and implant insertion and removal. If health and family planning are integrated, it may be necessary to train more FWAs to provide both immunizations and injectable contraceptives. Managers need training in such areas as problem solving, teamwork,

leadership, and provision of support for frontline workers. As mentioned earlier, the World Bank has a new project to improve organization and management. Some program staff are also being sent to Indonesia to study that program.

4. Expanding private sources of service: Almost 70% of USAID's population assistance now goes to support the private sector. Further expansion and integration of private family planning and health services is essential to promote long-term financial viability of the national program. While low family income levels ensure a continuing need for subsidized and inexpensive services, an increasing proportion of services could be provided through private channels. Consequently, there is a need for USAID and the BDG to continue their support for research, pilot testing, and policy changes aimed at motivating more private nonprofit and for-profit organizations to provide services, including long-term contraceptive methods. At the same time, there may be a need to establish mechanisms to promote and enforce high standards of client service, regardless of source. In some areas, close cooperation between private and government providers may be needed to avoid wasting scarce resources.

5. Program research and evaluation: It will be important for USAID and other donors to continue supporting efforts to find higher quality and more cost-effective ways of helping Bangladeshis to improve their health and well-being. The USAID-supported prevalence surveys raise questions about population and health program coverage and impact that merit further study. For example, are people using traditional contraceptive methods because modern methods are not available, or are there other reasons? Since quality of care is a critical factor in increasing acceptance levels, can research and development approaches help to objectively define better approaches to ensuring high quality client treatment and service at various levels of the system? Also, more research should be conducted on the components of women's status, the components' mutability, and their contribution to fertility. USAID democratization and women-in-development projects could focus on increasing the legal rights of girls and women.

Perceived side effects result in high levels of discontinuation of oral contraceptives. Operations research and focus groups can be used to see whether counseling by FWAs and/or FWVs could prevent dissatisfaction leading to discontinuation of a method or help women to select a method with which they would be happier. Finally, USAID, the BDG, and other donors should continue to support regular, impartial assessments of program performance and national trends (e.g., CPS, DHS). The 1994 Demographic and Health Survey (DHS) should provide important data for (a) assessing the program's progress, and (b) deciding on any needed improvements in policies and operations.

4. Type 1 Integration Issues

A. Introduction

Type 1 integration is the integration of family planning services and information with health services and information. This is the more common approach to service delivery in developing countries. (For more details on definitions of integration, see our Phase One RTI report: Kocher, Brady, and Krieger, April 1994.)

B. Meeting the Unmet Demand for Service through Integrated Approaches

Health and family planning goals are both complementary and interdependent. For example, a leading reason for maternal deaths in Bangladesh is abortion, an important indicator of unwanted fertility. Similarly, a reduction in the infant mortality rate (IMR) should encourage smaller family size by increasing the likelihood that at least one son will survive to adulthood. The BDG has the following specific goals in its national development plan for 1990-95: reduce the maternal mortality rate (MMR) from 572 per 100,000 live births in 1990 to 450 by 1995; and reduce the infant mortality and neonatal mortality rates from 110 and 80, respectively, per 1,000 live births in 1990, to 80 and 65, respectively, in 1995 [Islam, 1992: 49].

Type 1 integration is already common at the subdistrict and lower levels in some areas of Bangladesh, but the quality of services is reportedly quite variable. Providing high quality integrated health and family planning services should motivate more people to visit the service outlet and, hence, to start practicing effective contraception.

Among other indicators, the estimated high number of abortions per year (about 750,000) suggests that there is much unmet demand for family planning services. While pursuing more integrated approaches, the government will need to ensure that the weaker health infrastructure does not weaken the stronger family planning structure. Again, relevant lessons can be learned from NGO efforts to provide integrated services.

For example, the Matlab and other NGO projects have successfully integrated certain key maternal and child health (MCH) services, such as immunization, into the community health workers' roles (that is, their NGO family planning outreach workers' role). Integration of immunization with the family planning program helped to increase contraceptive prevalence, but one Matlab attempt to integrate preparation and delivery of oral rehydration solution (ORS) into family planning outreach was associated with decreased contraceptive use (perhaps because of the time required to effectively handle the ORS tasks).

Increases in the number of clinics and other service outlets should also help to increase the CPR. Where density of service points is high, as it is in special pilot project areas like Matlab and some sites covered by NGO activities, prevalence rates of 50-60% have been achieved. Adequate outreach, including use of satellite clinics, will also be important in an integrated program. Research shows that the percentage of clients receiving methods through clinics (43%) is only slightly higher than the percentage receiving contraceptives from outreach workers (38%) [Population Reference Bureau, February 1994]. Moreover, until women's status improves, it will be imperative to bring contraceptive and health services to women in their homes.

Since the majority of unions apparently do not yet have a satellite clinic program and some of those that exist may be problematic, closer links should be forged between FWAs and FWVs in such underserved areas (FWVs can deliver both health and family planning care). Perhaps more FWVs could be recruited whose sole duty is to accompany FWAs on home visits to broaden the contraceptive methods available to homebound women and to deliver key health interventions (e.g., prenatal and postpartum care and immunizations), thereby helping to lower maternal and infant morbidity and mortality. These FWVs could also run the satellite clinics. The World Health Organization (WHO) is providing financial and technical assistance to improve MCH, so more FWA/FWV joint ventures could be good candidates for support under that program.

To sum up, effective integration of health and family planning will require attention to refining and developing appropriate integrated bureaucratic structures; careful selection of the health services that will be integrated at the community level; standards for choosing and preparing appropriate health/family planning workers to carry out the joint interventions; development and adherence to manageable job descriptions for workers; adequate health supplies at subdistrict and union level facilities; and general improvement of the quality of care at fixed site facilities. This approach to Type 1 integration can potentially help both to satisfy unmet demand and to create new demand for family planning services.

C. Addressing HIV/AIDS and Sexually Transmitted Diseases in an Integrated Program

Although the number of cases of AIDS in Bangladesh is reportedly still low, observers have voiced concern that conditions exist for a future epidemic in Bangladesh: rates of HIV/AIDS in India are much higher than in Bangladesh, and there is a great deal of movement across the borders; biomedical knowledge about HIV/AIDS and STDs is low among Bangladeshis; and there are many prostitutes [A. Scott, personal communication to Krieger, June 1994].

A number of policy changes, many requiring Type 1 integration, would need to be instituted to prevent and manage the potential threats posed by HIV/AIDS. For example, condoms are currently distributed and marketed solely as a family planning method. Policy, both in USAID and the BDG, would need to allow for condoms to be marketed and distributed for dual purposes (i.e., as a contraceptive and to protect against STDs and HIV transmission). The BDG has an AIDS committee, but observers remark that its role has been problematic. Bangladesh will need to officially recognize the potential danger posed by the world pandemic and allocate financial and human resources to meet the challenge. Clinical staff in both the family planning and health wings of the MOHFW would have to be trained and equipped to handle both education and counseling, and clinical management of STDs and HIV/AIDS.

Finally, since Bangladeshi women greatly fear infertility which may be caused by STDs, the public could be educated about STDs as one possible cause of infertility. This is another important way in which reproductive health and family planning could be integrated.

The BDG needs to take a proactive role in lessening the impact of the potential AIDS epidemic in Bangladesh. A strong management structure and program need to be developed to disseminate information and services that could both lessen the magnitude of this problem and improve significantly the prevention and treatment of STDs and thereby help women address infertility problems associated with STDs.

5. Type 2 Integration Issues

A. *Assessing Constraints on Programmatic Interventions*

Type 2 integration refers to the integration or linkage of health and family planning to other sectors of national development (education, employment, etc.). The RTI Team found that many people prefer the term "linkage" to "integration" since the latter conjures up ideas of overly complicated schemes and efforts; some negative perceptions stem from the past Type 2 integration failures in various USAID cooperating countries (as discussed in the Phase One report).

However, establishing linkages or synergistic relationships among multiple policies or programs may be a cost-effective approach, make interventions more implementable and appealing to clients, and be a feasible concept to both donors and host countries. Moreover, as donor funding becomes more constrained, some donors may give increased attention to some forms of Type 2 integration. The need is to keep the number of linkages manageable, given the usual staffing, funding, and structural constraints in public sector programs.

Type 2 integration or linkage in population includes factors that go beyond the delivery of services but that have an impact on either the demand for or the availability of services. One of the most commonly mentioned Type 2 interventions is increasing female education since this is correlated with high contraceptive prevalence in many countries. However, research on Bangladesh suggests that the role of increased female education in increasing contraceptive prevalence is unclear since education alone may not sufficiently enhance the status of women. Therefore, even more highly educated women may lack personal freedom of choice on issues of family planning and reproductive health. Thus, *USAID and other parties concerned with enhancing the status of women need to consider interventions that link increased education and training to areas such as employment generation, business credit, and increased legal rights.*

As indicated in the RTI Phase One report, there is very little discussion in the literature of current or ongoing *government programs* that could be considered as Type 2 integration. The new Intersectoral Population Activities Project being developed by the World Bank and the BDG is expected to be operational in 1995 and will make funds available to test various integrated approaches in the private and public sectors in Bangladesh. It is assumed that the USAID Mission will want to track this project to see which activities have relevance for its program. As discussed earlier in this report, some smaller Type 2 integration and linkage efforts being implemented by NGOs in Bangladesh merit attention to see which elements can be replicated.

