

3880001 (4)

PD-AAD-129-A1

MAR 1, 1976

ACTION MEMORANDUM FOR THE ADMINISTRATOR

THRU : EXSEC

*A. Shalinski*

FROM : AA/PPC, Philip Birnbaum

SUBJECT: Population/Family Planning Project for Bangladesh

**PROBLEM:** Because this grant project proposal totals more than \$2.0 million, your signature is required to authorize the attached project.

**DISCUSSION:** The proposed population/family planning grant assistance under this three-year project, which is a continuation of A.I.D. bilateral and centrally funded support begun in FY 1973, is directed at strengthening selected critical components of Bangladesh's institutional capability to enhance fertility control. Through FY 1975 A.I.D. has financed the provision of contraceptives adequate to ensure sustained delivery of contraceptive supplies in support of the Bangladesh Government's family planning program.

For FY 1976 it is proposed that the project be expanded to incorporate technical assistance for the government's Population Control and Family Planning Division, training for staff personnel and field workers, local costs of establishing four new family planning clinics, plus continued provision of contraceptives. Total proposed A.I.D. cost for three years is \$15,283,000. Of the total \$2.8 million being requested for FY 1976, approximately \$.8 million will finance the new activities proposed, and the balance will provide contraceptives. (During the formal review session of the attached Project Paper issue was raised that the proposed supply of oral contraceptives for FY 1976 may be low because of recent favorable distribution developments implemented by the Bangladesh Government. USAID has been asked by AID/W to re-evaluate the projected oral contraceptive requirement. Should more than \$2.8 million for FY 1976 be required as a result of the new assessment, an increase of funds in FY 1976 would be reviewed for further consideration at a later date.) For the final 2 years of the project (FY 1977-78) an additional \$12.4 million is proposed for continued support and development of the Bangladesh Government's nationwide family planning program. This project is found on p. 51 of the NESAC CP. (FY 76)

Bangladesh is ranked (by the United Nations) among the least developed countries. Further, the population problem there is critical and considered by A.I.D. as needing top priority action which is the thrust of this project. The USAID Mission to Bangladesh has carefully reviewed the request and selected to

support those components, principally training and logistical support, which comprise the most critical constraints within the Population/Family Planning sector of Bangladesh.

The Bangladesh Government (BDG) proposes to contribute \$25,929,000 during the next three years to the population and family planning program as a part of this project. During this same period, United Nations Fund for Population Activities (UNFPA), International Bank for Reconstruction and Development (IBRD) and other donors plan to make major contributions totalling some \$40.3 million to the Bangladesh program.

Top officials of the Bangladesh Government have proclaimed population growth to be the nation's number one priority problem, and they continue to reiterate that checking this growth is everyone's business. The BDG has taken positive steps to strengthen its family planning program in a number of ways: (1) It has approved the Family Planning Program of the First Five Year Plan. (2) It has appointed new Secretaries of the Health Division and the Population Control and Family Planning Division to assure cooperation. (3) It has undertaken recruitment for first 6,000 of the 18,000 new union-level field workers who will provide family planning information and contraceptives approved under the Plan and (4) The President's Advisor on Health and Population has issued an order that the 12,000 family welfare workers under the Health Division will be active providers of family planning information and contraceptives.

This Project Paper has been reviewed and cleared by all A.I.D. Offices and Bureaus concerned.

RECOMMENDATION: It is recommended that you approve the attached Project Paper (PP) in order to enable the program to move quickly in a country that occupies a top priority position for population/family planning assistance.

Attachment: Project Paper, Project No. 388-0001

APPROVED: \_\_\_\_\_

DISAPPROVED: \_\_\_\_\_

DATE: 3/23/76

Clearance:

AA/PHA: Henry S. Hendler HS Date 7/10/76  
GC, CGladson CG

PROJECT PAPER

PROJECT No. 388-0001

POPULATION/FAMILY PLANNING

BANGLADESH

December 12, 1975

USAID/Bangladesh

AGENCY FOR INTERNATIONAL DEVELOPMENT

**PROJECT PAPER FACESHEET**

TO BE COMPLETED BY ORIGINATING OFFICE

1. TRANSACTION CODE (CHECK APPROPRIATE BOX)

ORIGINAL  CHANGE

ADD  DELETE

PP

DOCUMENT CODE

3

2. COUNTRY/REGIONAL ENTITY/GRANTEE

Bangladesh

3. DOCUMENT REVISION NUMBER

4. PROJECT NUMBER

388-0001

5. BUREAU

A. SYMBOL AS

B. CODE 2

6. ESTIMATED FY OF PROJECT COMPLETION

FY 1978

7. PROJECT TITLE - SHORT (STAY WITHIN BRACKETS)

[Population/Family Planning]

8. ESTIMATED FY OF AUTHORIZATION/OBLIGATION

A. INITIAL [9/76] B. FINAL FY [78]

9. SECONDARY TECHNICAL CODES (MAXIMUM SIX CODES OF THREE POSITIONS EACH)

420

430

450

460

10. ESTIMATED TOTAL COST (\$000 OR EQUIVALENT, \$14.0 Tk)

PROGRAM FINANCING	FIRST YEAR			ALL YEARS		
	B. FX	C. L/C	D. TOTAL	E. FX	F. L/C	G. TOTAL
AID APPROPRIATED TOTAL						
(GRANT)	( 2,796 )	( )	( 2,796 )	( 15,283 )	( )	( 15,283 )
(LOAN)	( )	( )	( )	( )	( )	( )
OTHER						
1. U.S.						
2. OTHER						
HOST GOVERNMENT		7,761	7,761			
OTHER DONOR(S)	10,599		10,599	40,324	25,929	25,929
TOTALS	13,395	7,761	21,156	55,607	25,929	40,324
						81,536

11. ESTIMATED COSTS/AID APPROPRIATED FUNDS (\$000)

A. APPROPRIATION PURPOSE (AID & GRANT) CODE	B. PRIMARY TECH. CODE	FY 76		FY 77		FY 78		ALL YEARS	
		2. GRANT	3. LOAN	4. GRANT	5. LOAN	6. GRANT	7. LOAN	8. GRANT	9. LOAN
PH 341	440	2,796		5,000		7,487		15,283	
TOTALS		2,796		5,000		7,487		15,283	
12. ESTIMATED EXPENDITURES		2,538		2,093		2,907			

13. PROJECT PURPOSE(S) (STAY WITHIN BRACKETS)

CHECK IF DIFFERENT FROM PID/PPP

[ A functioning national institutional structure providing family planning services and population/family planning (Pop/FP) information and education on a continuing basis to the people of Bangladesh. ]

14. WERE CHANGES MADE IN THE PID/PPP FACESHEET DATA NOT INCLUDED ABOVE? IF YES, ATTACH CHANGED PID AND/OR PPP FACESHEET.

YES

NO

15. ORIGINATING OFFICE CLEARANCE

16. DATE RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

SIGNATURE

Joseph S. Toner

TITLE

Director  
USAID/Bangladesh

DATE SIGNED

MO. DAY YR. 12/31/75

MO. DAY YR.

AID 13:0-4 (5-75)

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PART I. Project Summary and Recommendation

A. Recommendations:

• Approval of Grant:		\$ 15,282,300 *
FY1976 and IQ	\$ 2,796,600	
FY1977	4,999,100	
FY1978	7,486,600	

\*This includes \$13,540,500 of bilaterally programmed but centrally procured and funded contraceptives.

- Waiver of Section K of SPA to permit sale of donated contraceptives without establishing a special account. Such a waiver was granted for prior years' contributions of contraceptives.

B. Description of Project

1. Assistance under this three-year project, which is a continuation of A.I.D. bilateral and centrally funded support begun in FY1973, is directed at strengthening selected critical components of Bangladesh's institutional capability to cause a decline in the population growth rate through a reduction in the fertility rate.

These components include:

- a. Commodity support in the form of contraceptives and medical instruments and equipment for clinical contraceptive services.
- b. Training in program management, family planning services delivery, population dynamics, population/family planning education and information, program evaluation, research, and data management.
- c. Technical assistance in program evaluation, operational research, information and education, training, and supply management.
- d. Establishment of family planning clinics in four medical college hospitals for fertility regulation training of medical students and practicing physicians and for delivery of high quality family planning services.

The project anticipates up to 650 to 700 man/months of short- and long-term training in the U.S. and third countries and approximately 78 man/months of consultant services. Second and third year training and technical assistance requirements are of course subject to on-going reassessment of program needs.

2. The Population Control and Family Planning Division (PCFPD) of the Ministry of Health, Population Control and Family Planning (MOHPCFP) has legal responsibility for planning and executing the national program of population control and family planning. The PCFPD, together with its operations arm, the Directorate of Population Control and Family Planning, are responsible for the planning and utilization of assistance under this project. In addition to managing the Government's national family planning program, the Division and the Directorate provide technical and material support and evaluation assistance to the population/family planning education and/or service delivery programs of the Ministry's Health Division, other development ministries and nongovernmental organizations. They are also a focal point for coordination of external assistance from multiple donors.

3. Successful accomplishment of the project activities proposed for the three-year period will result in:

- a. Adequate and sustained levels of contraceptive supplies.
- b. A network with improved capability of delivering quality fertility control services easily accessible to the majority of the population.
- c. Networks capable of stimulating increased demand for services.
- d. A data collection and analysis system capable of identifying problems and measuring progress in program implementation.
- e. An improved manpower development capability.
- f. Enhanced competence in program management.

These outputs are essential to achievement of the project purpose: a functioning national institutional structure providing services and population/family planning information and education on a continuing basis to the people of Bangladesh.

However, outputs flowing from A.I.D. inputs, in themselves, will be insufficient to achieve the stated purpose. The timely and successful accomplishment of activities financed by the BDG and other donors are necessary complementary outputs. These activities, which together are expected to lead to achievement of the project purpose, are described in Part II.B. A summary of the multi-source inputs is provided in Annex G .

4. The following conditions are expected at the end of the project, June 30, 1978 as a result of activities of the host country, A.I.D., and other donors (see Part II.B. for details):

- a. The sanctioned nonmedical, paramedical, medical, and supervisory staff have been recruited and trained and are carrying out their respective assigned tasks.
- b. Adequate in-country and in-pipeline supply levels are being maintained; the supply and logistics system is sustaining adequate stock levels at service delivery points and is capable of projecting commodity needs.
- c. Training facilities are established and functioning.
- d. The national policy and coordination bodies are functioning, and the PCFPD is staffed and carrying out its management and coordination functions in implementation of the national program.

- e. A coordinated national program of information and education is in progress through the national service delivery program; nonhealth sector development programs; the mass media; formal and nonformal education systems; nongovernmental organizations; and programs for identifiable segments of the population, such as labor, women, and youth.
- f. An action research and evaluation capability has been developed in the PCFP Directorate which is being applied to collection and analysis of service statistics and conduct of sample surveys and special studies for problem identification and for measurement of progress.
- g. The social science research capability of the Bangladesh Institute for Development Studies and academic institutions has been upgraded and is being applied to population/family planning-related questions.

C. Summary Findings

1. Technical Analysis including Environmental Assessment

Any realistic approach to population/family planning in Bangladesh must focus on the rural countryside where 90 percent of the total population reside. Indeed, an approach which does not concentrate on rural Bangladesh is destined ultimately to fail. The BDG population/family planning program has been designed with this fundamental reality in mind. More specifically, it has been designed to reach rural women not only at village level but at their doorsteps. This approach has been demonstrated to be technically sound in Bangladesh provided that adequate numbers of trained field personnel are available, a continuing and reliable contraceptives distribution system is in place, and effective leadership and direction of the overall program is furnished by the central authorities. USAID concludes that the program strategy adopted by the BDG is technologically sound and that the assistance to be provided from U.S. sources for key components can be utilized effectively. The project is in readiness for obligation and use of the additional funds programmed for FY 1976-78.

The project meets the requirements of Section 111 of the FAA prohibiting the use of funds for the performance of abortions or to motivate or coerce any person to practice abortions, and Section 610(a) requiring detailed technical, financial and other planning.

The environmental impact of the project is favorable. The man/land ratio in Bangladesh is among the highest in the world, with but nine-tenths of an acre of arable land available per agricultural worker. A significant

reduction in the rate of population growth will reduce mounting pressures on the land and help relieve future burdens on the government for the provision of social services and basic infrastructure.

## 2. Financial Analysis and Plan

The Population/Family Planning component of the BDG Five Year Plan (1973-78) calls for an overall investment of approximately \$50 million at the current exchange rate. The project Financial Plan indicates a total availability of funds over the Five Year Plan period amounting to \$104.8 million for this sector, more than double the amount originally contemplated. Much of the increase is accounted for in the BDG's own budgetary allocations for Population/Family Planning, which amounted to \$3.0 million in FY 1973 and are projected to rise to a \$9.3 million annual level in FY 1978. Due to the increased level of annual BDG allocations for population/family planning and the high interest of external donors in this sector, the recurrent operating and maintenance costs of both the project and the BDG's overall program are deemed adequate and reasonably well assured.

## 3. Social Analysis

The socio-cultural feasibility of the project hinges upon the installation of an extensive network of government family planning workers at village level. The spatial and social isolation of women in rural Bangladesh precludes an approach in which family planning information, services, and supplies are made available at small town or other centralized locales. Purdah, or the tradition of secluding women from public view, is widely observed in Bangladesh. An effective family planning delivery system must therefore be one designed to overcome strong cultural obstacles to the adoption of modern fertility control practices. To accomplish this,

family planning information, services and supplies are to be provided through means of 13,500 female and 12,000 male family welfare workers who will personally visit fertile couples in their homes. USAID finds this strategy conceptually sound in the social context of Bangladesh.

#### 4. Economic Analysis

The analysis shows that the social benefit of preventing one birth in Bangladesh is approximately Tk. 2,800, while the public program cost per tubal ligation or vasectomy is on the order of Tk. 100-250. The benefit cost ratio for condoms is 15.7 to 1 and for pills 5.5 to 1.

A total of Tk 17.35 is allocated for the family planning program in the BDG's Annual Development Plan for FY 1976. The target for births to be averted is 270,000. Based on these figures the social benefit is estimated at Tk. 78 crores. The analysis suggests that the social rate of return for public investment in birth control is not only high, but also possibly the highest of any potential investment in development activities.

From these favorable benefit incidence ratios we conclude that public investment in population/family planning is economically and socially advantageous, and on the basis of per capita improvement in welfare, an absolute requirement.

D. Project Issues

1. Degree of BDG Commitment

The major issue to be addressed is the degree of BDG commitment and priority accorded to population control. A.F.D. and other donors have been concerned with and frustrated by the apparent discrepancy between the BDG's articulate, well-reasoned expressions of urgent concern about the realities of too large a population growing too fast and their actual performance, which is far short of the effective program needed to cope with the problem.

Since the original Five Year Plan was approved in 1973, the BDG has been caught up in a non-productive debate over the question of integration of family planning into the regular health services, versus a vertical family planning program that would parallel the health services program. The result of this argument has been a totally confused field staff, delay in recruitment of additional field staff, and a central staff incapable of directing and implementing a program for lack of definition of objectives and delineation of program responsibility and authority.

This confusion has led in turn to arguments among the Planning Commission, the Ministry of Finance, the Establishment Division (which controls personnel ceilings) and the Ministry of Health, Population Control and Family Planning over the design of a feasible plan that can be financed and implemented. As a result, the Population Program Plan has never been approved since Independence.

The Health, Population Control and Family Planning Ministry has been divided into a Health Division and a Population Control and Family Planning Division, each headed by a Secretary. The Population Control and Family

Planning Division has responsibility for delivery of family planning and maternal and child health (MCH) services. In addition, the Health Division has 12,000 male multi-purpose field workers who make house-to-house visits. The delivery of family planning information and non-clinical contraceptives is supposed to be a major activity for each of these workers. However, with responsibility for population control assigned to another Division, the Health Division personnel do not presently seem to have a commitment to family planning. The degree of commitment can change with strong positive direction from the Health Secretary.

In addition to the existing field staff problem, more than half of the country's clinic facilities are also under the control of the Health Division. Thus, cooperation and coordination between these two Divisions is essential for program implementation. However, at the present time the Secretaries who head the two Divisions vie for program control and do not appear to cooperate to provide for a cohesive field program. This problem is recognized at senior levels of the RDG and there are indications that pressure is being applied to ensure cooperation.

The Population Control and Family Planning Division will eventually have 13,500 female field workers who are to be recruited, trained and put in position during this FYP period. The posting of these female field workers to complement the delivery of services by the 12,000 male workers has been proposed for two years. To date no recruitment has begun even though funds for training and salary support of 1,700 of the female workers has been available under UNFPA grant funding since July 1974. This problem will be corrected after approval of the new Population Program Plan discussed below.

This Project Paper discusses the issues that were raised in the prior review of this project in Part II A (4) below. The Paper also reviews the new organization that has finally been created to deliver population control services. In addition, a Population Program Plan for the last three years of the FYP has been written that has the general agreement of the concerned approving ministries. The BDG has set the end of December 1975 as the target date for formal approval of this Plan. Approval should correct many of the major issues that are delaying program implementation.

## 2. Contraceptive Supply Levels

The Office of Population, A.I.D./W, has instructed USAIDs to build up as rapidly as possible to a supply level of sufficient oral contraceptives and condoms in country to supply 10% and 5%, respectively, of eligible couples for one year, and a like amount in the pipeline. Requirement levels by the end of the project period, reflecting BDG and USAID projected usage estimates, approximate the PHA/POP guideline. Projected requirements used in this project will be reviewed on a continuing basis and second and third year Project Agreements will reflect any change in requirements based upon actual offtake and program trends. The recruitment, training and positioning of the female field workers as well as a renewed commitment towards family planning on the part of the in-position male field workers is essential if the BDG contraceptive targets are to be met that will contribute towards reducing the country's growth rate.