B. *Developing Policy and Planning Linkages*

The RTI review suggests that Type 2 integration may be more feasible for governments when it concerns *policy or planning* actions rather than efforts to coordinate large multisectoral *program* actions. For example, the BDG could (1) establish a social sector coordinating board to formulate and monitor the implementation of coordinated policies designed to achieve mutually-reinforcing results in broad-based education, employment promotion, health care and family planning services, and social welfare services; (2) identify and remove unwarranted legal barriers to the provision of health and family planning supplies and services; and (3) establish/promote government and private sector health and social security insurance schemes that reimburse clients

for the costs of health and family planning services. USAID/Bangladesh is looking at possible policy and planning linkages through the RAPID and Options projects and in discussions with other donors in Bangladesh.

C. Efforts to Influence the Demand for Service

Achieving a CPR required for replacement-level fertility in Bangladesh will probably require approaches that go beyond supply-side initiatives and increase the level of demand. These may include policy and structural changes that (a) enhance the education, status, and employment of women; (b) support significant further reductions in infant and child mortality; and (c) contribute to improved economic conditions [World Bank, 1992a: 43-44]. The World Bank supports several education sector activities related to Type 2 integration [World Bank, 1992: 44]

As suggested earlier, donors and the government should also examine some of the more successful Type 2 integration interventions undertaken by NGOs. However, rather than trying to manage such projects, the government should facilitate and perhaps provide some funding for NGOs to handle the replication and expansion of successful efforts on a community-by-community basis. There is still a need to ensure that the supported NGOs develop replicable models, as BRAC and the Grameen Bank seem to have done. These two organizations link micro-enterprise development at the community level with poor women's empowerment (and, in the case of BRAC, also poor men's empowerment). And many of their projects include family planning education and motivation. One study found that length of membership in BRAC among village women was correlated with increased acceptance of a family planning method. Over time, such NGO efforts could be expanded to produce a broad impact on women's status, health, and well-being.

D. Efforts to Increase Financial Sustainability

The search for more cost-effective approaches should be an integral part of all USAID-supported efforts. However, for the foreseeable future, Bangladesh will still need considerable donor support. Still, it may be possible through NGO and/or private sector Type 2 integration projects to experiment with innovative financing schemes, such as contraceptive buying pools within micro-enterprise projects. As mentioned above, programs that link family planning and income generation or village development are being undertaken in Bangladesh by a few NGOs, but the populations covered are reportedly quite small. However, it may still be worthwhile to examine the cost-effectiveness and sustainability of these approaches to see if they can be replicated on a larger scale. Currently, users pay for about 3% of the costs of family planning; the BDG pays for about 37%, and donors cover the remaining 60%.

Commodity pricing also has an important influence on contraceptive prevalence. Recently, the social marketing project instituted a sharp price increase in contraceptives, and sales fell precipitously. The social marketing project thus learned that any price increases should be introduced gradually. The influence of contraceptive pricing on women's role and status is also marked. In the private sector, a packet of three condoms sells at the same price as a full month's supply of oral contraceptives [WHO/HRP, 1994]. This is one reason why oral contraceptives rather than condoms are the most popular method. This pricing scheme also transmits the message that fertility management is the woman's responsibility.

6. Principal Recommendations

A. Introduction

The RTI Team's Phase One and Phase Two findings would tend to support the following World Bank conclusions that effective approaches are those tailored to particular local conditions:

There is no single "best design" for a family planning program in Bangladesh. Some successful projects have used an integrated approach emphasizing health services, while others have emphasized the provision of contraception. Still others have worked through development programs, with family planning consigned to an ancillary service role. Some successful projects function as women's programs. Organizational philosophies and designs of successful projects thus differ [World Bank, 1992a: 100].

Nonetheless, the RTI Team encountered some common success elements in many of the reports that at least merit consideration in planning new efforts to improve services.

B. Some Common Elements in Successful Client Service and Outreach Efforts

The Team concludes that *top priority in Bangladesh should go to the improvement of client services and information*, a priority that is probably already reflected in Mission planning. This entails defining the key impediments to achieving quality of care and then focusing resources where they will have the greatest impact on removing these impediments. Since the Mission's comparative advantage (vis-à-vis other donors) is using NGOs and other private sector approaches to innovation, this may be the most logical channel for pursuing quality improvement.

Successful service delivery projects exhibit some common elements that may be of interest to Mission staff as they proceed with their planned review and reprogramming exercise in health and population. Some of these elements are covered in the informal project planning checklist for Mission staff (Annex to the Phase Two report). The following key components of successful outreach and client services are required for Bangladesh (based on a 1992 World Bank study and other studies).

1. **High-quality worker-client relationships.** These relationships must include frequent contact and good rapport between outreach worker and client (including the worker's genuine concern for the client's needs). In some cases, care must be taken to select workers with adequate community status.
2. **High quality of information and services.** Highly competent outreach workers and other service providers as well as supplies and equipment must be available and clinical facilities must be sanitary.

3. **Strong management and supervisory system (within the service organization).** The system must include teamwork and cooperation to achieve objectives and provision of strong moral and logistical support to field staff (assigning a small, manageable territory to each outreach worker); the organization must have flexible and effective mechanisms for resource allocation.
4. **High-quality training institutions and programs.** Training curricula and staff must be kept current with changing technologies and operational requirements; skill-based or competency-based training is critical for producing service-provider competency.
5. **Adequate transportation and logistical support for outreach workers.**
6. **Reliable contraceptive supply systems for community-based distribution staff.**
7. **Flexible adaptation of strategies and organizational designs to fit local social conditions.**
8. **Female rather than male outreach workers (since most clients are female).**

C. Other Lessons Learned from the Bangladesh Program

The following are additional components identified as important to the success of the Bangladesh population program [see especially World Bank, 1992a: 108-10]. Despite the considerable success achieved as a result of these and other factors, many recent reports emphasize the urgent need to upgrade the quality of services.

1. **Use of media and communication.** Owing to extensive publicity, program outreach, and mass communication, knowledge of contraception is virtually universal.
2. **Extensive outreach networks.** A cadre of female workers has been hired, trained, and equipped to deliver family planning services to couples in their homes.
3. **Clinical back-up.** MCH clinics now blanket the country and serve as primary care facilities for IUD insertion, treatment of side effects, and provision of basic family planning ancillary health care. (Staffed by a female paramedic and a medical assistant, clinics are now located in over 2,700 of the 4,325 unions in Bangladesh. If the conservative goals of the World Bank-BDG Fourth Population Project are met, by the end of 1995 all unions will be equipped with MCH clinics, and more than half of all couples will live within five miles of a clinic.)
4. **Accessible nonclinical supply sources.** Nearly all pharmaceutical outlets in Bangladesh are supplied with low-cost, subsidized contraceptives.

5. **Ancillary health services.** Efforts to extend child immunization services to rural households have been linked to family planning outreach activities. Successful MCH outreach services have contributed to the credibility of family planning. Much needs to be done to improve the quality of such services. Nonetheless, basic MCH care facilities are closely linked to the availability of family planning.
6. **Surgical contraception.** Voluntary sterilization services are offered in every subdistrict hospital in Bangladesh by medical officers trained to provide free voluntary sterilization to clients.
7. **NGO services.** While primarily organized as a public sector program, the family planning program in Bangladesh is increasingly dependent on the activities of NGOs; over 20% of all modern method users are supplied by NGOs.
8. **Type 2 integration.** Our review suggests that many NGOs have developed effective Type 2 integration activities. These experiences should be more systematically assessed with lessons learned disseminated widely among the NGO community. However, for the BDG, Type 2 integration at the *policy and planning* levels is more feasible, and is thus more likely to be successful, than is the implementation and management of large Type 2 multisectoral *programs*.

D. A Few Closing Suggestions for USAID/Bangladesh

1. USAID should continue its current mix of funding--70% for NGOs and 30% for government. This ratio appears to be well-suited to the conditions of Bangladesh (especially since other donors are already providing funding for government programs).
2. A priority for USAID funding should be to support sustainable NGO and for-profit innovations that show the greatest promise for replicability, either on a national or a regional level. Priority should be given to improved models for integrated client services and quality of care (including the management, training, and supervisory systems needed to support high quality client counseling and service).
3. USAID should encourage funding of efforts to better disseminate the lessons learned from private sector approaches (within the government, academic, and private sectors). Likewise, USAID should stimulate the government to adopt appropriate private sector approaches in the national program (in concert with other donors).

4. USAID and the BDG should continue to seek innovative approaches for increasing the role of the private sector in service provision, including mechanisms for subsidizing services provided through private sector channels.
5. Continuing studies are needed to identify the specific aspects of successful NGO programs that enable them to reach 50-60% contraceptive prevalence and to test whether these interventions could be replicated and generalized.
6. A priority for USAID should be the development of policy and program innovations to reduce the large numbers of maternal deaths and abortions.
7. Additional research should be supported to determine why many women use oral contraceptives, how they feel about other methods, and what features of clinical methods make them less desirable. Such research results should be important in understanding why so many women rely on oral contraceptives when surveys show that they are also very knowledgeable about other modern methods.
8. The progress of the satellite clinic program should be monitored closely in order to assess its success and detect in the early stages aspects that should be modified.
9. The BDG and donors should support the improvement of government training facilities, curricula, and programs. Improved training is needed for managers, supervisors, and service providers at all levels.
10. Health and family planning services, which are often not integrated in practice at the subdistrict, union, and community levels, should at least be integrated for specific MCH interventions. For example, family planning and EPI (expanded immunization program) could be integrated by making both services available at the same health facility, or through a "team approach," by using one family planning and one health fieldworker working in tandem. The team approach is a service delivery strategy that has been successfully used by UNICEF in its program in Bangladesh.
11. USAID should continue to support NGO projects that act to increase the reproductive rights and status of women. This includes support for integrated efforts that link family planning/health/nutrition services with employment generation, education/training, and/or credit programs (e.g., BRAC-style projects). The Mission and other donors should use consortia meetings and other channels to engage in policy dialogue with the BDG on specific actions to enhance women's status (including action to increase women's access to management and fieldworker positions in the MOHFW).

12. USAID and the BDG should increase the support to NGOs for replication and expansion of successful projects. Innovative financing schemes would enable more NGOs to participate. The BDG could remove unwarranted legal barriers to the provision of health and family planning supplies and services; and establish/promote government and private sector health and social security insurance schemes that reimburse clients for the costs of health and family planning services.

13. USAID should attempt to persuade the BDG to establish a much more systematic and comprehensive approach to social sector policies and programs. USAID should consider urging the BDG to establish a social sector coordinating board (or other supra-ministerial body) to formulate and monitor the implementation of coordinated social sector policies designed to achieve mutually-reinforcing results in broad-based education, employment promotion, health care and family planning services, other social welfare programs, and other BDG initiatives intended to enhance the status and well-being of women.

Appendix 1. Glossary

ANE	Asia/Near East
BDG	Bangladesh Government
BRAC	Bangladesh Rural Advancement Committee
CAs	Cooperating Agencies (U.S. organizations that are carrying out USAID-sponsored projects)
CBD	Community-based distribution
CPR	Contraceptive prevalence rate
CPS	Contraceptive prevalence survey
DHS	Demographic and Health Survey
EPI	Expanded Program for Immunization
FPP	Family planning program
FWA	Family welfare assistant
FWV	Family welfare visitor who is a paramedic
HRP	WHO Task Force on Human Reproduction
ICDDR/B	International Centre for Diarrhoeal Disease Research/Bangladesh
IEC	Information, education, and communication
IMR	Infant mortality rate (the number of deaths to infants under one year of age for every 1000 live births)
IUD	Intrauterine device
LIP	Local Initiatives Project
MMR	Maternal mortality ratio (the number of pregnancy-related deaths for every 100,000 live births)
MOHFW	Ministry of Health and Family Welfare, Government of Bangladesh
NGO	Nongovernmental organization
OCs	Oral contraceptives
OD	Organizational development
ORS	Oral rehydration solution [or salts]
<i>pardah</i>	Social isolation of women
RLF	Replacement-level fertility (representing a Total Fertility Rate of approximately 2.1 if infant and child mortality have declined to relatively low levels; if infant mortality is in the range of 50-75 per 1000 births, RLF would be approximate 2.3-2.4).
RTI	Research Triangle Institute
STD	Sexually transmitted disease
TFR	Total fertility rate (the average number of lifetime births women will have based on current age-specific fertility rate)
Upazila	subdistrict
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

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Comparison of National Population Programs: Indonesia and Bangladesh

A Study of the Integration of Family Planning and Other Population Activities with Health and Other Development Interventions

Phase Two Report

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1. Background

In September 1993, the USAID Asia/Near East (ANE) Bureau requested the Research Triangle Institute (RTI) to examine some of the issues of population integration and make suggestions to the Bureau on future program strategies and design. Phase One of the study focused on global trends and consisted of a brief literature review and interviews in Washington, D.C., with government and private sector professionals concerned with population and health projects in developing countries. The Phase One Report was submitted to the ANE Bureau in April 1994. Phase Two of the study consisted of case studies on Indonesia and Bangladesh. The Indonesia study included a two-week visit to Jakarta by the study team. The time period in which the team was available to visit Dhaka was inopportune for USAID/Bangladesh, so the team conducted the Bangladesh case study in the U.S. In addition to the country reports and this short comparative paper, the RTI team prepared an informal checklist to help USAID staff identify and analyze key issues in designing health and population projects.

This paper uses information from the RTI Phase One Report and the two case studies to make some general comparisons of program progress and issues in the two countries. Indonesia and Bangladesh are each discussed within each section of this paper. It also includes suggestions for USAID to consider as it implements its new initiatives in health and population. For a fuller discussion of the issues in this paper, please refer to the other papers in the Phase Two Report. Also, bibliographic information is provided in the Phase One Report and in the Bangladesh and Indonesia case studies in the Phase Two Report.

2. Role of USAID in Population Program Successes

During the past 20 years, the population programs in Indonesia and Bangladesh have overcome tremendous socioeconomic, management, and other obstacles to provide access to family planning information and services for much of their populations. This access has resulted in impressive reductions in fertility and population growth rates in both countries. While both countries still face significant challenges in the population and health arena, they deserve enormous credit for their accomplishments so far. USAID played a major positive role in these sectors in both countries from the inception of their efforts. USAID/Indonesia reportedly provided 80% of the funds of the Indonesian national program in the early years. While USAID financial support was important in both countries, equally critical were the day-to-day interactions and technical assistance of USAID Mission staff as they helped host country counterparts define directions and get these pioneering programs off the ground.

These two countries remain important to USAID, particularly as partners in the new U.S. global initiatives in health and population. The lessons learned from past experience in Indonesia and Bangladesh, and those to be learned from current efforts, should be relevant for other USAID-supported countries in Asia and elsewhere. These two countries are also engaged in mutual cooperation efforts in population. Bangladesh has sent significant numbers of Bangladeshi program staff to Indonesia's international training courses in family planning, and several Indonesian family planning program officials have visited Bangladesh.

3. National Political Support for Population

A common prerequisite for program success is support from top-level political leaders. The Indonesian family planning program enjoys strong political support at all levels. President Soeharto is personally involved in supporting policies and program actions and in attending national ceremonies honoring family planning acceptors. Although the Chairman of the National Family Planning Coordination Board (BKKBN) has always reported directly to the President, the creation in 1993 of the position of Minister of State for Population gives the Chairman additional influence vis-à-vis other ministries. Dr. Haryono Suyono, Chairman of the BKKBN, also serves as the Minister of State for Population.

The leadership of the Indonesian program has been visionary and innovative throughout the history of the program, continuously responding successfully to new challenges and problems. A current problem identified by the RTI team, and also raised by several sources in discussions with team members in Jakarta, is low proportion of users of long-term methods, especially of sterilization. It should be a priority of the national program to add voluntary sterilization as an official contraceptive method. However, the top leadership is reluctant to openly endorse voluntary sterilization because of the opposition of religious leaders and political opponents. The current political leadership has been in power for over 25 years and is acutely sensitive to criticism. Nonetheless, voluntary sterilization is supported in a low-key manner (including service subsidies paid through BAPPENAS--the economic planning agency).

In Bangladesh, top government leaders have supported population efforts but have not been as directly involved as those in Indonesia. In terms of official reporting relationships, the head of the family planning directorate reports to the Secretary of Health and Family Welfare (who reports to the Minister of Health and Family Welfare). The head of the family planning program thus lacks the direct access to top political leadership enjoyed by his Indonesian counterpart. It is not known whether this has affected the program head's ability to get things done.