## 3. Realization of Other-Donor Output Objectives

We have indicated that achievement of project purpose depends upon the successful outcome of not only A.I.D. activities but those of other donors and the BDG as well. By far the largest amount of other-donor

support comes from the UNFPA and its associated implementing Specialized Agencies and the IBRD/IDA and the six bilateral donors associated in the World Bank project. In the case of the latter, the BDG met the conditions precedent for credit effectiveness in September 1975, including creation of the mechanism for the Bank's disbursement of funds. Implementation of the pilot information/education projects of nonhealth development ministries has begun. A resident representative to monitor progress of the project is about to be posted to Bangladesh. Several of the UNFPA projects have been in operation since FY75. Others have been delayed for the necessary modifications to make them consistent with the new Government population/family planning organization and its redesigned program. The resident UNFPA representative is negotiating additional projects for the as yet unprogrammed balance of committed funds. A good climate of cooperation exists among the donor agencies represented in Dacca, facilitating the monitoring of each other's progress and concerted action towards solution of our common problems of program implementation.

b. Recommended Resolution of Issues

The Mission believes that withdrawal of A.I.D. support to the population or other sectors would exacerbate the BDG's problems rather than ameliorate them. Experience over the past few years indicates that aid donors' reiterated expressions of concern about the progress of the population program have been somewhat instrumental in expediting resolution of some issues and in refocussing attention on population growth as the most important among a myriad of pressing problems.

We intend, therefore to continue our established practice of using every opportunity to make high-level representations of our interest and concern. This will be done in coordination with other donor agencies in Bangladesh. Beyond this, we recommend that the level of discussion be raised to that of a special Bangladesh Aid Consortium meeting to review the population problem and the BDG's plans to check uncontrolled population growth.

The above notwithstanding, we recognize that the population control program is a Bengali program and that the decisions and solutions must be Bengali. If solutions are slow to emerge, results may be less than hoped for in the projected time frame, and the project implementation schedule may have to be revised to reflect a reassessment of the program's absorptive capacity. However, the more important consideration is that the program design and implementation are functional and durable in the context of Bangladesh.

## PART II. Project Background and Detailed Description

### A. Background

The period of explosive population growth in Bangladesh began after World War II, triggered by a dramatic decline in the crude death rate. The nature and magnitude of the present population problem are discussed in detail in the population sector analysis section of the Bangladesh Development Assistance Paper (DAP) (Dacca, December 1974). In brief, the late-1975 population is nearing 80 million--over 1400 people per square mile. If the estimated 3% annual rate of population growth is sustained, the population will double in about 23 years. Over 90% of the people are rural; nearly 80% are illiterate. The society is conservative, traditional and largely Muslim. The majority of women are secluded in their homes. Average per capita income is about US\$70 per year.

#### 1. The Pakistan Period.

First efforts to promote the idea of family planning and to provide services were begun in the early 1950s by the nongovernmental Family Planning Association. A modest governmental program was started in 1960, providing services largely through existing health facilities. In 1965, a greatly expanded program was launched, implemented by a specially created single-purpose family planning organization. By 1968, according to the findings of a National Impact Survey, about 70% of the target population in East Pakistan knew about some method of family planning; about 8% reported that they had ever used a modern method of contraception, and only 3% to 4% of eligible couples were currently practicing birth control.

2. The Bangladesh Program.

During the two years immediately following Independence, there was a protracted debate within the BDG--first, whether or not to have a family planning program; then, whether family planning should remain a unipurpose program or be combined with malaria and smallpox eradication and other preventive health services. In late 1973, the decision was made to launch an integrated health and family planning program.

In January 1974, the newly created cadre of multipurpose Family Welfare Workers (FWWs) of the Ministry of Health and Family Planning began delivering family planning information, contraceptives, and a variety of preventive health services through regular rounds of home visits in rural areas throughout the country. At the same time, the network of thana\* and urban family planning clinics, staffed largely by paramedicals, was reactivated after having remained virtually dormant since the troubles in 1971. FWws number nearly 12,000; nearly all are male workers from the malaria and smallpox programs. There are between 450 and 500 family planning clinics, whose female paramedics are trained to insert IUDs.

One year later, in January 1975, the BDG reversed its earlier decision and assigned the family planning program to the newly created Population and Family Planning Division in the renamed Ministry of Health, Population and Family Planning. In March, a government order transferred responsibility for maternal and child health (MCH) services

\* A thana is an administrative unit comprised of an average of ten unions, 15 to 20 villages, and 150,000 to 200,000 population.

as well from the Health Division to the Population and Family Planning Division. In April, the Government approved the field structure of the rechristened Population Control and Family Planning Division, simultaneously inserting the word "Control" into the name of the Ministry as well. Of particular note in this action is the authorization to employ three women and one man per union as home visiting MCH/FP workers, or about 18,000 new full-time employees. Their principal qualifications are education to secondary level and established residence in their respective areas of work assignment. According to this plan, the Health Division's some 12,000 FWs will continue to distribute contraceptives during their home visits, concentrating on males as potential acceptors, thus complementing the PCFPD's field structure.

The implementation organization of the PCFPD is the Directorate of Population Control and Family Planning. The Directorate supercedes and incorporates the functions and many of the personnel of the National Family Planning Board and its subordinate units, vestiges of the Pakistani program. Formal BDG approval of the organizational structure and the staffing pattern of the Directorate was issued in September 1975. By the end of September, some of the key staff appointments had been made, with the bulk of staffing actions still to follow.

Thus, nearly a year after the Government's decision to abandon their one-year attempt at integration and almost four years since Independence, an organization has at last been approved to implement the redesigned family planning program. During this year, it should be noted, the

FwWs and the clinics have continued to function as they had in 1974. During 1975, quantities of conventional contraceptives reported distributed to users have continued to rise, as have adoption rates for sterilization and IUDs. In addition, increasing numbers of Bengali and foreign voluntary organizations are finding ways to include family planning education and/or services as an integrated component of their development or relief programs.

A word is in order about the organization of the Directorate, inasmuch as it has come into being since the DAP sector analysis was written and its constituent units will be chiefly responsible for the utilization of A.I.D. inputs. Under the direction of a Director-General who reports to the Secretary of the PCFPD in the Ministry, there are three principal units headed by Directors. The Service Delivery Unit is responsible for procurement, stores and supply, the fertility control services delivered by the field and clinic staffs, and training of the service delivery and supervisory personnel. The functions of the Planning, Statistics, Research and Evaluation Unit are as implied in its title. Similarly, the name of the Information, Education and Motivation Unit suggests its areas of responsibility. Sections charged with administrative services, budget and finance, and personnel report to the Director-General through his Deputy Director for Administration. The creation of a national-level Population Control and Family Planning Training Institute has been proposed to the Government but has not yet been approved. Its functions would include training of Directorate and high-level supervisory personnel, and development of curricula and training materials.

3. A.I.D. Population Assistance to Date.

An early A.I.D. action, begun in FY1973 and continued in FY1974 and in this project, was to meet the BDG's obvious need to establish and maintain the pipeline of contraceptive supplies. From FY1974, A.I.D. has been the only donor supplying contraceptives to the national program. Another early program need, to which A.I.D. responded by allocation of Relief and Rehabilitation Grant funds, was the initial orientation and training of the 12,000 multipurpose FFWs of the integrated health and family planning program.

Beyond these bilateral program actions, A.I.D. has supported a variety of program initiatives since 1972, using the mechanism of A.I.D./W Central grants and contracts to intermediary organizations and institutions. Among these are:

- a) a commercial marketing of contraceptives program administered by Population Services International, which has just completed the test marketing phase in preparation for launching a nationwide sales program;
- b) field research on the effectiveness and acceptability of a variety of contraceptives under Bangladesh conditions, supported through Johns Hopkins University;
- c) under the auspices of The Pathfinder Fund and Association for Voluntary Sterilization, establishment of high quality, full-service clinics to meet the need for facilities for training doctors, of which none had existed before, as well as to augment service delivery capacity;

- d) with the Cholera Research Laboratory, an experimental intensive effort to introduce contraceptives into rural homes; and
- e) other innovative experimental and demonstration projects under voluntary agency sponsorship. See Annex H for a summary of A.I.D. assistance since 1972.

4. The USAID Evaluation Review on June 30, 1975 of U.S. assistance to the BDG population/family planning program noted some deficiencies, particularly in the areas of administration, the adequacy of the project-related organization, and resolution of bureaucratic problems. Although the field workers of the integrated health and family planning program were functionally integrated, their separate parent services were left intact at national, district, and thana levels with their still-separate budgets. Such an organization was totally inappropriate to the task and led to a situation of divided loyalties, contradictory orders to subordinate levels, and conflict. Because of this unresolved dissonance, the BDG was unable to give formal approval to the five-year population/family planning plan. Although many actions and activities described in the plan were in fact being carried out, key staff appointments could not be made failing a resolution of the organizational issues.

With the BDG's decision to redesign its approach to population control and its recent approval of an organizational structure and staffing pattern, there is now a potentially coherent organization with

which to work. For the first time since Independence, identifiable individuals have been put in charge of such critical program elements as supply, service delivery, evaluation, and communication. The PCFPD's recognition of their need now to develop staff competence in these areas is reflected in their request to A.I.D.

5. The Present BDG Request for Assistance.

The BDG request, to which this project responds, was necessarily delayed until it could accurately reflect the Government's newly formulated approach to fertility control and its new organizational structure. The backbone of this approach is MCH-based family planning services brought to people's homes in rural areas, where over 90% of the population live, backed up and augmented by clinical services in both rural and urban areas. The core program, based in the PCFPD and its Directorate, is complemented importantly by the preventive health services field staff, the FWs; by the medical and paramedical personnel and the hospitals and clinics under the direction of the Health Division; and by the information and education activities of the other development ministries and voluntary organizations which are in contact with the people.

The commodity support requested is obviously indispensable to a program offering family planning services. The training and technical assistance components of this project are judged essential to the development of a viable organization to bring the services to the people. Some of the most crucial program needs derive from a shortage of trained manpower. In some specialized areas, pre-Independence training programs have left a legacy of highly educated, competent, senior-level talent, but serious gaps remain in the middle and lower ranges.

We have already noted the absence of fertility-related content in medical education and, by implication, the limited experience among medical college faculty to teach it. There is a dearth of persons in the entire country who have the education or experience to design and manage a communication campaign or to produce the materials needed for information, education, or training. There is a shortage in the PCFPD of persons who can process and analyze program performance data or design and conduct surveys and other studies.

Both the training and the technical assistance inputs of this project are planned with these program needs in mind. Numerous staff members as well as program administrators will receive on-the-job training as they work with consultants on practical problems. Short-term and long-term training opportunities will be provided in the U.S. and in third countries. The projections of second and third year training inputs under this project are subject to revision as a more definitive assessment of training needs emerges from program experience. While recognizing that realities may dictate a later reconsideration, at present we do not plan to finance any education at the Ph.D. level.

There are certain differences between the A.I.D. inputs proposed in the Project Paper and the BDG's application for assistance, Annex D. Oral pill quantities have been increased over the request figures to provide a more realistic lead time than was calculated in the request; i.e., oral pills required for usage in 1980, which must be programmed in FY1978, were not included in the BDG request. The quantity of condoms requested, on the other hand, was reduced because in calculating the requirements there was a sizeable BDG underestimation of in-country and

pipeline stock levels.

USAID considered the IUD requirements, as stated in the request, to be overestimated. This was based on our doubts that the popularity of IUDs would increase to the BDG projection of 35% of total users in the near future, if ever. In discussion with BDG, it was agreed that USAID would be willing to reconsider this judgment in future years, based on program performance and the placement of enough additional trained paramedics to insert IUDs. This we believe to be feasible, given the relatively short lead time required to procure IUDs.

Medical kit requirements were revised, taking into consideration UNFPA/WHO plans to make complementary contributions. Depending on the rate at which additional doctors are trained in sterilization procedures, USAID is prepared to reevaluate medical kit requirements and increase our contribution if appropriate.

We have not agreed to the BDG's request for motor vehicles for the four family planning clinics. Given local driving conditions and maintenance capabilities, the most appropriate vehicles are better supplied by other donors. The composition of the equipment component of the clinic request and the operating costs and salary support components are all subject to further negotiation. They are included in this project as requested in order to get AID/W's approval in principle. When the activity is approved, we would request an intermediary, such as Pathfinder, to conduct a hospital-by-hospital review of requirements and implement the activity.

The request for a service statistics consultant has been dropped because a slight modification in the task to be undertaken under the proposed University of Michigan grant, which was suggested by the BDG and

USAID, would address the needs in that area. We have also anticipated that the services of a consultant for the on-going in-country training program may be needed for a second year.

It is obvious that there is no guarantee against further fundamental changes of program direction, even though such action in the near future would inevitably raise questions of BDG seriousness of commitment. We are hopeful, however, that the present decision will be allowed to stand and the responsible organization will be permitted the time it needs fully to develop its capability to mount an effective program.

Therefore, in the conviction that the U.S. has the relevant competence to help in some of the areas of critical program need, the mission believes that it is appropriate to broaden the range of our bilateral assistance activities, as described in this paper. Given that Bangladesh appears to be further along the path towards probing the limits of human crowding than other countries, that there are powerful social forces militating against a rapid change to a preference for the two-child family as the norm in Bangladesh, and the awful penalties of delay in reducing fertility rates, the mission anticipates a probable need for continued assistance beyond the three years of this project. In such a case, we will submit an amendment or a new proposal in due course.

**B. Detailed Description**

**Program Goal:** A reduced rate of natural population growth as a critical factor in social and economic development.

The target set for the First Five Year Plan period ending mid-1978 is an annual rate of natural increase reduced from 3% to 2.8%. This would require a decline in the crude birth rate from 47/1000 to 43/1000, in view of the expected decline in the crude death rate from 17/1000 to 15/000 during the same period. The BDG calculates that this target will require the prevention of 1.1 million births during the July 1973--June 1978 Plan period. The number of continuing users of contraception would have to increase to slightly over 1.5 million couples by the fifth year--about 10% of eligible couples and about double USAID's mid-1975 estimate of prevalence of contraceptive use. The stated goal is an intermediate one en route to the Government's ultimate goal of achieving a replacement level fertility rate by the turn of the century.

Several activities are in progress which will establish important baseline data against which to measure progress toward goal achievement. The Bangladesh Survey project of the World Fertility Survey, financed under an A.I.D./W grant, is beginning in late 1975. The UNFPA is providing assistance to the BDG for processing and analysis of the February 1974 Bangladesh Population Census. The United Kingdom financed a retrospective sample survey of fertility and mortality in early 1974, which also served as a quality check on the Census. Some of the U.S. assistance under this project will develop the program data collection and

processing and survey methodology capability in the PCFP Directorate which will be needed for measuring progress. Similarly, Ford Foundation inputs are directed at the need for demographic and other social science research competence in other selected organizations.

Project Purpose: The following statement of purpose and conditions expected at the end of the project describe the national program elements-- regardless of funding source--considered essential for goal achievement over the life of the project.

Purpose: A functioning national institutional structure providing family planning services and population/family planning information and education on a continuing basis to the people of Bangladesh.

Conditions Expected at End of Project:

We have classified the wide-ranging, interrelated "conditions expected at the end of project" according to six key components of a functioning national organization conducting an effective population/family planning program. Inputs and Outputs, in turn, are organized according to these EOPS categories.

As noted in the summary description, this project is part of a multidonor effort to help the BDG achieve their goal. The creation of many of the conditions which will indicate achievement of purpose assumes timely introduction and effective management of inputs from the BDG and other donors, successfully leading to the requisite outputs. Some of these inputs will be referred to briefly in the following

discussion. For fuller details of the interrelated efforts directed towards the various program elements, see Annex G .

1. Service Delivery - Field Personnel

1.1. Nonmedical Personnel

- a. 12,000 trained male Family Welfare Workers (FWWs) under the Health Division of the MDPCCP continue to provide, as part of their health services, nonclinical family planning (FP) services, related information, and referrals for those wanting clinical means of contraception. Each FWW covers an area with about 6,000 population, visiting each home about every six weeks. It is estimated that these workers will spend about 5% of their time on family planning.
- b. About 13,500 trained female Family Welfare Assistants (FWAs) under the PCFPD are making regular home visits in their assigned areas of 5,000 to 7,000 population each and providing nonclinical FP/MCH services, related information, and referrals for those wanting clinical means of contraception. Three FWAs are assigned to each of approximately 4,500 unions. UNFPA and IBRD projects are to finance the training costs and salary support for 5,500 FWAs; the BDG, the balance. Ford Foundation plans short-term consultant services in training methodology.

1.2. Paramedical Personnel

About 1452 female Family Welfare Visitors (FWVs) under PCFPD are providing FP services (orals, condoms, IUDs), related information, MCH services, and referrals. There is one FWV each at 422 thana MCH/FP clinics (including those thanas located at district and subdivision headquarters) and 1030 union subcenters. In addition, 422 senior FWVs, designated as Thana Clinic Supervisors, are giving technical supervision to the union subcenter FWVs. Thana- and union-level FWVs provide technical FP/MCH supervision to the FWAs. To augment the existing numbers of paramedics, UNFPA and the IBRD group are supporting the costs of training, technical assistance, and expansion of training facilities.

1.3. Medical Personnel

- a. 422 Thana Technical Officers (TTOs) under the PCFPD are providing clinical services (male/female sterilizations and IUDs), one per thana-level MCH/FP clinic. They provide technical backstopping and supervision and follow-up support for the thana- and union-level clinical personnel and the field workers.
- b. 58 District and Subdivisional Medical Officers under the PCFPD are providing clinical services (male/female sterilizations and IUDs) at the district and subdivisional FP/MCH centers, of which they are in charge.

- c. 19 District Technical Officers of the PCFPD are giving technical supervision to the entire clinical programs in their respective districts. They are also organizing mobile clinical activities and providing clinical services.

1.4. Other Supervisory Levels

- a. Approximately 4,500 Male Union Assistants (MUAs), one per union, are providing nontechnical supervision to the FWAs in the unions, keeping accurate FP acceptor records, and providing information and contraceptives among the male population of the union.
- b. 422 Thana Population Control and Family Planning Officers (TPCFPOs), each with an assistant, the FP Supervisor, are supervising the MUAs and administering the FP/MCH program in the thanas.
- c. 19 District Population Control and Family Planning Officers (DPCFPOs) are administering the district-level FP/MCH program and administratively supervising the district and thana FP/MCH officers and staff.