4. National Strategies for Addressing Population Issues

In Indonesia, population program goals and activities are integrated into national development plans. The country has set a goal of achieving replacement level fertility (2.1 lifetime births per woman) by the year 2005. Several team contacts expressed doubt that this objective will be achieved unless the contraceptive method mix includes a larger proportion of users of long-term methods. They also estimated that, in recent years, the level of IUD and sterilization acceptance had been declining while implant (Norplant) acceptance levels had remained about the same. Some senior BKKBN program managers apparently feel that the goal of replacement-level fertility can be achieved without the increased use of long-term methods. For example, they apparently think that replacement-level fertility can be reached by achieving high continuation rates among users of oral contraceptives and other temporary methods. Given the different views on recent progress and problems, the results of the 1994 Indonesia Demographic and Health Survey (DHS) will be very important for program decision-makers. The

DHS findings should either validate or invalidate interim reports that the national acceptance levels, continuation rates, and use of long-term methods are plateauing, thereby helping program leadership identify critical policy and program areas that need attention or changes.

The Government of Indonesia's (GOI) current policy is not to use acceptor or method-specific targets in its family planning program. Under a new "Demand Satisfaction" strategy, the BKKBN uses surveys of target groups to identify needs for family planning services. The program is then supposed to respond to these needs. However, most family planning services are provided by the Ministry of Health (MOH), not BKKBN. Initial surveys have been made, but it is too early to assess how the Demand Satisfaction strategy will be implemented. Indonesia has also recently promulgated a "Demand Creation" strategy that seeks to link education, income generation activities, housing, and other interventions to achieve its goal of "small, prosperous, and healthy families." Again, it is too early to tell how this strategy will be operationalized. Indonesia has just mandated an increase in compulsory free education from six years of schooling to nine years. Since girls are expected to attend school at the same ratio as boys, this additional schooling should contribute to further reductions in fertility during the next 10 to 20 years. (The Ministry of Education estimates that it will take a minimum of 10 years to fully implement this new policy of nine years of schooling.)

Bangladesh has also set a goal of achieving replacement level fertility by the year 2005, but many observers consider this goal to be highly unrealistic. The 1991 total fertility rate (TFR) was around 5, and the contraceptive prevalence rate (CPR) for modern methods was only 31% compared to Indonesia's TFR of 3 and modern methods CPR of 47%. The Bangladesh program sets specific recruitment targets by method, and service providers are urged to strive for these. The aim is to increase the percentage of long-term methods, but some studies suggest that such targeting has little or no impact on the actual contraceptive mix. Oral contraceptives are the most popular method, perhaps because they are more readily available than other methods.

The preliminary results of the 1993-94 Bangladesh DHS show that total contraceptive prevalence (modern and traditional combined) in Bangladesh has risen to 44.6%, with modern method prevalence at 36.2% [Government of Bangladesh, et al., July 1994]. While overall prevalence increased, voluntary surgical contraception (tubectomy plus vasectomy) declined from 10.3% to 9.2%. Oral pill prevalence increased from 13.9% to 17.4%. The DHS data indicate that family planning acceptance and use have not yet plateaued and are still increasing. However, Bangladesh family planning officials should learn from the experience of Indonesia and other countries that it may be difficult to increase prevalence beyond about 50% without new policy and program initiatives. This is especially relevant for Bangladesh where some important socioeconomic conditions have hardly changed in recent years.

5. Range of Family Planning Methods Made Available to Clients

From the viewpoints of quality management and meeting the needs of each user, a program should offer clients the full range of modern temporary and long-term methods. Table 1 shows the CPR and method mix for Bangladesh and Indonesia in 1991.

Table 1. Contraceptive Prevalence Rates in Bangladesh and Indonesia, 1991.

	Bangladesh	Indonesia
Overall CPR (%)	39.9	49.7
Modern method CPR (%)	31.2	47.1
Pills	13.9	14.8
Condoms	2.5	0.8
Injectables	2.6	11.7
IUDs	1.8	13.3
Tubectomies	9.1	2.7
Vasectomies	1.2	0.6
Implants (Norplant)	0.0*	3.1
Traditional methods	8.7	2.6

Notes: CPR = Contraceptive Prevalence Rate (percent of currently married women [ages 15-49 in Indonesia; ages 10-49 in Bangladesh] using a contraceptive method at the time of the survey)

Prevalence rates for Bangladesh in 1994 are as follows [Government of Bangladesh et al., July 1994]: overall: 44.6%; modern methods: 36.2%; pills: 17.4%; condoms: 2.2%; injectables: 4.5%; IUDs: 3.0%; tubectomies: 8.1%; vasectomies: 1.1%; traditional methods: 8.4%

*Implants are not available in the Bangladesh program.

Sources: (1) Mitra, Lerman, and Islam [Bangladesh 1991 CPS], July 11, 1992.
(2) Indonesia Demographic and Health Survey, 1991.

The official program in Indonesia provides condoms, pills, implants (Norplant), injectables, and IUDs. Indonesia is the world's largest user of Norplant. Voluntary sterilization, which is indirectly supported, is available from private and government facilities. Nongovernmental organizations (NGOs) handle training and technical support for voluntary sterilization services in both private and government facilities. The government has decreed that female sterilization can be provided only by hospitals with 20 or more beds. The number of sterilization acceptors reportedly has been declining because of increased costs and, according to NGO contacts, an "inadequate" government subsidy fee to service providers. NGO contacts reported that voluntary sterilization would gain more attention, support, and users if it were made an official program method.

Bangladesh's range of methods is similar to that of Indonesia, except that in Bangladesh voluntary sterilization is an important part of the national program while implants are not provided. The level of voluntary sterilization acceptors has also been declining in Bangladesh in recent years. This is apparently due not to a lack of demand nor to religious objections but to a lack of services (particularly readily accessible, affordable, and high-quality services).

Both country programs place the primary responsibility for contraception on women; neither appears to be making inroads in increasing voluntary male sterilization.

6. Effectiveness of Implementing Structures

In terms of information and service provision, the key government actors in Indonesia are the BKKBN and the MOH. BKKBN plays the dominant role in planning and evaluating the program while the MOH provides infrastructure and staff. Local governments are also involved in providing services. Anecdotal evidence suggests that the BKKBN exerts more influence and receives more resources than the MOH. Cooperation on program implementation between the MOH and BKKBN is also reportedly inadequate. Nonetheless, most past evaluations of the Indonesian program have lauded the effectiveness of the GOI, particularly the BKKBN, in mobilizing people and other resources at all levels to get family planning accepted and practiced. There is some risk that receiving too much praise for past successes will make program managers too comfortable with the status quo.

Many RTI team contacts in Jakarta stressed the urgent need to improve the quality of information and services for increasing CPR levels. Quality improvement will require greater attention to (1) providing better training and retraining of service providers (particularly on longer-term methods), (2) making service delivery systems more responsive to client needs and sensitivities (e.g., training and fielding more women physicians and paramedics), (3) continuing expansion of private sector participation (both for-profit and nonprofit organizations), and (4) upgrading clinical facilities and infection control systems. The 50,000-plus new *bidan di desa* (village nurse-midwives) have a major potential impact on improving community health and the use of family planning. The MOH and BKKBN could collaborate more closely on (1) planning the criteria for selecting, training, and placing of *bidan di desa*; (2) developing the training curricula and practicum; and (3) defining their job description, especially in how they can be better supported by BKKBN and MOH administrative and program structures.

To increase the number of acceptors using long-term contraceptive methods in Indonesia, the formal and informal reward systems for managers and service providers may need to be changed since these now tend to favor the short-term or repeat supply methods. However, emphasizing any one method or type of method over other methods can also be inimical to informed client choice and quality of care. Stocking large inventories of contraceptives has logistical benefits but can conceivably bias the method of mix in favor of short-term methods.

Many of the quality-of-care issues and proposed improvements cited for Indonesia are probably even more urgent for Bangladesh. Improving the quality of client services will require vigorous action to build the competence of service providers and to address serious sanitation problems in clinics and hospitals. A 1992 US-BDG (Bangladesh Government) team reviewing

clinical methods noted that more attention was needed to address staff attrition and institutional deterioration as programs age. That team's report suggested that investments to revitalize training institutions, programs, and staffs will be critical before training can be an effective tool for upgrading services.

In Bangladesh, the family planning and health directorates are both under the Ministry of Health and Family Welfare but reportedly go their separate ways in Dhaka and in most field offices. However, at the subdistrict or lower levels of the delivery system, more use is made of multipurpose workers or teams, and it is reported that family planning and health services such as immunization are delivered in an integrated manner. Bangladesh has achieved remarkable progress in child survival with its successes in diarrheal disease control and child immunization. However, maternal health and mortality have not received as much program emphasis or resources as has family planning. The same is true for Indonesia. To bring family planning and health services into better balance calls for stronger integration of program policy and implementation mechanisms.