2. Service Delivery - Supply and Logistics System

- 2.1. In-country logistics and distribution system ensures adequate warehousing and inventory control of program commodities and their timely distribution in quantities adequate to meet program needs at service delivery points.

2.2. The BDG system for estimating contraceptive and other FP commodity needs based on anticipated and/or target numbers of contraceptive adopters is operational.

Among the areas of the BDG program which need strengthening have been a loosely administered, cumbersome supply and transport management system and an inadequate, unreliable data base on which to calculate current or future commodity needs. A UNFPA grant through UNICEF, which is already under way, is developing a transport equipment maintenance organization which will serve the two divisions of the MOHPCFP. Another aspect of this grant, which is about to be initiated, is assistance in designing and making operational a warehousing, inventory control, and commodity flow system. A.I.D., in collaboration with UNICEF, will provide centrally funded short-term technical assistance in the stock records, requisitioning, and reporting aspects of the system. Complementing this input is the A.I.D. assistance in developing a useful system of program statistics reporting which will give more reliable information on commodity consumption rates and projections of future needs.

### 3. Service Delivery - Training Facilities

The following facilities will be established by the end of the project in order to train the paramedical, medical, and selected supervisory personnel required for the service delivery system.

No special facilities will be required for training of the nonmedical field workers--the FWs are already trained and working, and the FWAs and MUAs will be recruited by already existing district and

thana FP personnel and trained by the TPCFPOs, their assistants, and the FWVs.

- 3.1. 8 model FP clinics located at the 8 medical college hospitals are each providing practical undergraduate training to medical students as well as short-term training for doctors already in practice.

Until now, medical colleges in Bangladesh have taught virtually nothing about reproductive biology, fertility-health relationships, and methods of contraception and no practical training at all in sterilization techniques and IUD insertion. WHO, under a UNFPA grant, is assisting the colleges to integrate fertility regulation content into their curricula. IBRD will finance the construction and equipping of clinics at four of the teaching hospitals to make possible training under qualified supervision. A.I.D., under this project, will fund the remodeling of facilities and equipping of similar clinics at the other four teaching hospitals.

- 3.2. One college of nursing is training 60 nursing teachers annually who will in turn train FWVs.

IBRD will construct this new facility.

- 3.3. 17 training institutes are functioning each with a capacity to train 60 FWVs annually and to provide periodic refresher training for FWVs and district and thana officers already in service.

Seven existing facilities--4 Training cum Research Institutes and 3 MCH Training Institutes--will be merged by the end of the

project into 5 FWV schools. UNFPA will finance 4 new schools and the IBRD 8 new ones for an eventual total of 17 facilities.

3.4. One Family Planning Training Institute under the Director-General/FCFPD is training trainers and senior officers, providing policy guidance, and developing and reviewing curricula for FWV and field worker training programs.

This is a newly proposed institute to be financed by the BDG. The assumption is that all the relevant ministries will approve the proposal.

3.5. 8 thana-level rural health centers (with clinical facilities, 25 maternity beds, staff and student housing), each with 3 union-level subcenters are providing field training for medical and paramedical personnel.

These are new facilities to be financed by IBRD and associated donors.

#### 4. Management

4.1. The National Population Council is providing broad policy guidance for the BDG's efforts to reduce population growth. The Vice-President of Bangladesh is chairman of the Council; ministers of the various ministries concerned with population/family planning are members.

4.2. The National Coordination Committee is coordinating the population/family planning efforts of the concerned ministries and private sector organizations. The Committee is composed of the secretaries (highest civil service rank)

of the ministries with population/family planning activities and is chaired by the Minister of Health, Population Control and Family Planning.

4.3. The Population Control and Family Planning Division of the MOHPCFP:

- a. is serving as secretariat for the National Population Council and the National Coordination Committee;
- b. is planning and implementing the national service delivery program and evaluating its impact;
- c. is providing technical support to other ministries involved in Pop/FP for planning, implementing, and evaluating their population programs; and
- d. is coordinating external assistance in pop/FP and participating in periodic evaluations of program progress with the various foreign donors.

5. Demand Creation

5.1. The Information, Education and Motivation Unit of the Directorate of PCFP is established and staffed and is conducting a communication campaign in support of the service delivery system. The unit supplies technical support to the information and education programs of other ministries and agencies.

5.2. 14 pilot schemes (9 with IBRD support; 5 with UNFPA funds) have been implemented and evaluated. These pilot schemes are designed to integrate Pop/FP education into the development programs of the nonhealth development ministries.

The ministries involved are Rural Development and Cooperatives, Education, Agriculture, Information and Broadcasting, and Labor and Social Welfare.

- 5.3. The Women's Rehabilitation Foundation has incorporated Pop/FP content into their training courses. Training in income-producing skills and other appropriate adult education subjects is provided for about 2000 women per year in approximately 30 centers throughout the country. Center staffs assist would-be FP adopters to contact service providers.
- 5.4. Mass media are being used more extensively for Pop/FP information and education as a result of new and strengthened units of the Ministry of Information and Broadcasting, assisted by IBRD. Radio Bangladesh is broadcasting daily messages created and produced by a new Population Program Cell. A new processing laboratory and additional equipment in the Films Department has enabled them to produce about 10 new featurized documentaries on population for showing through commercial cinemas and the Department's mobile film program. A Feature Writing Bureau has been created which is placing material in the print and broadcast media. The BDG/IBRD targeted monthly output is four articles, four features, four personal interviews, three stories, three poems, a short drama, and six cartoons.

- 5.5. Work is well advanced on development of population education curriculum materials for introduction in fourth grade through university courses in the formal school system. This condition is dependent upon the successful negotiation and the timing of a proposed UNFPA grant.
- 5.6. A directory published by the Association of Voluntary Agencies in Bangladesh (AVAB) lists about 100 indigenous and foreign nongovernmental organizations, of whom 34 are members of AVAB. At the present time, approximately 25 agencies carry on some Pop/FP activities. By end of project, there is a 50% increase in the number of agencies which are involved in promotion of the small-family norm in the context of a variety of development programs. These activities are supported by a variety of Bengali and foreign voluntary agencies, by the USAID project for co-financing Private and Voluntary Organization projects, A.I.D./W Title X grants to intermediary agencies, and IBRD.
- 5.7. At least one social science research study in Pop/FP is in progress or completed by each of three universities and the Population Study Centre of Bangladesh Institute for Development Studies. Ford Foundation and IBRD provide the major donor support for this activity.
6. Evaluation (Program Impact/Effectiveness Measurement)
- 6.1. PCFPD is generating administrative information needed to measure effectiveness of various program components--  
e.g., delivery of services, training, and IEC--with data

obtained from service records and through small specialised studies.

- 6.2. A BDG-donors ex post facto evaluation is under way to measure progress towards goal achievement.

### Planned Outputs of the Project

#### A. Outputs and Output Indicators

The following outputs relate specifically to USAID inputs. In themselves, these outputs will help to create conditions necessary for significant progress towards an effective national institution for population control and family planning. Achievement of the full range of end-of-project conditions, of course, also requires the realization of outputs resulting from host country and other donor inputs. These additional outputs and the related inputs are discussed under "Assumptions for achieving outputs" and "Inputs".

#### 1. Service Delivery--Supply and Logistics System

- 1.1. Contraceptive supplies are deployed throughout the country and are readily accessible to field and clinic program personnel. Based on projected user estimates, in-country supply levels sufficient for one year's use are being maintained, with an additional year's supply on order, i.e., in the pipeline. The following are contraceptive requirements to meet these supply/pipeline considerations (see Annex I for calculations of oral pill and condom levels):

<u>Commodity Type</u>	<u>Est. In Country</u>				<u>Est. In Pipeline</u>			
	<u>FY75</u>	<u>FY76</u>	<u>FY77</u>	<u>FY78</u>	<u>FY75</u>	<u>FY76</u>	<u>FY77</u>	<u>FY78</u>
Orals (million monthly cycles)	11.80	15.50	16.75	20.00	11.50	17.25	31.25	46.15
Gonads(000 gross)	786	923	675	463	217	0	52	352
IUDs (000 pcs)	200	140	240	290	0	200	200	500
IUD Inserters(000)	20	14	24	29	0	20	20	50

1.2. Seven hundred union-level FP/MCH clinics are equipped IUD Insertion Kits. The BDG plans a phased opening of 1030 of these new subcenters (@3 per thana) over the remaining three years of the Plan period. We have agreed with UNFPA/WHO that they will supply the kits required for the balance of the clinics. Clinics will be equipped with the USAID kits on the following schedule: FY76--300 clinics; FY77--200 clinics; FY78--200 clinics.

1.3. Three hundred clinics, hospitals and physicians are supplied with equipment to perform vasectomies at the rate of 100 per year from FY76 through FY78.

2. Service Delivery--Training Facilities.

Four medical college hospitals (Dacca, Sir Salimullah, Mymensingh, and Rajshahi) have established, by converting available space, and equipped family planning clinics capable of providing medical students with practical training in advanced methods of fertility regulation. These clinics will become operational during FY77.

3. Other Output Categories

3.1. Program personnel, whose knowledge and skills have been upgraded through training in the U.S. and third countries, have been assigned in staff positions. No one questions that there will be a large need for staff training. However, inasmuch as the new national family planning organization is only partially staffed at present and implementation of the recast program has not yet begun, the suggested training needs and phasing are, at best, educated guesses and are subject to later revision and refinement based on actual program experience. Persons trained, based on present estimates of need, are the following:

<u>Broad Area of Study</u>	<u>Numbers of Personnel Trained, by Year of Completion of Training</u>					
	<u>(FY) '76</u>	<u>'77</u>	<u>'78</u>	<u>'79</u>	<u>'80</u>	<u>Total</u>
a. Program Management/ Administration .....	5	8	9	3	-	25
b. Demography, Population Dynamics, -Policy .....	-	-	1	2	1	4
c. Research & Evaluation, Statistics, Data Processing .....	4	3	4	1	-	12
d. Education, Communication ...	7	11	11	2	-	31
e. Social Sciences .....	-	-	1	2	1	4
f. Clinical Training .....	2	2	2	-	-	6
g. Training Methods, Materials Development .....	4	4	1	-	-	9
h. Short-term Observation, Conference Participation...	7	7	7	-	-	21
						<u>112</u>

Length of training: 32 long term (12 mo. or more) - 456 m/m  
 59 short term (under 12 mo.) - 207 m/m  
 21 observation, conferences - 21 m/m

3.2. Consultant services have produced the followings:

- a. A capability has been established in the national-level Family Planning Training Institute to plan and direct management training for appropriate categories of program officers. A training program has been planned, based on identified needs, and a curriculum and training materials have been developed, in the course of which the Institute faculty have benefitted from on-the-job training. This will be accomplished by the end of FY77. Quantifications will be determined by the consultant(s).
- b. The Information, Education and Motivation Unit of the FKP Directorate has developed the capability to plan and direct the communication aspects of the family planning program. By the end of FY77, a communication campaign has been designed and is in progress, materials have been produced, and technical inputs are being provided to the nonhealth ministries with population programs. Quantification will be determined by the consultant.
- c. Program staffs of large national organization with activities aimed at improving the status of women have gained the understanding and skills to incorporate family planning information and counselling into their programs; by the end of FY77.
- d. A system has been designed for the recording, reporting, and analysis of the program's service statistics. The

staff of the concerned Directorate unit and field personnel at various levels are receiving on-the-job training in its use, by mid-FY77.

- e. The capability to plan and manage the training function has been established in the PCFP Directorate. This includes the training of field, clinic, and supervisory personnel in the 17 regional training institutes and at district and thana offices.

#### 4. Means of Verification

1. Bills of lading, and arrival reports.
2. BDG reports of distribution of U.S.-supplied commodities to subordinate units throughout the country.
3. Spot checks in the field on supply levels and distribution system.
4. University progress reports on participants in academic programs.
5. BDG personnel records.
6. Consultant reports.
7. Spot checks in ministries/organizations receiving consultants and/or participants.

#### Assumptions for Achieving Outputs

- a. Re USAID-supplied commodities, it is assumed that:
  - aa. UNFPA/UNICEF will provide funds and technical assistance to improve PCFPD's transport and supply systems, including port clearance and storage. The facility for training, vehicle repair, and parts storage has been constructed and practical training is in progress. As of November 1975, the technical advisor nominee in commodity management has been approved by the BDG but has not arrived in country.

- b. Improved stock records and reporting resulting from the above UNFPA/UNICEF input, combined with improved services statistics resulting from a USAID input, will enable the BDG to determine the differential commodity requirements of the districts, as well as to project long-range commodity requirements for the country.
- c. A.I.D.-funded supplies will arrive at port as scheduled.
- d. The BDG, IBRD, and UNFPA will provide the training and salary costs for the various categories of field personnel to insure that adequate numbers of appropriately trained personnel are available to distribute/utilize A.I.D.-supplied commodities.

2. Re family planning clinics at four medical college hospitals, it is assumed that these hospitals have space available for this purpose, that the hospitals or the PCFPD can staff the clinics adequately, and that the medical college faculties are willing to include fertility regulation practice in medical education as a result of UNFPA/WHO assistance in curriculum revision.

3. It is assumed that the BDG will ensure the employment of participant countries on completion of training.

4. It is assumed that the BDG will identify and make available counterpart officers and staffs to work with consultants.

Planned Inputs of the Project

A. U.S. Inputs (bilateral)	FY76 & 1Q		FY77 (est)		FY78 (est)	
	Qty	(\$000)	Qty	(\$000)	Qty	(\$000)
1. Commodities		<u>2,184.0</u>		<u>4,506.5</u>		<u>7,097.0</u>
Type						
a. Orals (million MCs)	11.25	2,025.0	20.0	4,200.0	26.15	5,491.5
b. Condoms (000 gross)	-	-	52.0	270.0	300	1,554.0
c. IUDs (000 pcs)	200	10.0	200	10.0	500	25.0
d. IUD Kits (ea)	300	26.0	200	18.0	200	18.0
e. Vasectomy Kits (ea)	100	8.5	100	8.5	100	8.5
f. Clinic Equip.		114.5	-	-	-	-
	m/m	(\$000)	m/m	(\$000)	m/m	(\$000)
2. Local costs of establishing four new FP clinics(\$000)		<u>56.3</u>		<u>58.3</u>		<u>114.6</u>
3. Participant Training (short- and long-term):	<u>283</u>	<u>292.0</u>	<u>283</u>	<u>268.0</u>	<u>118</u>	<u>124.0</u>
a. Prog.Mgmt/Administration	66	52.2	66	52.2	39	31.0
b. Demog., Pop Dynamkes, Pop Policy	15	11.7	30	23.1	15	11.7
c. Research & Evaluation, Statistics, Data Processing	42	63.3	36	35.0	18	21.4
d. Educ., Communication	117	96.6	90	75.8	12	14.1
e. Social Sciences	18	13.6	36	27.3	18	13.6
f. Clinical Training	6	14.4	6	14.4	6	14.4
g. Training methods, Materials Development	12	23.8	12	23.8	3	8.4
h. Short-term Observation, Conference Participation	7	16.4	7	16.4	7	16.4
4. Consultant services in:	<u>36</u>	<u>264.3</u>	<u>24</u>	<u>166.3</u>	<u>18</u>	<u>150.0</u>
a. Management Training	-	-	6	37.3	-	-
b. I.C	18	135.3	-	-	-	-
c. Women's Progress	6	18.0	6	18.0	-	-
d. Training	12	111.0	12	111.0	-	-
e. To Be Determined	-	-	-	-	18	150.0
Totals:		<u>2,796.6</u>		<u>4,999.1</u>		<u>7,486.6</u>

Means of Verifications: Inputs will be verified by the Project Implementation Orders issued for technical services, participant training, and commodities. In addition, the FP clinic inputs will be verified by BDG personnel records and expenditure reported related to the FP clinics and by inspection of the clinic sites.

Assumptions for Providing Inputs: It is assumed that:

1. U.S. appropriations for Population activities will continue to be available.
2. Prior to signing second and third year ProAgs, the BDG and USAID continue to agree on the program requirements which might be met through U.S. assistance, taking due consideration of the BDG requests to and the plans of other donors.
3. The BDG will make available appropriate staff persons for training in U.S. and third countries.
4. That the BDG will approve the establishment of a national-level Family Planning Training Institute, which will be the counterpart institution of the requested management training consultant(s).

B. BDG Inputs

The MCH/FP budget for the last three years of the Five Year Plan, FY76-78, has been proposed at the following annual levels:

	<u>Total Amount</u>	<u>(\$000 equiv), (011/1)</u>	<u>Including Foreign Exchange Component of:</u>	<u>(\$000 equiv) (011/1)</u>
FY76	Tk. 159,761,380.	11,416.	Tk. 34,383,950.	2,456.
FY77	187,596,204.	13,400.	42,067,050.	3,005.
FY78	195,125,458.	13,938.	46,257,725.	3,304.

This is the budget for only the MCH-based family planning program conducted by the PCFP Directorate. Population-related activities of other ministries and organizations, including the Health Division of the Ministry, are not included.

The foreign exchange component of the Directorate budget is entirely financed by external donors and refers to expenditures outside Bangladesh, e.g., for imported commodities and foreign consultants. Some portion of the taka costs of the budget are borne by donor contributions as well. It has been impossible to separate completely all the donor-funded local costs to arrive at the precise amount of the BDG contribution. However, we have been able to identify the major local cost items to be funded by external resources. The amounts shown below and in Annex J as BDG financial contribution, while not exact, we believe to be reasonable approximations.

The net planned contribution by the BDG to the national family planning program, per se, excluding known donor contributions for foreign exchange and local cost expenditures, is as follows:

<u>Category</u>	(\$000 equiv. @ 14/1)			<u>Total</u>
	<u>FY76</u>	<u>FY77</u>	<u>FY78</u>	
Personnel Costs (salaries and allowances)	4,256	5,436	6,040	15,732
Travel of Participants on National Airline	25	25	15	65
Program Operating Costs*	<u>3,480</u> <u>7,761</u>	<u>3,317</u> <u>8,778</u>	<u>3,335</u> <u>9,390</u>	<u>10,132</u> <u>25,929</u>

\* Includes such operating costs of various organizational units as rental, maintenance, office supplies and postage, utilities, furniture and locally procured equipment, vehicle maintenance and POL. Also includes such program costs as a portion of in-country training, publicity and other communication materials, locally purchased medicines, and a portion of construction costs.

It should be noted that the donor inputs shown in the financial analysis table, Annex J , are considerably larger than the donor-contributed portion of the Directorate's budget, because they include support allocated for the population activities of other ministries and organizations.

C. Other Donors (see Annex G for summary data)

1. UNFPA. In early FY75, UNFPA signed an agreement with the BDG for a \$10 million, three-year program of assistance in the population field. While implementation of some projects is proceeding, others have been delayed pending BDG decisions on their program strategy and organization. Some projects which had been approved are now being revised to reflect vastly changed realities. There have also been delays in the development of proposals by various ministries. Thus, it seems likely that the period of the grant may be extended, perhaps by two years. Principal activities approved and pending are the following:

- a. Expansion of Census data processing and analysis capability, implemented with UNDP and UNOTC.
- b. Population education and services in rural cooperatives, industries, plantations, and trade union institutions, with ILO.
- c. Improvement of transport and supply management systems, with UNICEF.
- d. Training of 1,800 female field workers and approximately 1,200 clinic-based paramedics, with WHO.
- e. Integration of human reproduction and fertility regulation subjects into medical college curricula, with WHO.
- f. Support for establishment and equipping of union-level MCH/FP clinics, with WHO.
- g. Development of Pop/FP communication strategy in the Ministry of Information and Broadcasting, with UNESCO.

- h. Introduction of population education into the professional pre-service training of agricultural extension personnel.
- i. Supplying equipment for mobile sterilization teams, with WHO.
- j. Development of communication cell in the PCFP Directorate.  
(Note: this proposal is still under discussion with BDG and USAID; UNFPA input may be hardware, with USAID supplying technical assistance.)
- k. Involvement of rural youth organizations in population education, with ESCAP.
- l. Introduction of population education into the formal school system nationwide, with UNESCO.

2. IBRD/IDA. Under the World Bank project, assistance totalling \$45.7 million has been programmed for a four-year period. The Bank's projected expenditure schedule, reflected in the Other Donor Inputs Summary, Annex G , and the financial analysis tables, Annex J , was developed in early CY75. At that time, it was expected that the BDG would meet the conditions precedent by April, 1975. In fact, the conditions for credit effectiveness were met only in September. Nearly 60% of the project costs are for construction, an activity fraught with the probability of schedule slippages. When these factors are added to certain limitations in BDG absorptive capacity, it is reasonable to assume that the expenditure time frame will have to be extended. A revised expenditure schedule is expected to be developed early in CY76.

Six bilateral donor countries plus the BDG are associated with IBRD in the project. Respective contributions are as follows:

	(\$000)
IDA	15,000
Australia	2,599
Canada	1,995
West Germany	5,985
Norway	8,342
Sweden	3,000
United Kingdom	3,136
	<hr/>
	40,057
BDG	5,647
	<hr/>
Total	45,704

The project consists of the following components:

- a. Construction, furnishing and equipping and supporting training and training-cum-service facilities. These include a college of nursing, eight family welfare visitor training schools, eight thana health complexes including dormitories for trainees in field practice, 24 union MCH/FP subcenters, and family planning clinics at four medical college hospitals.
- b. Training and salaries for 3,700 union-level female field workers.
- c. Pilot projects to incorporate Pop/FP information and education into the programs of the Ministries of Local Government, Rural Development and Cooperatives; Labor and Social Welfare; Agriculture; Education; and Information and Broadcasting.
- d. Research and evaluation: a) establishment of an evaluation unit in the Health and Population Planning Section of the Planning Commission; b) evaluation studies of the nonhealth ministries' pilot projects; c) a study of determinants of reproductive behavior; and d) a study of the pronatality impact of national laws.
- e. General support for strengthening the population program organization, including management studies, building utilization studies, and a national seminar for political leaders.
- f. Funds for support of selected voluntary organization programs.

3. Ford Foundation assistance in the population field is on the order of \$500,000 per year. A major focus is on a long-range effort to upgrade professional competence in population-related research and education among personnel of universities, the Population Study Centre of the Bangladesh Institute of Development Studies (BIDS), and other institutions and organizations. Funds are provided for small grants to selected research and evaluation studies. Complementary grants are made to small projects, often nongovernmental, with innovative or experimental value. The Foundation has a continuing interest in exploring ways to involve women more actively in the national life. The Population Council collaborates with Ford in providing consultant services to Population Study Centre of the Bangladesh Institute of Development Studies.

4. AID/W Centrally Funded Grants and Contracts

Through FY75, approximately \$2.5 million of Title I funds has been allocated to Bangladesh projects through AID/W contracts and grants to intermediary voluntary organizations. Some of the major activities were referred to in Part II, para. A.3. of the Project Paper. See Annexes G and H for details. Inasmuch as support levels to these intermediaries are determined in AID/W and individual projects may be proposed and approved at any time during the year, it is impossible to project future year inputs. However, we expect that this useful and flexible mechanism will continue to be used and that the varied character of the activities undertaken will not change.

**PART III. Project Analyses**

**A. Technical Analysis including Environmental Assessment.**

The national family planning program has been designed for maximal technical feasibility in the economic, social, and physical conditions of Bangladesh. Specifically:

- Over 90% of Bengalees live in rural areas. Lack of transportation facilities restricts their movement. Most women are not permitted to venture outside of their homesteads. Nearly 80% of adults are illiterate and few rural people have operative radio receivers. The BDG program, therefore, has been designed to bring information, education, and contraceptive supplies directly to the homes by field workers who visit homes regularly.
- Rural communities are traditional and predominantly Muslim. Nearly half of the field workers in the Government's program are to be women, thus facilitating access to the female population. Most of the field workers will be residents of the areas where they work. It is expected that they will have easier entree and greater credibility than outsiders would have in traditional communities which have had limited outside contacts.
- Current estimates place the number of qualified doctors in Bangladesh at 8-10,000. About three-fourths of them are in urban areas. Doctors outnumber nurses by about 10:1. Accordingly, the BDG has authorized specially trained paramedics to insert IUDs, and both paramedics and the nonmedical field workers are entrusted with screening and supplying oral pill clients, thus greatly reducing reliance on scarce medical personnel.
- To ensure continuity of supply to users when regular house call schedules are disrupted by cyclones or flooding, to which Bangladesh is subject, the BDG plan includes provision for stocking contraceptives with village depot holders.

• The program offers clients a variety of methods of birth control-- oral pills, condoms, IUDs, foam, vasectomy, and tubectomy. USAID has supplied and will continue to supply under this project commodities for all of these methods. With other donor--but not A.I.D.--support, the BDG is gaining experience with menstrual regulation in a few selected clinics. The decision to offer a wide range of methods is consistent with recent Population Council research findings showing a significant positive correlation between the degree of success in reducing fertility and the number of methods offered in various country programs.

• The BDG, with support from an AID/W grant to Johns Hopkins University, is evaluating the performance and acceptability of a variety of steroidal preparations and IUDs in the particular health and cultural conditions of Bangladesh. Voluntary organizations and UNFPA are assisting or planning to assist the BDG to conduct trials of injectibles under Bangladeshi conditions as well.

• Because of the early age at marriage of Bangladeshi women and, until now, little attempt by couples to regulate fertility, about two-thirds of a woman's children have been born by the time she reaches 30, with about half of her reproductive years still before her. Therefore, the BDG is taking steps to increase the availability of sterilizations. With A.I.D. and other donor support, training and retraining of doctors in sterilization techniques is to be emphasized. Program administrators are encouraging the use of the mini-laparotomy technique of female sterilization. This procedure is done under local anaesthesia, does not require sophisticated and delicate equipment, and greatly reduces the demand on hospital beds. It is therefore well-suited to local conditions. Similarly, because vasectomy is an out-patient procedure with minimal risks, the BDG is planning to form mobile teams to conduct

vasectomy camps at work project and other easily accessible sites.

. A large number of retail shops already exist throughout the country. They are being tested for their suitability for commercial marketing of oral pills and condoms under an agreement between the BDG and Population Services International, with AID/W funding. Once the national sales program gets under way, the number of total contraceptive supply points is expected approximately to double, and users who prefer this more anonymous and informal method of procurement will have access to very reasonably priced supplies.

In sum, the BDG has taken account of the circumstances in which they must operate and has designed a program which is both technically sound and appropriate.

The program assisted under this project addresses the problem of a population already too large and growing rapidly which is straining the capacity of the land and other resources to sustain it. To the extent that the program succeeds in reducing population growth rate--and sooner rather than later--the impact of the program on the environment can only be favorable.

FAA Section 611(a) and (b) are not applicable.

B. Financial Analysis and Plan

The Financial Plan of Population and Family Planning Project (Annex J) indicates total project requirements of \$104,841,000 which includes both a foreign donor contribution (in foreign exchange for foreign and local costs) and a BDG contribution in local currency over the years 1973 to 1978. The actual amount expended during the period from FY 1973 thru FY 1975 was \$22,788,000. The proposed amount to be expended during the period from FY 1976 thru FY 1978 is \$82,046,000.

The amounts shown as "Other Donor" cost are not only for the Population Control and Family Planning Division, but include foreign donor funds distributed to other BDG agencies for population programs. These amounts in some cases are not yet final, but they are the best figures available for the moment.

The revised First Five Year Plan of the BDG for the proposed Family Planning Scheme which shows the requirement for three years from 1976 to 1978 was analysed for the BDG contribution. The donor contribution information was obtained directly from the donors rather than the estimates of the BDG. The analysis indicates a local currency component and foreign exchange component of 77% and 23% respectively. The foreign exchange portion also includes some amounts which will be spent in local currency.

The sources of the funds for the project will be AID (Mission and Washington), IBRD/IDA, UNFPA, Ford Foundation, and the BDG. The total

contribution over the period from 1973 to 1978 of AID grant funds will be \$23,713,000 1/. The other donor contributions over the same period will be \$44,401,000 and BDG contribution will be \$36,720,000 in taka. The detailed break-down of project costs is shown in financial plan by year and component for both the actual and projected amounts.

Out of the combined contribution of AID, other donors and the BDG to the project over the six year period (1973 to 1978), the BDG's contribution will be 35% and the AID contribution will be approximately 24%.

The actual amount spent during 1973 to 1975 by BDG is about 47% and by AID and other donors is about 53% of the combined total costs of the program. The proposed three year amount will be BDG about 32% and AID and other donor about 68%. The percentage of BDG contribution is higher in the years from 1973 to 1975 but the absolute amount in the latter years will be significantly more than the earlier years. The following is a summary of the contribution by percentage for the project period.

	<u>USAID and other Donors</u>	<u>BDG</u>	<u>Total</u>
Actual (1973 - 1975)	53%	47%	100%
Proposed (1976 - 1978)	68%	32%	100%
Project Total (1973 - 1978)	65%	35%	100%

It is apparent from the analysis of the data presented in the financial plan that with the combined efforts of the BDG, AID and other donors that the BDG program as planned is adequately financed.

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1/ Total amount in log frame summary also includes over \$2 million estimated requirement to pay for unpaid balance of 11.5 MCs of oral contraceptives ordered in FY 74.

The sources of the funding seem secure. The RDG is committed to the program as evidenced by their previous contribution and their planned expenditures evidenced by their Five Year Plan. It is relatively safe to assume that the other donors will continue their programs.

## C. Social Analysis

### 1. Socio-Cultural Feasibility

In considering the socio-cultural feasibility of this project, four cultural characteristics are paramount. First, Bengali society is predominantly rural and dependent on agricultural pursuits for its livelihood. Approximately 90% of the population lives and works in 65,000 villages in rural Bangladesh. Communication with the rural areas is difficult. Roads are poor or non-existent; even small transistor radios are too expensive for the bulk of the rural population; electricity is not available; and 80% of the population is illiterate and, therefore, unable to read any sort of printed media. Further, many villages are completely inaccessible during the monsoon season due to high water. Many rural people, particularly women, never leave the village, unless it is to visit a nearby village to visit relatives.

The "Pakistan National Impact Survey, 1968-69" showed that 75% of all rural women had never visited a city or town. An additional 15% had not visited a city or town within the past year. There probably has been no significant change in these statistics in the past 6 years. Information and motivation for family planning must, therefore, be carried on by means of extensive, frequent personal contact in the villages. For this reason a fairly extensive network of government family planning workers is to be installed at local level.

Second, Bangladesh is 85% Muslim. The Muslim religion imbues its followers with a strong sense of fatalism best typified by the expression, "inshAllah". The will of Allah is a strong factor in the personal lives

and choices of most Muslims. While studies show that most pregnancies are unplanned, the pregnancy may be looked upon as Allah's will. The village imams are no longer as powerful as they once were but their influence is still strong. This influence can be counteracted by respected village elders or local opinion makers. It will be important for the BDG field workers to involve these local leaders in Family Planning motivational efforts.

Third, the rural society of Bangladesh is male-dominated to a degree difficult to envision in developed nations. All basic decisions about family life are made by men. Women are sheltered and protected from outsiders, particularly males from outside the village. A woman has no other role than that of mother and housewife. The number of sons she is able to bear is the key to her status. Because of these factors and because virginity is important, girls are married soon after puberty. Seventy-nine percent of all rural married women were married before their fifteenth birthday.<sup>1/</sup> Thus most women are exposed to the risks of pregnancy throughout their child-bearing years. In this society, women are more apt to desire contraceptive practices than men, assuming they know about family planning methods. It should be noted, however, that family planning in the sense of planning each birth is practically unknown. The Bengalee woman is more likely to wish to cease having children after 4 or 5 pregnancies, simply because she can no longer bear the burden. Thus, sterilization programs are at least equally important as the temporary contraceptive techniques. In any event, it is critical

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1/ "Pakistan National Impact Survey, 1968-69."

that rural women have access to family planning services. Given traditional attitudes, these women will have to be reached by female family planning workers.

Fourth, 25% of all children die before their fifth birthday. This high mortality rate when combined with the traditional role of women has a major influence on the contraceptive behavior of women. The rural woman's ability to produce sons is critical to her status in society. To have at least one and preferably two sons reach maturity is critical to both her own and husband's security in old age. Thus a woman will probably not practice contraception until she and her husband feel relatively satisfied that there will be one surviving son and, as noted above, the burden of too many pregnancies and children becomes too much for the woman. For this reason, female family planning workers will be equipped to provide advice on maternal-child health care.

After considering these factors, it is the conclusion of the Mission that the project is culturally feasible. In fact, much of the project is designed to overcome the cultural obstacles to family planning.

## 2. Spread Effects

### a. The Diffusion of Innovation

This project is not focussed on a particular area in Bangladesh but rather, in terms of project purpose, is designed to reach all fertile couples nationwide. Achievement of the project purpose, however, is substantially dependent on outputs produced by the BDG and other donors. Ultimately, the diffusion of family planning information and services will depend upon the 13,500 female field

cadre of PCFPD and 12,000 male family welfare workers under the Health Division who will be communicating directly with fertile couples at the local level. The operation of these field personnel are described in the Administrative Analysis.

b. Leadership/Authority

As noted above, Moslem beliefs have a deep influence on attitudes toward family planning. Moslem religious leaders, or imams, are no longer as powerful as they once were in influencing behavior. Many village imams, however, believe that family planning is against the will of Allah and this belief is shared by orthodox Moslems in the rural areas. There are other village leaders whose influence is great enough to counteract that of the imam if it is exercised. These local leaders fall into three categories, mattabors, sardars, and gundas. The mattabor is the traditional village elder, who holds his position by dint of age, respectability, wisdom, and, usually, family status. He normally sets the standard of moral behavior in the village and is the adjudicator of disputes between families within the village. Depending on its size a village may have more than one mattabor in which case a non-formal village council may be in effect to handle major problems for the village.

The second type of leader, the sardar, is an economic leader, i.e. the well-to-do of the village. Normally, the sardar is the largest farmer in the area, although occasionally he may have other sources of wealth. He is usually the more innovative farmer in the area, e.g. the first to adopt high yielding varieties,

irrigation pumps, fertilizer, etc. In many instances, the sardar and the mattabor may be the same person but the sardar, because of his wealth, is the more politically influential with thana and district level government. Villagers look to the sardar to deliver government resources to the village. Traditional politicians look to the sardars as the base of their local political support.

The gunda, or village strongman, is somewhat analogous to the popular American concept of the Mafia godfather. Feared by the villagers because of his propensity for violence, he often becomes the most influential leader when law and order break down. Gundas are often employed by sardars to settle economic or political disputes.

Normally, the gunda would not have influence on family planning attitudes. Mattabors and sardars most definitely will have an influence. Of the two, the sardars's role is most apt to be the key one. USAID personnel, in speaking with sardars, have noted that they not only find family planning acceptable but are quite open that they practice family planning. This may be because they have a keener appreciation of what family planning means economically to them and their children plus their ready access to government services, including family planning, at the local level. The sardar is in the best position to demand that family planning services be delivered to his village.

The one drawback to use of the sardar in influencing behavioral attitudes is his perception of his own interests. It is highly unlikely that he will be motivated by solely humanitarian interests. He will have to be persuaded that he has a personal economic and social stake in the well-being of his fellow villagers. This can, perhaps, be done by pointing out that he and his fellow sardars cannot exist as islands of wealth in a sea of poverty without adverse consequences.

c. Patterns of mobility

The section on social-cultural feasibility noted that women are fairly immobile, tied to their houses and villages. Men are slightly more mobile but are unlikely to migrate long distances. The exception to this are the landless poor who migrate frequently, looking for work.

These patterns of mobility, or immobility, are the same in the vertical economic and social sense also. It is unlikely that one can expect to improve one's economic lot except very marginally. For most people, the avoidance of regression down the economic ladder is a larger factor.