In both Bangladesh and Indonesia, the target audience or program clients are almost entirely women while program managers at the middle and top levels are almost entirely men. Therefore, it is reasonable to assume that gender issues related to client needs are not being fully addressed. USAID and other donors are aware of this sensitive issue. USAID/Indonesia is raising the ratio of women trainees in its participant training program as a step towards increasing the cadre of Indonesian women managers. USAID and other donors also need to be sensitive to gender when designing and negotiating programs to increase opportunities for women to move into management and leadership roles in health and population programs. For example, donors can do more to support increased access of qualified women to management training and other professional enhancement activities supported under joint projects.

7. Worker-Client Service and Relationship as the Key to Success

The service providers and field workers who directly interact with clients ultimately determine the success or failure of a national program. In Bangladesh, adequately trained workers who interact well with clients and who have community status are thus able to move the national program ahead in spite of a reportedly fragmented and inflexible central bureaucracy. However, it is also assumed that there must be some action-oriented managers in the Ministry system who do try to ensure that field workers get support. NGO staff and service providers visited by the team indicated that Indonesian women prefer female health care providers. One-on-one counseling, where the client and provider can comfortably interact privately, can improve the quality of choice and method continuation by the client.

As resources are allocated to any program, it is critical to ensure that sufficient funds reach down through the organizational system to the workers who recruit and serve clients. USAID staff can be sensitive to this need at the project design stage and can act to prevent an undue share of funding from being absorbed by central bureaucratic overhead functions that add little value to client services. In Indonesia and Bangladesh, field workers are also critical in building user-groups and other structures for expanding and continuing program activities at the community level.

8. The Role of NGOs and the Private Sector

Strengthening NGOs to contribute to health and family planning interventions is a natural part of Type 1 integration because some NGOs successfully deliver both health and family planning care. NGOs play a significant role in both the Indonesian and Bangladeshi programs although the participation of NGOs in Bangladesh is broader and more diverse, and their work has received more funding support from the USAID Mission. The BDG is now emphasizing closer cooperation with NGOs.

One of USAID/Indonesia's main goals in the last five years, and in the years immediately ahead, has been to promote stronger private sector participation and performance in both population and health. For both Bangladesh and Indonesia, a review of NGO activities could reveal areas in which the USAID Global Bureau's Offices of Population and Health could agree on joint funding in order to achieve a synergistic effect and increase the impact of USAID investments. Both Bangladesh and Indonesia want to increase the proportion of family planning acceptors who obtain their contraceptives from the private sector. As the agenda of activities supported with USAID population funds expands in both countries, NGOs and the private sector could begin diversifying from providing primarily family planning services into providing reproductive and maternal health services. Both Bangladesh and Indonesia have strong social marketing programs that have expanded sales of contraceptives (and have increased contraceptive use) by customers who pay for the commodities, as well as promoted use of oral rehydration solution (ORS) for treatment of diarrhea. Sustaining and institutionalizing these programs within host country structures will greatly contribute to further increases in private sector participation in both countries.

9. The Role of Integrated Approaches

A. Type 1 Integration: Linking Health and Family Planning

Type 1 integration refers to linking family planning and health, both information and services. This type of integration is occurring in the Indonesian and Bangladeshi programs, although forms and specific components vary. While headquarters' structures tend to operate vertically in both countries, more integration is occurring at the field level. For both Bangladesh and Indonesia, the team believes that Type 1 integration makes sense because it better serves the needs of most clients. Women are the largest client group, and they generally want help with a combination of personal and family health needs. However, USAID has tended to operate vertically, and in recent years family planning has been given relatively more resources than basic health. In view of Administrator Atwood's public statements urging broader approaches, it now seems appropriate for USAID to provide stronger support for a basic integrated package of family planning and maternal and child health (MCH) information and services in most countries, including Indonesia and Bangladesh. The specific elements of the package should be primarily determined by the USAID Mission staff and counterparts in each country in collaboration with program clients. Combining family planning and health services should produce a beneficial synergy for both. However, the team recognizes that there are situations in which vertical approaches are appropriate. (This is discussed in detail in the Phase One Report.)

B. Type 2 Integration: Linking Health and Family Planning with Other Development Sectors

There is broad agreement on a major goal of Type 2 integration: the achievement of relatively equitable social and economic development so that fertility can decline further towards replacement level. Although Type 2 integration is more comprehensive than Type 1 and can be complex to carry out programmatically, lessons that have been learned from the successes of Southeast Asian countries demonstrate that it can be done. By getting their macroeconomic policies right and investing in broad-based education and health programs side-by-side with strong family planning programs, these countries have been able to achieve their fertility goals.

One feasible approach to Type 2 integration is to focus on policy and legal interventions that can influence the supply of and demand for family planning and health services. USAID Missions could assist host country governments in formulating coherent and mutually-reinforcing social sector policies and legal reforms that can impact fertility and population growth. In both Indonesia and Bangladesh, USAID could support stronger advocacy for increasing the importance given to family planning, MCH, and other social services in national development policies, planning, and resource allocation. Steps could be taken to remove legal restrictions on nonphysicians to permit them to provide specific family planning services that they are technically competent to provide. Especially in Indonesia, political and legal actions can be taken to facilitate the increased participation of NGOs and the for-profit sector in providing family planning, health, and other services. USAID has supported research and development activities related to the removal of legal, policy, and other constraints to the improvement of programs. This support should be continued, and it could be expanded to include assessment of legal barriers to increased social, economic, and political opportunities for women in both countries.

The RTI team believes that support for social sector policy integration (and, in many cases, policy reform) should be a priority in areas such as female education and literacy programs, promotion of micro-enterprises and other employment opportunities for women, family planning, and reproductive health services. Achieving coherent and mutually-reinforcing social sector policies would facilitate funding and support for interventions in key sectors that can impact on health, family planning practice, and fertility. For example, numerous studies suggest a strong relationship between women's educational attainment and their subsequent contraceptive use and fertility. Coherent, integrated social sector policies could redirect government expenditures (e.g., an increase in expenditures on primary and secondary education rather than on post-secondary education) and promote private sector initiatives in those areas that will speed the achievement of desired health, fertility, and other developmental outcomes (e.g., increasing the status and well-being of women).

Thus, the RTI team believes that increasing compulsory education in Indonesia by three years (from six years to nine years) will have a positive future impact on fertility. In Bangladesh, where the low status of women and lack of employment opportunities limit their mobility and freedom of choice, the relationship between women's education and contraceptive use has not been as strong, especially at low levels of schooling. USAID/Bangladesh's successful Secondary School Scholarship for Girls Project is a good example of how a targeted education intervention can enhance the status and potential of young women within their families and communities and (probably) contribute to fertility decline.

Other feasible approaches include national policy changes to encourage small families through, for example, income tax exemptions, allocation of public housing, and school tuition assistance. However, care must be taken to avoid the coercive aspects associated with some countries' efforts to influence families' decisions on family size.

Finally, Type 2 integration could take the form of "multi-sectoral" or integrated development programs that simultaneously pursue efforts in family planning/health and other areas (agriculture, environment, infrastructure, etc.). Such programs are reminiscent of earlier community development or integrated area development projects supported by USAID. Actually, the RTI Team did not find any major government sponsored programs of this type at this time, although some NGOs are working on smaller scale multi-sectoral projects. Since past experience suggests that large government-led, multi-sectoral efforts are very difficult to manage or replicate and had little development impact, we do not recommend that USAID Missions venture into such programs. However, Missions may wish to support targeted NGO efforts where these will help improve the quality and/or availability of health and/or family planning information and services. Some NGOs (particularly in Bangladesh) use program approaches and resource structures that seem replicable and have potential for wider impact.

10. Redirecting USAID/Washington and Mission Strategies and Resources

With the issuance of USAID's new sustainable development policy and strategies, both the Indonesian and Bangladeshi Missions are in the midst of reviewing their goals, strategies, and program portfolios in population and health. Given the recent restructuring of the Regional and Global Bureaus, the means by which Mission plans and activities will be effectively supported by USAID/Washington have not yet been fully articulated. The RTI team understands that Administrator Atwood wants the Agency to continue to play a major leadership role among donors in the population and health sectors. The guidelines for effecting this are still being formulated.

Given the Agency's renewed emphasis on "integration" as an approach, the RTI team believes that these Agency initiatives present new opportunities for USAID/Washington and the Missions to take a fresh look at the possibilities within their portfolios of better and more effective integration or linkages within the population and health sectors and of alliances and synergies between population/health and other development sectors.

As part of the new approach, USAID can do more to support high quality integrated health and family planning services and information (Type 1 integration). The study found that, over the last 15 years, there has been a clear trend towards Type 1 integration in USAID- and other donor-funded programs. For political, bureaucratic, and practical reasons, Type 1 integration has become almost *de facto* in public sector programs although the configurations of integration vary from country to country.