It has already been stated that because of geographic immobility, low literacy rates, and other factors, villagers will have to be reached in their home villages by government family planning workers. Thus, the mobility of family planning workers is critical. As previously noted, communication and transportation are very poor, with many villages completely isolated during the monsoon.

Government workers will have to be motivated to get out to the villages and will have to be provided the means of transport to do so. USAID and UNICEF have supplied a large number of bicycles for field level workers under past agreements. USAID Population officers have suggested to the BDG that they approach the Japanese for both two and four-wheel vehicles. Thus far, however, no action has been taken.

### 3. Social Consequences and Benefit Incidence

The Economic Analysis section calculates the social benefit to the nation of an averted birth. If the project purpose is achieved no groups are apt to be adversely affected since no group has a vested interest in couples having more children than they want. Some groups, however, will benefit more than others, at least in the short term. The most immediate beneficiary will be the mother. First, she will face the risks associated with pregnancy less often. Second, fewer children represents a lessening of her work burden which is financially non-remunerative. Third, and as a result of the first two, she should be healthier. Fourth, with few children to look after she may be able to devote her time to pursuits which have an economic return to the family, e.g. cottage industry, vegetable gardening, etc.

The children which parents choose to have are the next important beneficiaries. Assuming that the family income remains relatively stable they should be better fed, better educated, better clothed, and generally better cared for since the family income does not have to be stretched as far. Husbands and fathers will benefit due to less pressure on them as

breadwinners. In the sense that the entire family benefits, even elderly people should benefit since they normally depend on their grown children for support during their old age.

The main social consequence of a successful program is likely to be the increase of the woman's influence in family life, particularly since the behavioral attitudes toward her status in the family will be heavily modified. If these attitudes are modified and if she able to use her time in a more economically productive fashion, she will have greater independence and a greater authority in family matters. This would represent a minor social revolution. Of course, if power or authority is reviewed in a zero-sum context, the husband may then be said to lose authority or power within the family. It does not seem likely that he will perceive things in this fashion but if he does, it must be weighed against the economic benefits which will also be accruing to the family.

Ideally, one aspect of the family planning message should be to encourage people to plan ahead, to anticipate consequences of actions, and to have confidence in their ability to affect their circumstances. In promoting family planning, people are urged to adopt an innovation, to engage in behavior which is nontraditional, and to establish and maintain contacts with groups outside the community.

All of these (ideal) characteristics of family planning are, of course, the classic catalog of modernity. Theoretically, one would suppose that a Bengali family who adopted birth control practice would have moved some distance from the traditional and towards the modern end of the continuum. This, one intuitively feels, would have a liberating and modernizing effect on other facets of family and community life. Thus, successful promotion

of innovations and new ideas in agriculture, family planning, health, nutrition and education should all interact in a mutually supporting way.

Other social consequences are not easy to predict. Certainly, over the long-term, the fact that social services do not have to be stretched as far as they normally would will lead to better education, health, etc. On the other hand, if the population growth rate is not brought under control the consequences are apt to be mass starvation, widespread violence, and other Malthusian horrors.

D. Economic Analysis

1. Incentive Schemes to Encourage Acceptance of Population Control

As will be shown in later sections of this economic analysis, in Bangladesh the case can be made that unchecked growth of the population is causing such dire social and economic consequences that the population program should include economic rewards to induce people to "recalculate" their desires for additional children.

The Government of Pakistan had such a program that provided (Rps) Tk 50 per vasectomy, but due to false reporting and poor case selection, the BDG dropped this program because it was difficult to administer and viewed as uneconomical. However, if out of 100 vasectomies reported, only 20 actually took place, and if out of these 20, only 5 were effective in terms of preventing births, the cost per effective vasectomy would have been Tk 1,000 rather than Tk 50. Even at this level, at today's prices Tk 1,000 is equal to approximately 1/3 of the social cost to the government of supporting an additional birth as outlined below.

Because it has been shown that in Bangladesh a woman's fertility decisions are determined by and large by her husband, and because the husband handles the budget, incentive schemes may offer greater scope for reaching the primary decision maker. Incentive schemes should focus primarily on those couples who may be encouraged to permanently limit their family size through sterilization. Over time the objective of such a program would be to urge acceptance of a smaller and smaller family norm.

It can be assumed from existing data that the average number of live births per woman is slightly over six, and the social benefit of preventing each birth is approximately Tk 2,800. The public program cost per tubal ligation or vasectomy may be on the order of Tk 100-250, which still leaves excess "social benefit" which could be shared with the recipient as an incentive. These costs have to be compared to the possible social benefit of averting one, and as many as 2-4, births per couple, depending upon age and other fertility related factors. The cost-benefit analysis clearly shows that a considerable amount in terms of immediate or deferred payments in cash or kind could be paid per acceptor. We have chosen to discuss two types of deferred payment systems below.

In Bangladesh we believe there is a large and growing demand for sterilization that cannot as yet be met due to lack of trained physicians. Even with mini-laparotomy, the hospitals and staff tend to be cautious and keep their patients for two to five days. The operation thus becomes expensive. Therefore, we wish to popularize vasectomy which involves a less complicated out-patient procedure. We believe that some form of monetary incentive will bring about a demand for vasectomies.

However, because we are concerned with the possible problem of buying decisions of the poor, or creating unhappy clients once the money is spent, we propose to discuss now and to develop at a later stage a project proposal to test two incentive schemes that have been suggested by population program personnel over the past several years.

Noting the savings to the nation of a birth averted, we plan to propose a Taka 1,000 bond be paid to a vasectomy acceptor who has two children;

Taka 800 to an acceptor with three children; Taka 600 with four children; and Taka 400 with five children. Each bond would be redeemable in four yearly installments at local banks. The first payment would be authorized one week after surgery during the post-operative check-up. Dividing the payments would reduce the chances of buying decisions for immediate cash and would hopefully keep a client in a satisfied frame of mind for four years and thus identifiable for program communication purposes. The bond would be transferable to the wife should the husband die.

The second program we wish to test would be the issuance of a free life insurance policy on the eldest son, or if no son, on the eldest daughter of a vasectomy acceptor. The policy would pay off if the child dies before the father, thus compensating for lack of a social security program. Again, policy values could be adjusted to the number of living children already born to a couple. An insurance policy program would be least likely to be associated with buying decisions; would create a form of a social security program for a selected clientele; and could be managed by the life insurance company.

The delivery of sterilization services can be implemented through hospitals, thana health centers, private clinics, and by use of mobile vasectomy teams at major rural works sites. The overhead costs (and risks) of these operations are quickly being reduced by new technologies. Two model clinics in Dacca are teaching doctors these newer techniques each month and the UNFPA has proposed supporting up to 19 mobile vasectomy teams this next year.

Once we are confident that qualified staff is available to deliver services, some financial arrangement should be made with the private medical sector to increase their involvement in the program. At this

point, a major communications effort using all media, village markets, and program field workers would be implemented to advertise and explain the program.

## 2. The Macro Economic Effects of Population Growth

An additional 2.4 million new people each year is only part of the population problem. The burden of an unchecked population growth rate is also compounded by the 50% of the population under 15 years of age, and therefore dependent; and by the some 800,000 net additional people each year seeking work. The food, shelter and education requirements of the first group, and the employment creation needed for the second group become staggering.

The consumption needs of each year's additional population are necessarily added to the backlog of unmet needs for the total population. The economy's ability to provide for its additional numbers, and its whole population, is compounded by the fact that production increases require even larger investments. Even in an unsophisticated economy this "capital-output ratio" may be a low two to one, i.e., each taka of output requires an investment of two takas. (Development generally entails a process of capital deepening, which is a way of saying that with each Annual Plan the capital-output ratio goes up). Added to the cost of the future is that of maintenance for the present; a portion of each year's national output has to be spent for the maintenance of this existing economy--for factory, house, and equipment repair--which subtracts from the economy's ability to supply the additional population with the same set of goods and services that the existing population consumes. In Bangladesh it is estimated that two percent

of the national income is spent for maintenance of the existing capital stock. As a consequence of these two facts, providing for the additional population becomes more costly, and unmet needs of the existing population remain unmet.

In arithmetic terms the investment rate would have to be as high as 8% to even ensure a stagnant per capita income level for a population growth rate of 3%. This is calculated by adding the two percent needed for depreciation to the capital-output ratio of 2, times 3%--the population growth rate, i.e.,  $2\% + (2 \times 3\%) = 8\%$ . Since Independence the domestic savings rate has been 4-5%, not the minimally required 8%. Foreign aid only imperfectly makes up the difference. Real capital income fell 20% in the two years after Independence and only recently has it started to recover.

It is also worth emphasizing that the choice of development strategy has a direct bearing on the capital-output ratio and therefore on the cost of population maintenance. Sophisticated technologies consume more capital and provide less employment than "more appropriate" choices of technique and organization. Inappropriate developmental strategies can have the effect of negating hard won decreases in the population growth rate.

Some people have noted that there is severe underemployment in agriculture and have gone on to conclude (erroneously) that industrial growth is the necessary alternative. This "trickle down" strategy de facto relegates most of the additional labor force to idleness as the incremental capital-output ratios are higher in industry (3.55 to 1) than in agriculture (0.8 to 1). Additionally, a given investment in industry employs fewer people than a similar level of investment in agriculture. According to

FY 74 national income data, the capital cost of a job created in manufacturing was Tk 97,000; and in agriculture, Tk 3260.

3. Bangladesh and Other Developing Countries - Preconditions for the Acceptance of the Small Family Norm

Recent articles by William Rich 1/ and Robert E. Hunter, et al 2/ have popularized a theory that has been circulating among population experts for some time; namely, that it is possible to achieve a demographic transition prior to achieving the development standards of western countries if the development strategy is predicated upon growth with equitable distribution. The economic and social indicators table in the Hunter article provides evidence that falling population growth rates are associated, or follow, government efforts to improve per capita income, employment rates, land tenure, infant mortality, and literacy. While these data do not "prove" the case, they are persuasive that the respective development strategy of the Philippines, Taiwan, and Korea are contributing to a reduced population growth rate while the strategies of Mexico and Brazil are not. It is also apparent that no single variable is the key but that the government has to introduce reforms across a broad front.

Whether viewing the stable and high population growth rate or its discouragingly low economic and social indicators, it is clear that Bangladesh is still below the social and economic standards of other IDCs. Comparison of Bangladesh data with cross country economic indicators included in the Hunter table supports a broad-based agricultural strategy on population

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1/ William Rich, "Smaller Families through Economic Progress", ODC 1973.

2/ Hunter et al, "A New Development Strategy? Greater Equity, Faster Growth, and Small Families", ODC 1972

control grounds. However, it remains to be seen whether the small family norm will be increasingly accepted by a 1976 population which is still far poorer than its regional neighbors.

#### 4. The Consumption Burden of an Additional 2.4 Million People

New mouths consume very little in an aggregate sense. However, a considerable resource burden is implied if each maturing age cohort is to be supplied with the minimally necessary goods and services. A macro analysis disguises the specific burdens that fall upon individual families and the government. This burden falls on top of existing unmet needs, and when the annual growth rate in real terms is only 1 or 2%, it is clear that marginal (and therefore average) improvements per capita are impossible.

The private burdens are more difficult to evaluate than the public. Family pressures can become so severe that members are pushed into a state of destitution during times of crisis. Additional children cannot receive schooling and more of the family's resources have to go for maintenance and housing. Average farm sizes are believed to have dropped 30-40% in the last 15 years.

The annual public costs include the supply of foodgrain of some 373,000 MTs (@ 15 ozs. per day) at a cost of \$75 million (@ \$200 per MT of wheat); the supply of edible oil at \$2 million; and eight yards of cloth per capita at a cost of \$11 million, for a total of \$88 million per year. Costs of education, health and other public services are additional.

There are presently some 9.3 million children in school (primary and secondary) out of a school age population of 22 million. An additional 11,000 schools and 60,000 teachers are needed each year just for the incremental growth of school aged children, yet only 9,000 new teachers

are graduating each year. At present there are only some 33,000 primary and some 7,000 secondary schools and 115,000 primary teachers and 50,000 secondary teachers. At least an additional 165,000 school teachers would be needed if all eligible children were in school. It is clear the overall educational establishment is deteriorating.

5. Calculating the Social Benefit of an Averted Birth

The cost of unchecked population growth in poor countries is intuitively obvious, and increasingly this cost is being quantified. Setting aside methodological issues for the moment, the social return to the prevention of an additional birth is positive, i.e., population control is needed, and the social return in Bangladesh according to the only available study, by A. R. Khan, places the benefit at Tk 1,918 (1972) per averted birth.<sup>1/</sup> (A similar study for Kenya by PSI<sup>2/</sup> places the social benefit at \$223 or Tk 3211). Expenditure allocations to achieve a targeted birth rate reduction would therefore be warranted up to the level of Tk 1918 for each birth aversion required. Actual expenditures have been less than this (as will be noted in a later section) which suggests that the Government could increase social welfare (in the sense of freeing up resources for development) by allocating additional funds to an effective population control program, if lack of funds is judged to be a limiting factor in increasing contraceptive practice.

The Tk 1918 figure has been calculated by comparing the entire stream of benefits created, and costs entailed, by each individual over the course

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<sup>1/</sup> "The Cost of Population Growth" Ministry of Health and Family Planning, 1972.

<sup>2/</sup> "Population Services, Inc. "A Study of the Social Costs and Benefits of Implementing a Nationwide Non-Medical Contraceptive Social Marketing Program in Kenya", 1973.

of his or her life--in Bangladesh--of 48 years. Using an interest rate of 15% the present value of all projected benefits (i.e., the individual's net contributions to production--namely agriculture) are discounted to the present. Similarly, the value of goods and services, both public and private, consumed by this individual are discounted at the same rate to the present. These streams of costs and benefits, similarly (shadow) priced and discounted, are then compared for their absolute difference, i.e., Tk 1918 under Khan's assumptions.

There are many technical points that do not seriously alter this analysis. The one assumption that needs to be aired, however, is that A.R. Khan has assumed that the productivity of an additional laborer is zero, i.e., that he contributes nothing by his labor to total agricultural production. In light of recent increases in landlessness and destitution, this is certainly true for some groups of people, and as a generalization probably holds for the population as a whole. (However this assumption certainly runs contrary to the perceived benefits--however faulty--by farm families of additional children. It also runs contrary to the actual returns to labor in HYV areas). Be that as it may, the Tk 1918 figure is an evaluation of only the costs of an individual's consumption requirements (foodgrain) over his life, as A.R. Khan has assumed laborers' net contribution to be zero at the margin. Khan has not attempted to evaluate the cost of all goods and services which an individual consumes, such as cloth, edible oil and schooling. Because he has used food, the single largest item, as a proxy, he has understated the social benefit on an averted birth.

Agricultural labor productivity is certainly low if not zero, and given the rise in international commodity prices, particularly grains and fertilizers, it cannot be claimed that the cost of human maintenance has decreased. Precisely because the Government is not finding productivity employment for 800,000 new laborers a year, a low (if not zero) marginal productivity assumption is safe.

Using A.R. Khan's discounted present value formula, his Tk 1918 estimate is recalculated in light of the international commodity inflation of the last three years. If we apply a 50% increase to the foreign exchange cost of an annual consumption package of goods and services in Bangladesh (e.g. to rice, adjusted by .6 to shadow price the taka), we obtained a new discount present value of all future costs of Tk 2877.

If we remove A.R. Khan's assumption that the marginal productivity of labor is zero and assume instead that each laborer's net contribution (qua labor) is 1/4 MT of rice per year then the present discounted value would be approximately Tk 876. Applying this to our recalculated present value of consumption costs, we obtain a net social benefit of a birth averted of Tk 2001. This lower figure attributes some employment benefits from the introduction of HYV nationwide (which for our purpose here is assumed to be premature).

The actual program cost of averting one birth is calculated by estimating the total number of fertile years (ages 15 through 44, or 30 years) and the average number of births per woman (which in the case of Bangladesh is 6.2). From this procedure the average cost of averting one birth therefore depends upon the effective delivery and utilisation of a contraceptive method to either spouse over a five year period. A five year

supply of condoms from the market costs Tk 183 or of pills costs Tk 520. Most contraceptive supplies are available free through the Government's programs, but their real costs need to be recognized.

On the basis of our new calculations, we obtain a benefit cost ratio of 15.7 to 1 for condoms and 5.5 to 1 for pills. The social rate of return for this kind of public investment is very easily the highest of any possible public developmental activity.

6. The Government's Population Control Program

The Five Year Plan Population Program is designed to cause a birth rate reduction from 47 per 1,000 to 43 by averting 1.1 million births in order to achieve the targeted population growth rate reduction from 3.0% to 2.8% by the end of the Plan period--by FY 78. (This target takes into account a death rate reduction from 17 per 1,000 to 15). It has been estimated that during the first two years of the Plan, between 275-300,000 births were averted which leaves a remaining target of 800-825,000 to be achieved in the remaining three years. On a straight line basis, the FY 76 target becomes approximately 270,000.

In section V the social benefit of an averted birth was estimated to be Tk 2,877, say Tk 2,900. The Five Year Plan target of 1.1 million births averted implies a social benefit (resources freed) of Tk 316 crore. Or in terms of the remaining target, Tk 233 crore. The resources costs of not averting these births is real enough as has been enumerated in section IV.

The family planning program in the FY 76 ADP is allocated Tk 17.35 crore. The births averted target for FY 76 is approximately 270,000. From this it can be estimated that the social benefit is Tk 78 crore, and the cost

Tk 17 crore. The actual cost per birth averted--including overhead costs-- is Tk 643 per averted birth. The same overhead costs could minister to a much greater delivery of contraceptive services.

Care has to be taken to ensure that the high social benefit of an averted birth is not used as a way to disguise program inefficiencies. If the Government was to rely entirely upon market sales of pills and condoms to avert 270,000 births a year (by way of example) the cost at current market price for a pill program would be Tk 14 crore ( $270,000 \times 5 \times (500 \div 5)$ ); and for condoms would be Tk 5 crore ( $270,000 \times 5 \times (183 \div 5)$ ). These prices reflect scarcity prevailing for imported goods.