Findings from the Study, which apply to both the Indonesian and Bangladeshi USAID Missions, suggest that to promote better Type 1 integration, priority needs to be given to following:

- a. identifying and targeting the most critical barriers to delivering high quality client services and information (including definition and enforcement of performance standards for managers and service providers at all levels);
- b. supporting first-line service providers through policy, structural, and supervisory improvements;
- c. assessing and upgrading key training institutions, curricula, and programs;
- d. removing regulatory and other impediments to the expansion of private sector services (e.g., facilitating provision of modern methods by nonphysicians and provision of almost all clinical methods by well-trained paramedical staff); and
- e. identifying the more innovative and cost-effective service providers (private and public) and replicating/expanding their approaches.

Again, the specific package of services to be supported in each country would be determined by the most urgent problems identified in ongoing Mission portfolio revision and planning exercises.

Missions could also provide limited support for Type 2 integration actions that go beyond service delivery to affect either supply or demand variables. Activities could include (1) policy analysis and improvement to remove critical constraints, (2) feasibility studies and pilot projects to test new approaches, and (3) expansion of successful pilots or prototypes. An integral part of the Mission strategy could be to serve as a catalyst for program improvement and innovation. Compared to many other donors, USAID's comparative advantage is its strong relationship and program experience with private sector organizations. The private sector can usually innovate faster than most government agencies. Similarly, private sector organizations should be better equipped to develop more cost-effective and sustainable approaches to the provision of quality services. Where USAID resource limitations dictate, Missions may also shift from being major program funders to leveragers of investments by others, particularly for expansion of successful pilot efforts. Thus, it is important to design and implement research and development or prototype projects in concert with other donors or local funding sources such as local governments and for-profit organizations.

The RTI team believes that support for these two types of integration would be more successful if there were (a) innovation and teamwork at all organizational levels, (b) commitment of adequate staff and funds to implement new activities, and (c) strong positive managerial leadership at all levels that rewards creativity and collaboration among fieldstaffs. Training, motivation, and empowerment of USAID fieldstaff to work with host country counterparts on continuous innovation should be a central element of the new management paradigm. USAID/Washington should support Missions' integration initiatives in population and health with adequate central and regional resources.

11. Defining the Role of the ANE Bureau in Promoting Integration as Part of Its Population and Health Sector Programming

Under USAID's Sustainable Development Strategy, population and health is one of the five priority areas (along with economic growth, democratization, environment, and humanitarian assistance). Under USAID's reorganization, the new Global Affairs Bureau serves as the central base for all Agency technical staff and for providing field and program support to Missions. The restructured ANE Bureau will work collaboratively with the Global Bureau at the strategic level. This is the basic framework within which the ANE Bureau will be casting itself as it defines its strategies and role in meeting the Agency's goals and objectives in population and health in the region.

The ANE region's large population is a key factor in global population growth and in the region's health status. Thus, ANE as a region is critical to the achievement of the Agency's priority goals. Moreover, some ANE countries, like Bangladesh and Indonesia, have had valuable experiences in population and health program design, management, and implementation that are relevant for other countries. Given the impact of population growth on development in the region, the ANE Bureau should take a proactive role in the Agency's global efforts to address population and health concerns.

The following are some options that the ANE Bureau can examine in defining its role within the Agency with reference to the population and health sector:

- a. Prepare an ANE Bureau Strategic Action Plan. The ANE Bureau may consider formulating a small team of ANE central and field senior managers and technical staff to develop quickly, in collaboration with the Global Bureau, a Strategic Action Plan containing timeframe, budget, and staffing estimates for implementing population and health programs in the region. This plan would define the Bureau's strategy and comparative advantage in (i) supporting field Missions and (ii) coordinating USAID plans and strategies for the ANE region with the State Department and other donor units concerning population and health. As part of this Action Plan, the ANE Bureau could work with field Missions to develop strategies for influencing individual country donor consortia to increase the attention given by host countries and other donors to population and health needs.
- b. Give Health and Population adequate priority in Mission portfolios and staffing patterns. The ANE Bureau should ensure that population and health priorities are integrated into Missions' portfolio planning and staffing exercises and in USAID/Washington regional initiatives. The focus of these activities should be consistent with the ANE Bureau Strategic Action Plan. However, Mission and Bureau staffs can be held accountable only for goals over which they have some control and influence. Without a strong resource base for leveraging and follow-up, ambitious goals cannot be fully supported.
- c. Assess the critical ANE Population, Health, and Nutrition (PHN) staffing requirements. In cooperation with the Office of Human Resources, the Global Bureau, and other concerned offices, the ANE Bureau could assess existing and required Bureau and Mission staff resources for implementing the Bureau's population and health strategies. The

assessment would include options for recruiting the needed technical and managerial talent given (i) the current and projected staff levels in USAID, and (ii) the division of labor among USAID offices involved in health, population, and related activities. The assessment should include all staffing categories and sources (USDH, FSN, contract, IPA, PASA/RSSA); types of specialties; and allocation of staff between headquarters and field units; and staff training required. If adequate staff cannot be provided, program commitments should be adjusted commensurately.

- d. Career development in PHN. The ANE Bureau should encourage the Agency to develop appropriate career development, reward, and advancement systems to encourage highly talented staff to pursue careers in health and population.
- e. Develop a technical talent pool. To help Missions and host countries in assessing needs and planning new approaches, the Bureau could support the creation of a U.S. and Asia/Near East talent pool to provide short-term technical assistance to interested countries; for example, for macro and sectoral policy analysis and planning, promotion of legal reforms, and designing Type 1 integrated activities and operations research-type activities to test Type 2 integrated initiatives.
- f. Support continuous program improvements and innovations. A priority field and program support package in population and health could be developed between the Bureau and field Missions, in collaboration with the Global Bureau, to fund (i) implementation of specific initiatives, technical/management improvements, or program innovations, and (ii) development of organizational systems and internal processes that support continuous program innovations over time. Working with host country counterparts, USAID-supported teams could develop and test some of the more promising Type 1 and Type 2 integration initiatives in ANE pilot countries. Within the restructured ANE Bureau, this proactive effort could be managed as a partnership between individual management units or as a collaborative effort between ANE units and the Global Bureau.
- g. Advocate for population/health state-of-the-art training for USAID technical staff. The ANE Bureau could advocate within the Agency for in-house and outside training for population and health staff to help them perform more effectively under the broader, more integrated population and health guidelines. USAID's defunct state-of-the-art courses in population, health, and nutrition could be revived with emphasis on broader macro and intersectoral (including policy) development approaches. Long-term academic training and internships may be needed to prepare some key staff for technical leadership in important areas and for representing USAID in regional and global interactions and exchange of information and ideas.
- h. Cooperation and collaboration with other donors. ANE Bureau technical staff could maintain both formal and informal dialogues with counterparts in headquarters of other donor units such as the World Bank, WHO, and UNICEF to exchange information and progress reports on their respective programs, discuss their respective comparative advantages in donor assistance, and coordinate regional and country program plans including plans for integration in the population and health sector.

Planning Integrated Population Programs: An Informal Checklist For USAID Mission Staff

Annex to the Phase Two Report on

**A Study of the Integration of Family Planning and Other Population
Activities with Health and Other Development Interventions**

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1. Objectives of the Checklist

The planning framework and sample checklist in this paper respond to the request of USAID staffs for some guidelines or reminders that can assist in the planning of integrated population and health projects. This paper is a byproduct of a study of population integration issues conducted for USAID's Asia/Near East Bureau under an indefinite quantity contract (IQC) with the Research Triangle Institute (RTI). The authors have drawn on the literature and interviews with USAID and other professionals in such areas as population, health, economic development, and organizational and program innovation. Readers desiring more information on definitions and research findings can consult the Phase One report to USAID/ANE: Kocher, James E., et al., *A Study of the Integration of Family Planning and Other Population Activities with Health and Other Development Interventions*, Research Triangle Institute (April 1994). The Phase Two report includes country case studies (Indonesia [on-site] and Bangladesh [desk study]), a comparative overview of the two country programs, and this checklist.

The study suggests that the factors contributing to the success of a given program or project may be unique to the existing conditions in a particular country or region at a given point in time. However, there are some common elements of success frequently mentioned by contacts and in literature. The checklist focuses on these. USAID Mission and Cooperating Agency (CA) staff and their host country counterparts need to decide which of these elements are relevant to their situation. In other words, *the program planning checklist is intended only as a starting point to help staff identify factors which may be critical to the success of their specific country efforts*. They should add and delete items to fit the checklist to local conditions. Readers interested in the management strategy or concepts underlying the planning checklist can look at the "open systems" framework in Attachment A to this checklist. The authors would appreciate your suggestions for improving the checklist.