Similarly a public program of tubal ligations would cost Tk 7 crore, and Tk 3.5 crore for vasectomies. (These estimates are based upon \$6 and \$11 per vasectomies and tubal ligations respectively plus overhead costs of 50%, calculated at the official rate).

Based on estimates of currently protected couples and what we believe to be plausible projections of contraceptive adoption and continuation in FY 76 and Interim Quarter, the following are estimates of births to be prevented in FY 76 and IQ:

<u>Method</u>	<u>Couple Years of Protection</u>	<u>Births Averted</u>
Oral Pills	365,400	73,080
Condoms	357,120	71,424
IUDs	116,500	23,300
Sterilizations	358,336	71,667
Foam	93,750	18,750
		<u>258,221</u>

While this does not appear to be disastrously short of the hoped-for 270,000 births averted in the 4-quarter BDG FY 76, it does point up the need for more efficient use of program resources. By FY 77, the new FP organization should be fully staffed, which should result in a substantial rise in adoption and continuation trends after FY 76.

#### 7. Conclusions

It has long been recognized that choice of development strategy has a great impact on the rate of growth of per capita income. In most countries these calculations are of passing interest; in Bangladesh they will make the difference between a deteriorating level of living and some very modest growth. Hard won gains in population control can be easily erased. The experience in other LDC's supports the thesis that growth with equity will "cause" a lowering of the birth rate, but it remains to be seen whether economic security can be improved by modest improvements in a level of living that is the world's lowest. The burden of supplying the existing population with a minimum package of goods and services is not being met; an additional 2.4 million people each year compounds this unmet need. "In 1974-75 Bangladesh received about \$12 per capita of external assistance. Gross investment converted at the official exchange rate was below \$10 per capita. If net investment is used and the conversion is made at an exchange rate reflecting more closely the purchasing power of the taka, the figure would be still lower. What this means is that domestic savings in Bangladesh were substantially negative and that a considerable portion of external assistance was in support of consumption." (Ref. IBRD, May 1975 page 26).

Alternative development strategies offer only a partial solution; an aggressive population program is an absolute requirement. Over time the social benefit of each averted birth will increase as labor productivity falls, as the cost of food and other consumer goods rise, and as the social burden of millions of destitutes becomes intolerable.

Present BDG population resource allocations are inefficiently utilized. The high social benefit of an averted birth is an argument for an expanded program, and incentives, not ineffectively utilized overheads. Our analysis strongly supports the expansion of incentive schemes, permanent forms of birth control, and the use of the private market. These approaches need to be expanded rapidly to reach rural gathering points.

PART IV. Implementation Planning

A. Analysis of the Recipient's and AID's Administrative Arrangements

1. Recipient

The key host country organization in the implementation of the project is the Directorate of Population Control and Family Planning. Headed by a Director-General, the Directorate executes the national MCH-based family planning program through its three operational units--Service Delivery; Planning, Statistics, Research and Evaluation; and Information, Education and Motivation. The field structure at subordinate levels is under the supervision of the Directorate. The linkages in this administrative structure have been described in Part II.B.

Counterparts for most of the A.I.D.-supplied consultants under this project will be Directorate personnel. Consultants on supply management will work with the chief supply officer under the direction of the Director, Service Delivery. Under the same Director, the training advisor will work with the Deputy Director (Training) on management of the training function. The service statistics consultant's counterpart will be the Deputy Director (Statistics and Evaluation), with supervision provided by the Director of Planning, Statistics, Research and Evaluation. Similarly, the communication consultant will work with the Director of the IEM Unit and his staff, and the counterpart for the consultants in management training will be the principal of the proposed Family Planning Training Institute.

The Directorate is the operational arm of the Population Control and Family Planning Division (PCFPD) of the Ministry of Health, Population Control and Family Planning, which is headed by a Secretary. In its capacity

as secretariat for the National Population Council and the National Coordination Committee, the PCFPD carries out the policy and intersectoral coordination decisions of those bodies.

The other principal BDG organization concerned with the project is the Health, Family Planning, and Social Welfare Section of the Planning Commission. The Section is responsible for technical review and approval of all population/family planning plans and proposals, whether they are BDG- or donor-funded. In this capacity it shares responsibility with the Division and the Directorate for coordination of donor activities.

There are acknowledged administrative difficulties, most of which are common throughout the government--features of the administrative environment. Among these are the following:

- a. Program personnel and other concerned persons have little role in decision making and administrators are deprived of vital information because of inadequate communication--vertically and horizontally within an organization and laterally among organizations.
- b. Seniority is given more weight than merit or technical competence in filling positions.
- c. It is difficult to protect an effective incumbent from routine transfer to another government department.
- d. Employees are rarely terminated for incompetence.
- e. Supervisors are used as inspectors rather than for staff development and helping staff find solutions to problems.
- f. Unsuitable candidates are often hired because they have been recommended by influential persons.

Beyond the problems presented by these aspects of the bureaucratic subculture, there have been certain recent events and decisions whose administrative consequences are imponderables, for the moment.

- a. As noted in Part II, para. A.2., for the first time since Independence, responsibility has been assigned for key functions of the program. We assume this will have a salutary effect on the morale and motivation of staff and, in turn, on program performance.
- b. Until now, little decision-making authority has been delegated by highest levels of government, with consequent delays in resolution of issues and in authorization actions. There was also considerable politicization of the bureaucracy until the recent past. It may be some time after the present period of political uncertainty stabilizes before it is known to what extent these administrative obstacles will be removed.
- c. In the reorganization of the family planning organization, some flexibility in assignment of personnel and expenditure of funds was lost when the Directorate assumed the functions of the Family Planning Board, which had been a semi-autonomous organization. To what degree this diminished flexibility will be a significant handicap to effective management is not yet evident.
- d. The continuing debate about whether family planning should be a separate program or integrated with health services has resulted in strained relationships between the two Divisions of the Ministry. This is unfortunate, since many of the facilities and staff under

under the Health Division, including the 12,000 male Family Welfare Workers, are assigned an important role in the program. Unless the contending factions can put the country's needs and the program's objectives above jurisdictional and personal considerations, these unresolved differences will continue to be damaging to the program.

In addition to problems relating to administrative environmental factors, there are others attributable to a need for increased staff competence. These are deficiencies which can be overcome without rendering the organization a misfit in the national bureaucracy. Some of the A.I.D. and other donor inputs, such as training and consultant services, are aimed at this kind of problem and are in response to BDG requests for assistance specifically in the area of developing administrative competence.

For problems relating to the "system", donor efforts to assist are principally in continuing the on-going candid discussion with host country officials about program status and actions which might facilitate program implementation. It seems obvious that if the BDG fully realizes the urgency of their population problem and are serious about their commitment to solve it, they would be able to justify taking extraordinary measures to cut through bureaucratic constraints. Problem areas which are appropriate to consider for such actions would include personnel assignments, flexibility in expenditure of funds, delegation of decision-making authority, and upgrading the priority status of population/family planning in review and approval actions by other ministries and in allocation of transportation facilities.

Host country officials, both in the program and at high levels of the Government, have shown themselves to be receptive to ideas, criticisms, and views from other perspectives. The maturity demonstrated by many BDG population program-related officials in their analyses of problems and their capacity for self-criticism augurs well for the future of the program. However, total solutions will not emerge quickly. Experience to date cautions against being overly sanguine about achieving maximum efficiency in program implementation in the short term.

2. A.I.D.

During the course of implementation of the project, a number of AID/W inputs will be required, such as:

- a. Action on Project Implementation Orders.
- b. Review and revision of the financial and contraceptive tables of the Annual Budget Submission.
- c. Critique of quarterly reports of users and prevalence of contraceptive use, as an aid in projecting future-year contraceptive requirements.
- d. Response to USAID requests for short-term consultants under AID/W contracts. For example, we may require the periodic services of a logistics consultant, in view of our heavy inputs of commodities. There may be a need for a family planning physician/medical educator to advise on the integration of practical fertility regulation training in medical college family planning clinics.

At present, the USAID Health and Population Division staff consists of two U.S. direct-hire, one Bengali professional, and one Bengali

professional, and one Bengali administrative/clerical employees. For some time we have been requesting the addition of one U.S. and one or two Bengali employees in order properly to discharge the responsibilities of the Division. These include the administration of a sizeable assistance project, monitoring the progress of the BDG program, preparation of program documentation (the major part of which is the technical division's responsibility in this mission), meeting AID/W reporting requirements, making field visits, maintaining liaison with other donors, and sustaining an on-going professional dialog with population program personnel. With the broadened range of activities under this project, the administrative and monitoring work load will increase accordingly. While the A.I.D. project monitors of AID/W contracts and grants with projects in Bangladesh are based in Washington, the USAID staff is required to keep currently informed on the progress of project implementation. We will continue to press for the augmentation of the Population Division staff.

Nearly all of the funds to be expended under this project are to be subobligated under PIOs for the procurement of commodities or training and consultant services. Disbursements will be made under standing A.I.D. procedures. The small amount of funds to be used for the local currency costs of establishing and operating four family planning clinics will be advanced to the BDG through an intermediary such as Pathfinder, and against a mutually agreed budget and expenditure schedule under terms to be specified in the Project Agreement.

B. Implementation Plan

This project paper covers three years of additional Title X grant assistance in continuation of A.I.D. project support that began in FY73. The initial component of the project as set forth in this paper would be financed in FY76. Subsequent Project Agreement funding and levels of assistance as described under U.S. Inputs would be adjusted each year to reflect program progress. The timetable presented below includes some major activities that are supported by other donors and the BDG. This is done because combined inputs are required to accomplish the project purpose.

<u>AID Grant</u>	<u>BDG/Other Donors</u>	<u>Target Date</u>
	Approval of BDG Pop Program Plan	Dec 75
Transmittal of Project Paper to AID/W		Dec 75
	Recruit and begin training 1,500 female field workers and 1,500 supervisors	Jan 76
	Staffing of Pop Control & FP Directorate substantially complete.	Jan 76
Approval of project paper by AID/W, including identified SPA waiver		Feb 76
Negotiate and sign ProAg PIO/Cs, PIO/Ts and PIO/Ps for first year project support		March 76
Resident hire women's program advisor available for project on part-time basis		March 76
AID/W approval of Mich/USA project	Agreement reached on U of Michigan technical support for research and evaluation	March 76

<u>AID Grant</u>	<u>BDG/Other Donors</u>	<u>Target Date</u>
TDY of AID/W training advisor to conduct review of BDG staff future training requirements and alter training schedule as necessary.		March 76
Select intermediary for hospital fertility clinic review and complete plan design. Intermediary to implement.	BDG assign counterpart for planning and implementation	March/April 76
	Agreement reached on training of medical students in hospital fertility clinics	April 76
	Recruit and begin training of 4,500 female field workers and 1,500 supervisors	June 76
	Establish and post staff to 300 union subcenters	June 76
Arrival of IE&C advisor for 18 month assignment	BDG provides office & admin support	Aug 76
Arrival of training advisor for 12 month assignment	BDG provides office & admin support	Aug 76
Departure of long-term participants		Sept 76
TDY of AID/W logistics consultant to review supply/distribution activity		Nov 76
	Recruit and begin training of 4,500 female field workers and 1,500 supervisors	Dec 76
Joint AID/USAID/BDG review of program progress		Jan 77
Negotiate and sign FroAg, PIO/Cs, PIO/Ps, and the PIO/T for management training consultant for second year project support		March 77

<u>AID Grant</u>	<u>BDG/Other Donors</u>	<u>Target Date</u>
Arrival of management training advisor(s) (short-term)	BDG office & admin support	June 77
	Establish and post staff to 365 subcenters	June 77
	4 fertility clinics operating in medical college hospitals	Sept 77
Departure of long-term participants		Sept 77
TOM of AID/W logistics consultant to review supply/distribution activity		Nov 77
Joint AID/USAID/BDG review of program progress. Decide upon additional consultant requirements. Determine future year assistance.		Jan 78
AID/W provides demographer and statistician to assist BDG in analyzing program accomplishment and in designing study to measure progress towards goal achievement at end of PYP.		Jan 78
Negotiate and sign ProAg, FPO/Cs and PIC/Ps for third year project support. Issue PIC/Ps as required based upon January review.		March 78
	Establish and post staff to 365 subcenters	June 78
Departure of long-term participants		Sept 78

The project as described in this paper will be monitored by the Health and Population Division of USAID in conjunction with the Population Control and Family Planning Division of the Ministry of Health, Population Control and Family Planning and the relevant Directorate. Monthly reports on commodity arrival and distribution will be provided to USAID by the Ministry as will monthly reports on acceptors of contraception by method for each District.

The Commodity and Logistics Section of USAID will monitor the arrival of all USAID-supplied commodities at port and will provide the Health and Population Division with reports on problems of port clearance and information on spot-checks on commodities distributed throughout the country. This information will be compared with information that will be made available to USAID from the commodity/logistics advisor posted to Bangladesh under the UNFPA/UNICEF logistics project.

The four fertility clinics to be established at the medical college hospitals will be designed and implemented through an intermediary such as Pathfinder with funds provided under the Project Agreement. This intermediary shall have the responsibility to monitor these clinics through an on-site review at least once a year for three years from start of implementation.

The participant training schedule included in the project paper has been reviewed with the BDG on several occasions. Some of the projected training requirements were developed prior to complete staffing of the various population organizations. USAID has reserved the right to bring in a training consultant to review staffing patterns, previous training and future training requirements with the BDG. This condition has been accepted. Moreover, the BDG has agreed to fund the travel of the selected

participants to the furthest distance the national airline travels. While USAID is in agreement that a major training effort is required over the next several years, and agrees with the type of training requested, we do expect to have some difficulty with the actual trainee selection process and the timeliness of processing participant training documentation.

Technical advisors requested by the BDG have been discussed in-depth and needs have been revised over the past few months. Each advisor has been assigned a counterpart and supervisor. The need for top quality advisors is recognized. The BDG reserves the right to review nominations. USAID believes there may be difficulty in recruiting long-term advisors for less than 18 months and has so informed the BDG. As the program proceeds, additional consultant requirements may be identified and requested.

Beneficiaries of this project assistance are ultimately the end-user of the birth control services. Reports from several large voluntary agency field projects and reports that result from USAID field visits and discussions with BDG program personnel will form the basis for obtaining the views of the beneficiaries. On the national level, continuing review of the activities of the technical advisors and discussions with their counterparts and supervisors as named by the BDG will provide feedback on the quality and usefulness of the assistance provided.

In addition to the above, the proposed joint AID/USAID/BDG review of the project each year prior to signing the second and third year Project Agreements should provide sound analysis for decision making. The standard USAID yearly project evaluation which will be conducted with the assistance of the USAID Research and Evaluation Officer will provide necessary feedback for project correction or modification.

C. Evaluation Plan

A major component of this project is to establish a functioning Planning, Statistics, Research, and Evaluation Unit within the PCFP Directorate. By the end of this project, this unit should be capable of conducting evaluations of BDC population programs. It is anticipated that personnel of this unit will participate in evaluations over the life of the project but in the initial evaluation in January, 1977, the primary responsibility will fall to the USAID staff.

Throughout the project the USAID commodity and Logistics Section will be collecting data on arrivals and distribution of USAID supplied commodities which, in turn, will be a key element of the evaluation process. In addition, USAID will rely heavily on its local staff to conduct on-site inspections in pilot areas and research reports. Also, important to the evaluation process will be the BDC's own reports and studies, as well as evaluations conducted by the INRD and UNFPA of their population activities. Naturally, the reports of consultants and intermediaries will have direct bearing on the evaluations. Finally, as indicated below, the assistance of AID/W in providing specialized consultants for evaluations will be required.

Evaluations will be keyed to significant milestones in the life of the project. A major element of the BDC project, but not AID-funded, is the training and placement of female field workers and their supervisors. By January, 1977, most of these workers will have been trained and placed in field locations. An evaluation at that time will enable the BDC and USAID to assess progress toward staffing these positions and the effectiveness of this category of personnel. Prior to this evaluation USAID will review training and staffing records with the PCFP Directorate, and make spot checks to review the performance of field workers. Also, shortly before this evaluation AID/W will be requested to provide a logistics consultant to review contraceptive supply and distribution activity as an input to the evaluation.

The second BDC-USAID evaluation will take place one year later, January, 1978. By this time, all PCFP Directorate positions, from headquarters to field level, should be staffed and operational. In addition, the four fertility clinics will have been operational for at least three months. Again AID/W will be asked to provide a logistics consultant in advance of this bilateral review to review the contraceptive delivery and supply system. In addition to reviewing progress toward achievement of project purpose, this bilateral evaluation will focus on BDC requirements for assistance following completion of the project in September, 1978. The

performance of the EOPD Directorate's Planning, Statistics, Research and Evaluation Unit in this evaluation will itself be an indicator of progress.

In conjunction with the January, 1978, evaluation, USAID intends to ask AID/M to provide a demographer and statistician to assist the EOPD in analyzing program accomplishment and in designing studies to measure progress toward goal achievement. This will be the first step in the ex post facto evaluation of this project. The evaluation studies will be well under way by the time this project officially terminates in September, 1978, with the final report done shortly thereafter. Since it is anticipated that a follow-on project will be needed, these evaluation studies will be useful in developing this **project.**

D. Conditions, Covenants and Negotiating Status

The BDG and USAID have agreed through discussion that the following conditions and covenants will be included in the Project Agreement to be signed in FY 76:

1. The BDG will submit regular reports to USAID on:
  - a) the receipt, clearance, and distribution to the districts throughout the country of AID-financed commodities; and
  - b) acceptors of contraception, by method and by district.
2. USAID reserves the right to use the services of a training consultant to review, with the BDG, the program's staffing and prior training; and experience of incumbents to identify training needs as a condition for programming participant training.
3. BDG agrees to finance the air travel of participant trainees to the furthest points served by the national airline on the trainees' routes.
4. A.I.D. population program support in FY 77 and FY 78 will be contingent on satisfactory progress towards full staffing of field worker positions with trained workers.
5. Details of the support to be given for the establishment of four family planning clinics will be worked out by an intermediary agency and the concerned host country agencies.
6. An annual joint BDG/USAID review of program progress will

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be made as a necessary step in negotiating the second and third-year Project Agreements.