Programs may be vertical, integrated, or a mixture of the two. While the checklist covers the major components of a generic population or health project system, the authors try to highlight issues related to "integrated" approaches. The study suggests that "integration" in population programs most commonly refers to the integration of family planning and health information and services (Type 1 Integration). Since most host country programs in Asia have already moved toward the integration of family planning and health, it seems sensible for USAID to do likewise. For one thing, clients prefer to make "one stop" visits to service points which offer a mixture of health and family planning services. Where family planning use levels are declining, offering integrated services (without reducing quality) can be one way to attract more clients. However, there may be situations where it makes sense to keep services separated or vertical. Some program managers also move beyond family planning and health service delivery to influence other development sectors (Type 2 integration). However, the objective is often to work on macro or environmental factors which affect fertility and the demand for health and family planning services. For example, increasing the educational attainment of females is often seen as having a positive impact on fertility reduction. Therefore, investments in educational programs benefiting females are seen as a Type 2 integration strategy (integrating education and fertility concerns). However, the correlation between female education and fertility may not be as strong where other external factors are also influencing personal status and behavior (e.g., as in rural Bangladesh).

2. Using the Program Planning Checklist

Part One of the Checklist covers various *external or environmental influences* which can have a positive, neutral, or negative impact on program operations, and Part Two encompasses common *internal program components and management issues*. One useful approach for using this checklist is for several people to work alone in completing the checklist and then meet to discuss their findings as a team and agree on follow-up actions. While more complex rating scales can be developed, most people express a preference for a simple scheme in which the user would answer checklist questions with: "Yes," "No," or "Don't Know". If you end up with many "Yes" answers, the potential for successful implementation should be higher; the reverse should be true if you end up with too many "No" answers. If there are many "Don't Know" responses, you may need to delay further planning until you get more information. Finally, you can cross out questions which are not applicable to your situation.

The checklist is to help you perform the following major management tasks:

- (1) review the major components of your planned program to identify likely *internal strengths and weaknesses*,
- (2) identify important *external influences (opportunities or threats)* which could affect program implementation, and
- (3) prepare a design and action plan to build on internal strengths and positive external factors, while reducing internal weaknesses and addressing some of the more important program risks which are identified.

Before planning a program, you should be clear in your own mind as to why you are pursuing an integrated or vertical strategy. Is the particular approach primarily to respond to a political priority of the donor or host country, or to respond to important host country/client needs? And, regardless of the approach you choose, will you actually be able to objectively evaluate the project and demonstrate that it did make a difference?

The May/June 1994 issue of *The Family Planning Manager* (MSH, Newton, MA) suggests that the following management actions can help a new integration effort work: (1) develop an integrated plan and budget, (2) be sure the plan reflects local conditions and resource availabilities, (3) keep plans flexible so you can respond to change, (4) provide equal pay for jobs of equal responsibility, (5) ensure that the organizational structure supports integrated approaches, (6) decentralize and allocate staff where they are most needed, (7) ensure that staff understand their roles under an integrated approach, (8) avoid weakening the skills of staff specialists (e.g., use them to maintain quality in each program component), (9) use competency based and case-based training, (10) ensure that workers have only one supervisor (train supervisors to oversee integrated efforts); (11) train and motivate managers to be trainers and facilitators, not inspectors, (12) integrate logistics systems only when they are operating at similar levels of effectiveness, (13) ensure that information management systems use compatible terms/forms and focus on outputs (e.g., services to clients), (14) offer as many services to clients as possible at a clinic or other service center, and (15) be sensitive to the needs of particular clients or groups (e.g., providing privacy and confidentiality).

PART ONE: EXTERNAL INFLUENCES OR PLANNING CONSTRAINTS

C1. Country Political Conditions:

Question	Response
C1.1 Would an integrated project be likely to make family planning more acceptable to any groups in the country?	
C1.2 Is there an absence of formal or informal groups that might object to an integrated project (e.g., anti-foreign or religious groups)?	
C1.3 Will the top political leadership support this project?	
C1.4 Are there active and influential women's groups which will support the program?	
C1.5 Do political stability and security conditions permit program implementation in target areas?	

C2. Legal or Regulatory Influences:

Question	Response
C2.1 Do existing laws/rules support the integrated approaches planned for the program?	
C2.2 Do laws/rules permit an adequate range or mix of modern contraceptive and health services to be provided to clients?	
C2.3 Do laws/rules permit the use of paramedics to provide many basic program <i>services</i> ?	
C2.4 Do laws/rules permit program actions to generate and use <i>income</i> (to promote sustainability)?	
C2.5 Will rules permit <i>program managers</i> at all levels to make flexible decisions on funds, personnel, etc.?	

PART ONE: EXTERNAL INFLUENCES OR PLANNING CONSTRAINTS

C3. Country Economic Conditions:

Question	Response
C3.1 Will the current economic conditions permit the program to function at required levels of effectiveness?	
C3.2 Will the economic/income status of the program target groups permit them to access/use program information and services?	
C3.3 Will this program have adequate priority in national development plans and budgets?	
C3.4 Is the physical infrastructure in the program service areas adequate (communications, roads, public transportation, etc.)?	
C3.5 Will future economic conditions permit adequate replication of approaches being tested or used in this program?	

C.4 Cultural Factors:

Question	Response
C4.1 Are there good qualitative ethnographic data on cultural factors related to reproduction, health, etc.?	
C4.2 Will the program design be flexible enough to accommodate needs of the different ethnic or subcultural groups in the country?	
C4.3 Do users and potential users of current health/family planning services have a negative view of the services? (If "No", why is the planned program necessary?)	
C4.4 Are traditional service providers (e.g., TBAs, traditional healers, Muslim teachers) integrated into the service provision structure planned under this program?	
C4.5 Does the proposed integrated approach address the reasons which women and men give for having many children?	

PART ONE: EXTERNAL INFLUENCES OR PLANNING CONSTRAINTS

C5. Technical Trends and Constraints:

Question	Response
C5.1 Will needed technologies be available when needed to support program innovations and continuous quality improvement (e.g., modern contraceptive methods, infection-control systems).	
C5.2 Are trained specialists available incountry to provide key services?	
C5.3 Are administrative and support staff trained and motivated to effectively support the use of new technologies in the program?	
C5.4 Are there adequate systems for measuring the technical quality and safety of client services?	
C5.5 Are there adequate systems to anticipate and quickly act on any technical problems or negative side-effects in program services?	

PART TWO: INTERNAL PROGRAM FACTORS

P1. Program Goals and Strategies:

Question	Response
P1.1 Are goals stated in clear operational terms which will permit reliable measurement of progress and impact on client groups?	
P1.2 Are goals based on valid data from (1) clients indicating what they need and (2) lesson learned from relevant completed programs ?	
P1.3 Will integration goals have a positive impact on provision of care at the lowest levels in the health care/family planning or education service delivery systems?	
P1.4 Does service delivery strategy target all members of the family rather than just women?	
P1.5 Are the implementing strategy and time frame realistic in terms of available staff, funds, and other implementation resources?	

P2. Program Inputs: Funds and Income:

Question	Response
P2.1 Is the estimated program budget adequate to achieve the stated goals?	
P2.2 Is there is a high degree of certainty that planned program funds will be authorized and available as needed?	
P2.3 Are efforts being made to increase the private sector's role in providing services on a self-sustaining basis?	
P2.4 Will the integration of funding for health and population be as easy to manage as a vertical approach?	
P2.5 Can program use its income or deobligated funds to finance operations (i.e., they not revert to the central treasury)?	

PART TWO: INTERNAL PROGRAM FACTORS

P3. Program Inputs: Ideas and Information:

Question	Response
P3.1 Will the program have specific internal systems for adapting and disseminating new knowledge and technologies in all major areas of management and service delivery?	
P3.2 Will the program have effective linkages between its staff and key sources of local and international expertise in all sectors?	
P3.3 Do main implementing agencies subscribe to relevant professional and technical periodicals or information services?	
P3.4 Is there a plan and budget to obtain technical assistance and training to help update staff on roles in new integrated approaches to service delivery?	
P3.5 Are funds and other support available to help program staff keep abreast of external trends (via TDYs, international and local seminars or other means).	

P4. Program Inputs: Human Resources:

Question	Response
P4.1 Will staff size, composition, and location be adequate to implement the program on schedule?	
P4.2 Will there be a good fit or match between staff specialties and skills and the work to be done under integrated approach (including an equitable distribution of workload)?	
P4.3 Will program have sufficient continuity of management and non-management staff to achieve longer term goals (Is management turnover rate about right)?	
P4.4 Are actions being taken to recruit and develop adequate numbers of women managers at all levels?	
P4.5 Is there a plan to develop local staff to sustain, replicate, or expand successful innovations developed under the program?	

PART TWO: INTERNAL PROGRAM FACTORS

P5. Program Inputs: Facilities and Work Environment:

Question	Response
P5.1 Will the location of clinic and service sites permit convenient access by clients?	
P5.2 Does size/quality of office space and service sites facilitate staff efficiency and provision of services to clients?	
P5.3 Will program have adequate equipment/supplies for internal operations and provision of integrated services to clients?	
P5.4 Will there be adequate systems for supply and resupply of clinics and outreach workers?	
P5.5 Are service sites in reasonably attractive locations (to prevent undue staff turnover)?	