7. Project Agreements will designate by title the counterparts and the supervisors of consultants to be supplied under the project.

8. The RUC reserves the right to review and approve consultant nominations.

9. The contribution of the host country shall be equivalent to at least 25 percent of the cost of the entire program to which A.I.D. will provide funding under this project.

10. None of the A.I.D. funds made available under the project shall be used to pay for the performance of abortions, as a method of family planning, or to motivate or coerce any person to practice abortion.

T E L E G R A M

AMEMBASSY DACCA

ACTION: AID

UNCLASSIFIED  
Classification

RCVD: 7 DEC 74

UNCLAS STAT: 268153

SUBJECT: POPULATION PROP

REFERENCE: (A) RAVENHOLT MEMCON DATED 9/19/74; (B) STATE 253261;  
(C) STATE 259782; (D) DACCA 5391

A. REFS (C) AND (D) CROSSED. GIVEN TIME NEEDED FOR PROP APPROVAL PROCESS PLUS PROAG NEGOTIATION, PROP SHOULD BE SUBMITTED AS CLOSE TO DECEMBER 31 AS POSSIBLE CONSISTENT WITH GOOD PROGRAMMING. PROP IS NOT REPEAT NOT ACCEPTABLE. IN LINE WITH REF (A) FOLLOWING POINTS SHOULD BE COVERED IN PROP WHICH SHOULD ENCOMPASS 3 YEAR TIME FRAME AND BE SUFFICIENTLY BROAD GAUGED TO ALLOW ADAPTATION TO POSSIBLE BDG CHANGES IN POLICY/ADMINISTRATION.

1. CONTRACEPTIVES - CRITICAL ELEMENT IS DELIVERY TO CONSUMER, PROP SHOULD IDENTIFY ACTIONS NECESSARY TO INSURE RAPID DISPERSMENT TO WIDEST POSSIBLE TARGET GROUP AND BY WHOM ACTIONS TO BE TAKEN. REGARDING THE CONTRACEPTIVE SUPPLY LEVEL, USAID CAN EXPECT TO RECEIVE THE ORALS ORDERED UNDER FY 73 AND FY 74 PIO/CS, WHICH INCLUDE 22 MILLION CYCLES ORALS. FOR CONDOMS SUFFICIENT FUNDS AVAILABLE IN FY 73 PIO/C TO PROVIDE 213,000 GROSS OF REQUESTED 250,000. UNDER FY 74 PIO/C (FOR PURCHASE UNDER CENTRAL FUNDED 600,000 GROSS REQUESTED WHICH NOW IN PROCESS PROCUREMENT. LETTER TO JORDAN FOLLOWS PROVIDING FURTHER INFORMATION/RATIONALE ON PHA/POP ADJUSTMENT TO FBS FOR CALCULATION ORAL AND CONDOM REQUIREMENTS.
2. MANAGEMENT OPERATIONS - IN CONNECTION WITH ABOVE, PROP SHOULD PROVIDE FOR ASSISTANCE IN IMPROVING PERSONNEL QUALIFICATIONS, CLARIFICATION OF ROLES FOR VARIOUS WORKERS, STRENGTHENING DELIVERY SYSTEM ORGANIZATIONAL STRUCTURE, IMPROVING LOGISTIC SUPPORT, AND IMPROVING BUDGET/ACCOUNTING SYSTEMS.
3. DEVELOPMENT OF FACILITIES FOR TEACHING OF FERTILITY CONTROL PRACTICES - PROP SHOULD INCORPORATE CURRENT MISSION THINKING ON ACTIVITIES WHICH SHOULD BE UNDERTAKEN IN THIS AREA. PER STATE 260338 CONSULTANTS AVAILABLE FOR ASSESSMENT OF NEEDS AND TO PROVIDE GUIDANCE IN THIS AREA. PROP CAN BE AMENDED LATER IF FOUND TO BE NECESSARY FOLLOWING STUDY BY MINKLER/LAUFE.

4. WOMEN'S PROGRAMS - TO EXTENT FEASIBLE, PROGRAM ELEMENTS SHOULD REFLECT JUDITH BRUCE'S ANALYSIS/RECOMMENDATIONS.
5. PARTICIPANT TRAINING - RECOMMEND, IN ADDITION TO OVERSEAS TRAINING PROJECTED FOR SUPPORT GENERAL PROGRAM, PROVIDE FOR TRAINING OF TWENTY-FOUR SELECTED CLINICIANS AND CADRE OF NURSE TRAINEES IN ADVANCED TECHNIQUES OF FERTILITY CONTROL AT UNIVERSITY OF PITTSBURGH.
6. POPULATION ASSISTANCE GRANT - REF (A) SUGGESTED THREE YEAR FUNDING LEVEL OF DOLLARS 125,000 FOR BDG TO USE TO ACQUIRE CONSULTANTS/OTHER TECHNICAL ASSISTANCE HELP IN PROGRAM DESIGN/ADMINISTRATION. PROP SHOULD DEFINE SPECIFIC SERVICES TO BE PROVIDED WITH UPDATED FUNDING PROJECTION AND REFLECT MISSION VIEWS ON AMOUNT ACTUALLY REQUIRED.
7. RESEARCH AND EVALUATION - MISSION SHOULD REQUEST BDG/PLANNING COMMISSION TO PROVIDE CLARIFICATION OF TREC AND RESEARCH AND EVALUATION SITUATION IN RELATION TO PPD ORGANIZATION AND FUNCTIONS IN TIME TO PERMIT INCORPORATION IN PROP. IF THIS NOT POSSIBLE, SUGGEST UNIVERSITY OF MICHIGAN PROPOSAL BE INCLUDED AND WILL MODIFY PROP LATER IF NECESSARY.
8. AGRICULTURE EXTENSION PROGRAM - MATTER STILL UNDER CONSIDERATION BY FAO AND USDA. NEITHER CAN MAKE ANYONE AVAILABLE UNTIL JUNE, 1975 IN ANY CASE. ACTIVITY SHOULD BE ALLOTTED IN PROP, BUT ONLY IN TERMS OF GENERALLY SUPPORTIVE AID STANCE - NOT BILATERAL FUNDING.
9. IN PREPARATION PROP, BELIEVE DESIRABLE TO INCORPORATE APPLICABLE PARTS OF SECTIONS I AND II OF REPORT "BANGLADESH POPULATION PROGRAM REQUIREMENTS AND PROJECT ASSISTANCE" PREPARED BY JORDAN DURING SEPTEMBER TDY IN AID/W. ALSO SUGGEST SECTIONS III AND IV OF REPORT BE INCLUDED POSSIBLY AS APPENDICES WITH APPROPRIATE MODIFICATIONS. KISSINGER

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

ANNEX B

Project Title and Number: Population/Family Planning, 38F-0001

Life of Project:  
From FY1973 to FY1978  
Total U.S. Funding: \$22,500,000  
Date Prepared: December 10, 1975

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	REPORT ASSUMPTIONS
<p><u>Program Goal</u></p> <p>Reduced rate of natural population growth as a critical factor in social and economic development.</p>	<p><u>Measures of Goal Achievement</u></p> <ol style="list-style-type: none"> <li>1. Annual rate of natural increase reduced by 0.2% (from est. 3% to 2.8%) by June 1978.</li> <li>2. Crude Birth Rate declined from 47 to 43/1000 (as Crude Death Rate drops from 17 to 15/1000).</li> <li>3. Prevalence of contraceptive use increased to about 10% of eligible couples.</li> <li>4. 1.1 million births averted during Plan period.</li> </ol>	<ol style="list-style-type: none"> <li>1. Demographic surveys.</li> <li>2. FP client records.</li> <li>3. Reports of prevalence of contraceptive use.</li> </ol>	<p><u>Assumptions for Achieving Goal Targets</u></p> <ol style="list-style-type: none"> <li>1. Crude Birth Rate will decline faster than Crude Death Rate through intensified services and education.</li> <li>2. Target of over 1.5 million users will avert the 1.1 million births needed to reduce annual rate of natural increase by 0.2%.</li> <li>3. Sufficient demand for FP services exists or will be generated by activities under project to attain projected number of users.</li> </ol>
<p><u>Project Purpose</u></p> <p>A functioning national institutional structure providing family planning services and population/family planning (Pop/FP) information and education on a continuing basis to the people of Bangladesh.</p> <p><u>PCFP = Population Control and Family Planning.</u></p>	<p><u>End of Project Status (by 06/30/78)</u> (Resulting from BDG's and all donors' activities.)</p> <ol style="list-style-type: none"> <li>1. <u>Service Delivery--Field Personnel</u> Following trained personnel are performing assigned duties:             <ol style="list-style-type: none"> <li>1.1. <u>Nonmedical Personnel</u> <ol style="list-style-type: none"> <li>a. 12,000 Family Welfare Workers</li> <li>b. 13,500 Family Welfare Assistants.</li> </ol> </li> <li>1.2. <u>Paramedical Personnel</u> 1074 Family Welfare Visitors</li> <li>1.3. <u>Medical Personnel</u> <ol style="list-style-type: none"> <li>a. 422 Thana Technical Officers</li> <li>b. 19 District Technical Officers</li> <li>c. 58 District and Subdivisional Medical Officers</li> </ol> </li> <li>1.4. <u>Other Supervisory Levels</u> <ol style="list-style-type: none"> <li>a. 4,500 Male Union Assistants</li> <li>b. 422 Thana PCFP Officers</li> <li>c. 19 District PCFP Officers</li> </ol> </li> </ol> </li> <li>2. <u>Service Delivery--Supply/Logistics System</u> <ol style="list-style-type: none"> <li>2.1. Adequate commodities are at service delivery points to meet needs.</li> <li>2.2. Operating system for estimating commodity needs.</li> </ol> </li> <li>3. <u>Service Delivery--Training Facilities</u> Following facilities are established and are training medical, paramedical, and selected supervisory personnel:             <ol style="list-style-type: none"> <li>3.1. 8 clinics at medical college hospitals.</li> <li>3.2. College of Nursing.</li> <li>3.3. 17 paramedical training schools</li> <li>3.4. 1 national FP training institute.</li> <li>3.5. 8 thana rural health centers each with 3 union subcenters and field practice areas.</li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>1. BDG training and personnel records.</li> <li>2.a. BDG reports of distribution of commodities to field outlets.</li> <li>    b. Spot checks in field.</li> <li>    c. BDG reports of stock levels and usage rates.</li> <li>3. Site inspections.</li> <li>4.a. Records of meetings.</li> <li>    b. Policy directives.</li> <li>    c. BDG personnel records.</li> <li>    d. Midcourse corrections in program implementation as a result of on-going evaluation.</li> <li>5.a. Special studies carried out by Research &amp; Evaluation section of Directorate, BIDS, and universities.</li> <li>    b. Research reports.</li> <li>    c. BDG personnel records.</li> <li>    d. Site inspections in pilot areas.</li> <li>6.a. Progress reports and demographic data collected and analyzed by BDG.</li> <li>    b. Evaluation study design; visual verification.</li> <li>7. Other means (related to all of the above)             <ol style="list-style-type: none"> <li>a. IBRD progress reports and periodic evaluations.</li> <li>b. UNFPA progress reports and periodic evaluations.</li> </ol> </li> </ol>	<p><u>Assumptions for Achieving Purpose</u></p> <ol style="list-style-type: none"> <li>1. BDG's commitment of will and resources will be sustained over life of project.</li> <li>2. BDG, UNFPA, IBRD and other donors will provide on a timely basis the necessary inputs to produce outputs leading to ECPS in the areas of service delivery, management, demand creation, and evaluation. (See details under "Inputs" and Annex G.)</li> <li>3. BDG Establishment Division will allocate enough positions to PCFP Division to allow latter to carry out its functions effectively.</li> <li>4. BDG will continue to encourage nongovernmental organizations to operate in Pop/FP area.</li> </ol>

CONTINUED

POPS, cont'd

- 4. Management
- 4.1. National Population Council providing policy guidance.
- 4.2. National Coordination Committee coordinating interministerial program.
- 4.3. PCFP Division and its Directorate are:
  - a. serving as secretariat for 4.1 and 2. above.
  - b. planning and implementing national service delivery program and evaluating its impact.
  - c. providing technical support to other ministries in FP.
  - d. coordinating external Pop/FP assistance and participating in periodic evaluations with foreign donors.
- 5. Demand Creation
- 5.1. Info/Educ/Motivation Unit of PCFP Directorate conducting IEC campaign in support of service delivery program.
- 5.2. 14 pilot schemes in Pop/FP info/educ under nonhealth development ministries are implemented and evaluated.
- 5.3. Women's Rehabilitation Foundation has incorporated Pop/FP education into training courses for about 2000 women per year in 30 centers throughout country, and established links with local service providers.
- 5.4. a) Daily radio messages are broadcast by Population Program Cell of Radio BD; b) Films Dept. of Min/Info & Broadcasting has used increased capacity to produce about 10 general audience films on population in 35mm and 16mm; c) Monthly average of 4 articles, 4 features, 4 personal interviews, 3 stories, 3 poems, a short drama and 6 cartoons are placed in print and broadcast media by Population Feature Writing Bureau of Min/Inf.
- 5.5. Curricula being prepared for introduction of Pop.Educ. in the formal school system from 4th grade through university.
- 5.6. Involvement of 50% more nongovernmental organizations in promoting FP through various development and social service programs.
- 5.7. At least one social science research study in Pop/FP under way or completed by each of 3 universities and BD Institute for Development Studies.
- 6. Evaluation
- 6.1. Client records, program reports, and special studies yielding administrative intelligence which is being used in program planning and replanning.
- 6.2. Ex post facto evaluation underway to measure progress towards goal achievement.

Inputs

Implementation Budget (FY76 and Available)

A. U.S. Inputs (bilateral)	FY76 & FY77		FY78		FY79	
	Qty (\$000)	(\$000)	Qty (\$000)	(\$000)	Qty (\$000)	(\$000)
1. Commodities:						
Type	<u>216.0</u>	<u>450.5</u>			<u>197.0</u>	
a. Orals (million MEs)	114 2025.0	20 4200.0	26.15	5191.5		
b. Condoms (000 gross)	-	52 270.0	300	1554.0		
c. IUD Kits (000 pcs)	200 10.0	200 10.0	500	25.0		
d. IUD Kits (ea)	300 26.0	300 15.0	300	15.0		
e. Vasectomy Kits (ea)	100 8.5	100 8.5	100	8.5		
f. Clinic Equipment	114.5					
	<u>m/m (\$000)</u>	<u>m/m (\$000)</u>	<u>m/m (\$000)</u>			
2. Local costs of establishing four new FP clinics (\$000)	<u>56.3</u>	<u>56.3</u>		<u>114.5</u>		
3. Participant Training (short- and long-term):	<u>283</u>	<u>292.0</u>	<u>283</u>	<u>268.0</u>	<u>118</u>	<u>125.0</u>
a. Prog. Mgmt/Administration	66 52.2	66 52.2	39	31.0		
b. Demog., Pop Dynamics, Pop Policy	15 11.7	30 23.1	15	11.7		
c. Research & Evaluation, Statistics, Data Processing	42 63.3	36 35.0	18	21.4		
d. Educ., Communication	117 96.6	90 75.8	12	14.1		
e. Social Sciences	18 13.6	36 27.3	18	13.6		
f. Clinical Training	6 14.4	6 14.4	6	14.4		
g. Training methods, Materials Development	12 23.8	12 23.8	3	2.4		
h. Short-term Observation, Conference Participation	7 16.4	7 16.4	7	16.4		
4. Consultant services in:	<u>36</u>	<u>266.3</u>	<u>24</u>	<u>166.3</u>	<u>15</u>	<u>150.0</u>
a. Management Training	-		6 37.3			
b. IEC	18 135.3					
c. Women's Programs	6 12.0	6 12.0				
d. Training	12 111.0	12 111.0				
e. To be Determined	-				15	150.0
Totals:	<u>2796.5</u>	<u>4992.1</u>		<u>2465.6</u>		

B. BDG Inputs	(\$000 equiv. @ 14/1)			
	FY76	FY77	FY78	Total
1. Personnel Costs	4,256	5,436	6,040	15,732
2. Participant Travel	25	25	15	65
3. Program Operating Costs	<u>3,480</u>	<u>3,317</u>	<u>3,335</u>	<u>10,132</u>
Totals	7,761	8,778	9,390	25,929

C. Other Donor and AID/W Inputs

See Annexes G and H .

Means of Verification (U.S. Bilateral Inputs)

1. PIO/Cs
2. Personnel records, expenditure reports, site visits.
3. PIO/Ps
4. PIO/Ts

Assumptions for Providing Inputs

B-3

1. EDG and USAID can reach agreement on program requirements, in consultation with other donors.
2. Appropriations for Population activities will continue to be available.
3. EDG will make available appropriate staff for training abroad.
4. EDG will approve establishment of FP Training Institute, for which management training consultant services are requested.

Means of Verification (BDG Inputs)

BDG budget documents.

Assumptions for Providing Inputs

1. Willingness of EDG to accord high priority to Pop/FP in budget allocations.
2. Adequate social, economic and political stability to permit orderly execution of program.