P6. Program Organization and Structure:

Question	Response
P6.1 Are family planning and health care structures integrated at all levels?	
P6.2 Will the job descriptions of managers, support staff, and service providers support an integrated approach to client services?	
P6.3 Will there be "unity of command" so that a staff person has only one supervisor and clear reporting responsibilities.	
P6.4 Do adequate structures exist for promoting cooperation among the different Ministries involved in the program?	
P6.5 Will action be taken to decentralize power and authority to those managers and staffs most directly involved in serving clients?	

PART TWO: INTERNAL PROGRAM FACTORS

P7. Program Management and Leadership:

Question	Response
P7.1 Are managers at all levels committed to making integration work?	
P7.2 Do managers actively encourage and reward staff creativity and innovation at all levels?	
P7.3 Are there clear management performance standards which are enforced?	
P7.4 Do managers at all levels support teamwork , cooperation, and open communication on program progress and problems?	
P7.5 Are there effective systems for training managers to provide effective and proactive leadership for integrated programs.	

P8. Program Monitoring and Outputs:

Question	Response
P8.1 Are there objective and effective systems for regularly monitoring the program's external impact and learning from experience over time?	
P8.2 Does monitoring system gather impartial data on the clients' perceptions of services provided them by the program?	
P8.3 Is control over funds and disbursements strong enough to prevent mismanagement, but flexible enough to move funds?	
P8.4 Will program collect and use data on key external stakeholders' views and level of support for the program?	
P8.5 Will the quality and quantity of program services and outputs be adequate to achieve desired external impact?	

PART TWO: INTERNAL PROGRAM FACTORS

P9. Assessing Program Results and Impact:

Question	Response
P9.1 Are program leaders clear about specific impact which must be made by the program on on the behavior of clients and other external stakeholders (e.g., changes in contraceptive practice, completion of basic immunizations, or use of ORS)?	
P9.2 Is there a clear end-means chain connecting strategic objectives of the program to the daily tasks performed by the service provider who interacts with clients (e.g., do all actors at all levels of the organization know how their work contributes to goals)?	
P9.3 Is there valid causal linkage between program's output and sectoral goals (e.g., between increased CPR and reduced TFR)?	
P9.4 Are program leaders able and willing to make major program shifts if feedback on impact indicates need to do so?	
P9.5 If this program is a smashing success, will you be able to clearly explain to a perfect stranger how it happened?	

NOTES FOR FOLLOW-UP:

A Systems Approach to Program and Quality Management

Attachment "A" to the Program Planning Checklist (Annex)

I. The Need for Continuous Program Improvement and Innovation

A. The Increasing Demand For High Quality Services: During the past thirty years, USAID-supported health and population programs have produced a positive impact on family health and well being in many countries. However, managers of such programs cannot rest on their laurels. Programs and organizations tend to lose momentum over time unless special action is taken to keep them effective and dynamic. Therefore, even countries which have had dynamic population efforts in the past are facing such problems as a decline or plateauing in the use of family planning methods. This may signal a need for program leaders and staff to pay more attention to the quality of their services and the quality of their relationships with their clients (customers). *Organizations which do not continuously innovate and improve their structures, processes, and outputs are not going to be cost-effective or competitive over the long term.*

Quality improvement and innovation can come through both major and minor changes. For example, a recent article by Linda Potter estimates that 63 million women take oral contraceptives (OCs), but OC failure rates may be as high as 15-20% in some areas. The article suggests that a global quality improvement effort which reduced failures rates by only one percent would result in several hundred thousand fewer unwanted pregnancies each year. In short, small gains can add up to a significant impact either on national or global scale. [See Potter, reference note 2 at end of paper.]

B. The Job of the Program Manager as Innovation Leader: As country leaders give more attention to such issues as democratization, privatization, and the role of women in development, greater pressures will be exerted on service providers to continuously upgrade their services and their relationships with their clients and communities. Family Planning organizations which have a service monopoly and assured funding from government and foreign donors may become rare. The same is probably true of programs managed almost exclusively by males. To meet changing macro conditions and external trends, program planning will have to pay more attention to (1) self-sustaining and replicable approaches and (2) fitting programs to the needs of clients rather than the needs of the service providers and funding agencies.

One implication of current trends in quality improvement is that program assistance managers in USAID will also need to devote more attention to the task of providing personal leadership for continuous innovation, focusing both on a program's internal operations and its impact on the outside world. USAID and Cooperating Agency staff may have to acquire new knowledge and skills in order to manage their programs as "systems" which are affected by key external or environmental trends and groups. The manager's challenge is to maintain a proper balance over time between internal program capacities and the demands being made on the program by changing external forces and groups. For example, many program managers are

facing shrinking financial resources, so they need to work more creatively with staff and other stakeholders to: (1) improve the quality of services and information provided to clients; (2) develop better schemes for income generation, cost-recovery, and longer term program sustainability; and (3) expand their client base.

II. Managing Programs as Dynamic Open Systems

A. Adopting More Flexible Management Frameworks: It may be useful for USAID staff to see themselves as managing program or organizational "systems" which are composed of interrelated and interdependent components (subsystems). Making changes in one part of the organization will often impact on other components (e.g., changing staff payment or incentive schemes can affect the types and quality of services provided to clients). The organization is considered an "open system" because it is affected by pressures emanating from external stakeholders or competitors. A program organization is thus an INPUT-THROUGHPUT-OUTPUT system whose life depends upon receiving inputs (resources) from elements in its external environment and processing these to produce outputs which are demanded by clients in the outside world (environment). Information feedback schemes are critical for tracking internal performance and external conditions at any given point in time and then using such feedback to make changes and improvements.

The Program Planning Checklist is designed to help staff to identify both internal and external factors which may affect the implementation of a new program. If the program is operating in a rapidly changing environment, then maintaining a proper fit between internal operations and external pressures is like shooting at a moving target. Managers must balance (a) the need for stability and steady progress toward established goals with (b) the need for continuous improvement and innovation to address changing client demands and other external conditions. Similarly, planning checklists need to be continuously updated to reflect the changing situation.

B. Major Components to Be Managed: The checklist covers the following system components:

1. Goals: Goals or objectives are desired future states which the program is supposed to reach. There is usually a hierarchy of goals extending from broad program or policy aims down to very specific operational tasks with deadlines. Even though not all levels need to be included in the program plan Managers need to link lower level and higher goals so that staff at different levels understand how they are contributing to the program.

2. Inputs: Inputs or resources are converted by the program into OUTPUTS at various cost levels. "Cost-effectiveness" refers to the production of outputs (client services) at "reasonable" levels of input use. When central "support" or administrative staffs consume a large share of inputs without improving outputs, the program is probably not cost-effective.

3. Through-puts: Through-puts(resource conversion or internal management processes) refer to the actions taken to use **INPUTS** to produce targeted **OUTPUTS**. One of the program manager's critical tasks is to ensure that internal staff and operations use resources efficiently to produce outputs which meet the needs of clients. Again, administrative and other program staff must add value to resources or they are not cost-effective.

4. Outputs: Outputs are the products, services, information, advice, etc. which the program will produce to achieve its goals. The level of demand for your program's outputs in the outside world will affect its ability to obtain adequate resources or inputs. Private corporations need customer demands for their products and services in order to survive. Public programs commonly compete with each other to obtain funds, staff, and other resources from legislative or other resource-allocating authorities.

5. Information Feedback: Effective program managers use several formal and informal feedback mechanisms to collect and use impartial and timely information on internal performance and external impact. They also systematically collect information on *external* trends and groups which can affect program progress. Feedback may indicate a need for changes in internal operations or program goals and priorities. Feedback systems need to be incorporated into initial budgets so they will be working when needed.

6. External Influences: External or environmental influences are trends and factors outside the program which may impact on operations (legal, political, cultural, etc.). While the manager may have little control over many of these influences, a proactive manager tries to (a) capitalize on positive trends and (b) reduce the impact of negative trends. Program managers may individually or jointly act to change external or macro influences (as when they lobby for statutory changes or more favorable interpretations of laws and rules).

Figure 1 shows some of the internal components and external influences related to a program system. Many influences on the program are mediated through external organizations, so a manager needs to identify the important entities (e.g., legislative bodies, special interest groups, consumer groups, or government agencies). All program managers face time deadlines, so the PASSAGE OF TIME appears as a discrete factor in Figure 1.

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2. For more information on reducing OC failure rates, see Linda S. Potter, "OC Effectiveness Requires Correct and Consistent Use", Outlook, Vol. 9, No. 2, June 1991. Program for Appropriate Technology in Health (PATH).