Outputs	Magnitude of Outputs
(Following outputs relate only to USAID inputs. Those resulting from host country and other donor inputs are cited in "Assumptions for achieving purpose," "Assumptions for achieving outputs", and "Inputs".)	
<b>1. Service Delivery--Supply and Logistics System</b>	
1.1. Contraceptive supplies are deployed throughout the country and accessible to program personnel at a level of one-year's requirement in country, with an additional year's supply on order.	
1.1.	Est. In Country
Commodity Type	FY75 FY76 FY77 FY78
	Est. in Pipeline
	FY75 FY76 FY77 FY78
Orals (million monthly cycles)	11.80 15.50 16.75 20.00 11.50 17.25 31.25 46.15
Condoms (000 gross)	786 923 675 463 217 0 52 352
IUDs (000 pcs)	200 110 210 290 0 200 200 500
IUD Inserters (000)	20 14 24 29 0 20 20 50
1.2. Union-level FP/MCH clinics are equipped with IUD Insertion Kits.	1.2. FY76 - 300 clinics FY77 - 200 clinics FY78 - 200 clinics
1.3. Clinics and physicians are supplied with Vasectomy Kits.	1.3. FY76 - 100 clinics and doctors FY77 - 100 -do- FY78 - 100 -do-
<b>2. Service Delivery--Training Facilities</b>	
Family planning clinics at medical college hospitals are remodeled and fully equipped.	2. 4 clinics by end FY77

Continued

Continued

Means of Verification (Outputs)

1. Bills of lading, arrival reports.
2. EDG reports of distribution of U.S.-supplied commodities to subordinate units throughout country.
3. Spot checks in the field on supply levels and distribution systems.
4. University progress reports on participants in academic programs.
5. EDG personnel records.
6. Consultant reports.
7. Spot checks in Ministries/organizations receiving consultants and/or participants.

Assumptions for Achieving Outputs

1. Re AID-supplied commodities, it is assumed that:
  - a. UNFPA/UNICEF will provide funds/technical assistance to improve PCPP Division's transport and supply systems.
  - b. UNFPA/UNICEF input, plus USAID activities to improve service statistics, will permit improved EDG capability to determine differential supply requirements of districts and long-range national requirements.
  - c. AID-funded supplies will arrive at port as scheduled.
  - d. EDG, IBRD and UNFPA will provide salary and training costs for field personnel to insure adequate numbers of trained personnel are available to distribute/utilize AID-supplied commodities.
2. Re medical college family planning clinics, space and staff are available and facilities willing to include fertility regulation practice in curricula.
3. Re participant training, EDG will ensure employment of trainees on return.
4. Re technical assistance, EDG will make available counterparts for consultants.

Outputs, cont'd

Magnitude of Outputs, cont'd

3. Other Output Categories

3.1. Personnel are assigned in staff positions following training in following fields (based on preliminary estimates of needs):

Numbers of Personnel Trained, by Fiscal Year of Completion of Training

	76	77	78	79	80	Total
a. Prog. Mgmt/Administration	5	8	9	3	-	25
b. Demography, Pop Dynamics, Pop Policy . . . . .	-	-	1	2	1	4
c. Research & Evaluation, Statistics, Data Processing	4	3	4	1	-	12
d. Education, Communication	7	11	11	2	-	31
e. Social Sciences . . . . .	-	-	1	2	1	4
f. Clinical training . . . . .	2	2	2	-	-	6
g. Training Methods, Materials Development . . . . .	4	4	1	-	-	9
h. Short-term Observation, Conference Participation .	7	7	7	-	-	21
						<u>112</u>

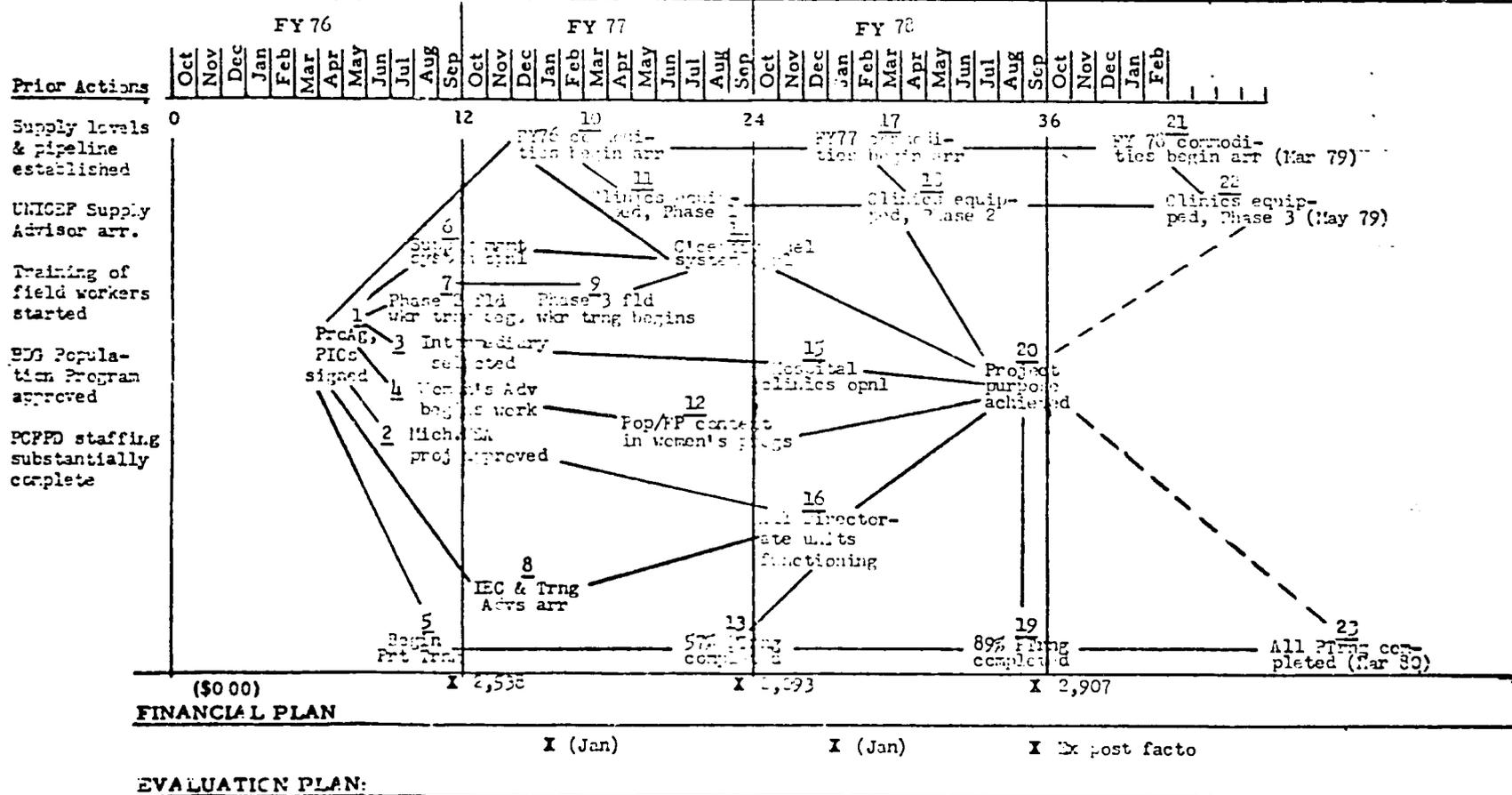
- 3.2.a. Management training capability established in FP Training Institute.
- b. Improved IEC capability in IEM Unit of Directorate.
- c. Women's program staff capable of integrating Pop/FP content into on-going programs.
- d. Program data system is designed, staff of responsible Directorate unit and field personnel trained in its use.
- e. Capability to plan and manage training function is established in PCFP Directorate.

- a. Training program planned; curriculum and training materials developed; faculty have received on-the-job training by end FY77. \*
- b. Communication campaign developed and in progress; materials produced; nonhealth ministries receiving technical support, by '77. \*
- c. A national women's program has Pop/FP information, education and/or services, by '77.
- d. System includes client records, periodic service reports, and systematic analysis of data, by end of FY77.
- e. Includes pre- and in-service training of field, clinic, and supervisory personnel in 17 regional training institutes and at district and thana offices, by end FY77.
- \* Quantifications to be determined by consultants.

PROJECT PERFORMANCE TRACKING NETWORK

ANNEX C

Country: Bangladesh	Project No. 368-0001	Project Title: Population/Family Planning	Date Feb.12, 1976	<u>X</u> / Original <u>  </u> / Revised	PPT Approval Joseph S. Toner, DIR
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CPI NARRATIVE

1. May 76 ProA; and POCs signed
2. Jun 76 Univ. of Michigan University Services Agreement project approved
3. Jul 76 Intermediary agency selected for development of fertility clinics at medical college hospitals
4. Jul 76 Adviser to women's program begins work
5. Aug 76 Participant trainees depart
6. Sep 76 Supply management system is operational
7. Sep 76 In-country training begins of the second one-third of field workers
8. Dec 76 IEC and Training Consultants arrive
9. Mar 77 Training of the final one-third of field workers begins
10. Mar 77 FY76 commodities begin arriving in country
11. May 77 Union subcenters (300) and vasectomy clinics (100) equipped with medical kits
12. Jul 77 Population/family planning content has been integrated women's training programs
13. Sep 77 57% of participant trainees have returned from training
14. Sep 77 Contraceptive delivery system is operational
15. Dec 77 Fertility clinics in medical college hospitals are operational
16. Dec 77 All PCFP Directorate units are functioning
17. Mar 78 FY77 commodities begin arriving in country
18. May 78 Additional union subcenters (200) and vasectomy clinics (100) are equipped with medical kits
19. Sep 78 89% of participant trainees have returned from training
20. Sep 78 Project purpose achieved
21. Mar 79 FY78 commodities begin to arrive, thereby maintaining in-country and pipeline supply levels
22. May 79 Additional union subcenters (200) and vasectomy clinics (100) are equipped with medical kits. This is part of long-range BDC plan to make clinical MCH/FP services more accessible.
23. Mar 80 Participant training completed, helping to insure successful continuation of program

Government of the People's  
Republic of Bangladesh  
Planning Commission  
External Resources Division.

No. 647/ERD(II)/USA(P)-10/75

September 30, 1975

From : Mr. Zeauddin Ahmad  
Deputy Chief

To: Mr. Michael Jordan, Chief  
Health and Population Division  
USAID, Hotel Purbani  
Dacca-2.

Subject: USAID Population and Family Planning Project  
1975-78 Grant Programme.

Dear Sir,

Please refer to our letter No.634/ERD-II/USA(P)-10/75 dated 25th September, 1975 and my telephonic conversation with you yesterday on the above subject. I have the pleasure to forward to you the Population Plan for 1975-78 sent to the Planning Commission yesterday by the Ministry of Population & Family Planning.

I would request you to kindly expedite the finalization of the \$10 million Population & Family Planning Project Grant for Bangladesh.

Sincerely yours,

Sd/-

(Zeauddin Ahmad  
Deputy Chief

REQUIREMENT OF CONTRACEPTIVES FOR FAMILY PLANNING  
PROGRAMME - 1975 - 1978

1. ESTIMATED REQUIREMENT OF PILL:

Year	No. of continued users of pill (@ 35% of total target user) cumulative over the years.	Estimated No. of cycles (@ 13 per acceptor, cumulative over the years)	Provision for - *(1) drop outs (50% dropout of total pill acceptors and @ 6 cycles per dropout)	Estimated wastage and others @ 20%	*(2) Advance supply for 1978-79	Total cycles required
1	2	3	4	5	6	7
1975-76	1,57,465	20,47,045	9,44,790	5,98,367	-	35,90,202
1976-77	3,32,971	43,28,623	19,97,826	12,65,290	-	75,91,739
1977-78	5,25,389	68,30,057	31,52,334	19,96,476	1,49,78,869	2,69,57,738
<b>Total:</b>		<b>1,32,05,725</b>	<b>60,94,950</b>	<b>38,60,135</b>	<b>1,49,78,869</b>	<b>3,81,39,679</b>

\* The total target continued users for all methods at the end of the plan period has been estimated at 15,06,000 for prevention of 1.1 million birth. \*(1) Since 50% of the total acceptors have been estimated to be drop outs, the number of dropout cases would be same as that of continued users. \*(2) The required supply for 1978-79 will have to be procured before the end of the plan period in order to keep the programme going.

Supply needed from USAID

Total requirement: 3,81,39,679 - 2,00,00,000 (present stock and quantity in the pipe line)  
= 1,81,39,679 Cycles.

ESTIMATED REQUIREMENT OF LOOP:

Year	No. of IUD continued user (@35% of total target users) Cumulative over the yrs.	Estimated units required (@ 1 per new recruit)	Provision for drop outs (40% dropout of total users and @ 1 per dropout)	Provision for re-insertion @ 20% of total contd. users.	Wastage and others 20%	Advance supply for 1978-79	Total No. required
1	2	3	4	5	6	7	8
1975-76	1,57,465	1,57,465	1,04,977	31,493	58,787	-	3,52,722
1976-77	3,32,971 (1,75,506 new recruit)	1,75,506	1,17,004	66,594	71,821	-	4,30,925
1977-78	5,25,389 (1,92,418 new recruit)	1,92,418	1,28,279	1,05,078	85,155	6,38,662	11,49,592
		5,25,389	3,50,260	2,03,165	2,15,763	6,38,662	19,33,239
Supply needed from USAID:							
Actual requirement = 19,33,239 - 1,00,000 (Stock)							
= 18,33,239							
Required No. of inserter (10% of loops) = 1,83,324							

B. Estimated requirement of condom:

Year	No. of continued user for condom (@ 15% of total target users) cumulative over the years.)	Estimated units required (@100 unit per acceptor)	Provision for drop outs (50% dropout of total condom acceptors and @ 50 pieces per dropout)	Estimated wastage and others @ 20%	Advance supply for 1978-79	Total pieces required
1	2	3	4	5	6	7
1975-76	67,485	67,48,477	33,74,238	20,24,523	-	1,21,47,258
1976-77	1,42,701	1,42,70,138	71,35,069	42,81,041	-	2,56,86,248
1977-78	2,25,165	2,25,16,596	1,12,58,298	67,54,979	5,06,62,341	9,11,92,214
		4,35,35,211	2,17,67,605	1,30,60,563	5,06,62,341	12,90,25,720
Supply needed from USAID						
Actual requirement = 8,96,012 - 6,00,000 (In stock and pipe line)						
= 2,96,012 gross						
i.e. 8,96,012 gross						

13  
D

Requirement of IUD Kits for Union sub-centres  
for 1975-78

Phasing	No. of sub-centres	Rate per clinic	Actual requirements
1975-76	300	2 sets	600 sets
1976-77	365	"	730 "
1977-78	365	"	730 "
<b>Total</b>	<b>1030</b>	<b>-</b>	<b>2060</b>

Supply needed from USAID = 2060 - 860 (UNFPA's Supply of IUD kits & previous supply of USAID) = 1200

Requirement of Vasectomy kits  
for 1975-78

Phasing	No. of clinics	Rate per clinic	Actual requirements
1975-76	200	2	400
1976-77	300	"	600
1977-78	123	"	246
<b>Total</b>	<b>623</b>	<b>-</b>	<b>1246</b>

(Vasectomy kits kind be provided to 356 RHC 19 district Hospitals; 8 medical college hospitals, 40 Sub-Division Hospitals, 19 district mobile teams; 200 rural doctors)

Supply needed from USAID = 1246-646(USAID's Previous supply & present stock) = 600

Long term fellowships

Sl.No.	Name of Agencies	Subject	Degree/Diploma	Man-month	1975-76	1976-77	1977-78	Total
1.	Population Control & Family Planning Division	a) Public Admn.	MPA/MS DFPO/Asstt. Director with 2-3 years experience in the present post.	24 m.m.	-	1(12 m.m.) DFPO	1(12 m.m.) Asstt. Director (Adm)	2
		b) Social Psychology	MA/MS DFPO/Lecturer of TcRI, with at least 2-3 years experience in their present post.	36 m.m.	-	1(18 m.m.) Lecturer of TcRI	1(18 m.m.) DFPO	2
		c) Anthrpology	MA/MS -do-	36 m.m.	-	1(18 m.m.) 1 DFPO	1(18 m.m.) 1 Lecturer of TcRI	2

Sl.No.	Name of Agencies	Subject	Degree/Diploma	Long term fellowships		1975-76	1976-77	1977-78	Total
				Man/month					
2.	Population Control & F.P. Division and ISRT, Dacca University	d) Statistics	M.S.	Asstt. Director/ Senior Statistician/ Lecturer, ISRT with at least 2 years exp- erience in the present post.	36 m.m.	-	1(18 m.m.) 1 Asstt. Director (Statistics)	1(18 m.m.) 1 lecturer ISRT	2
3.	Ministry of Education & Population Control & F.P. Division	e) Population Education	M.S.	Asstt. Director/ curriculum officer/ Training officer with 3-4 years teaching experience or training experience	45 m.m.	-	2(15 m.m. each) 1 Population Education Directorate 1 Training unit of PC & F.P.	1(15 m.m.) 1 Population Education	3
4.	Population Control & F.P. Division and Population Planning Section of Planning Commission.	f) Demography/ Population Dynamics/ Population Planning	M.S.	Asstt. Director/ Dy. Director(Planning)/ Asstt. Chief(Planning) with at least 3 years experience in their present post/Research Officer(?) with 1-2 year experience in the present post.	60 m.m.	-	2 AD/DD(P) of PC & FP. 1 S.C. Planning of Planning Commission.	1(15 m.m.) D.O.(Planning)	4
5.	Population Control & F.P. Division; Ministry of Information.	g) Communication	M.S.	Asstt. Director/ Dy. Director of IEM/ Dy. Director Mass Communication with 5-7 years experience.	45 m.m.	-	2(15 m.m. each) 1 IEM 1 Mass Comm. Deptt.	1(15 m.m.) 1 I.E.M.	3

Sl.No.	Name of Agencies	Subject	Long term fellowships				Total		
			Degree/Diploma	Man/month	1975-76	1976-77		1977-78	
6.	Ministry of Health and Family Planning	h) Population Education (Health)	MPH	Asstt. Director/D.D.MCH (PC&FP)/Public Health/Inst./Health Education Bureau.	72 m.m.	-	3(12 m.m. each) 1 D.T.O. 1(Medical College) 1(MCH Unit) 1(district lady doctor)	3(12 m.m. each) 1 D.T.O. 1 Medical College 1 Health Education Bureau	6
7.	-do-	i) Public Health Adm.	MPH/ MS	AD/DD of Director of F.P. in charge of Delivery of services/Asstt. Professor of preventive medicine/Asstt. Director (P) of Directorate of Health Services/Lecturer of TeRIS.	72 m.m.		3(12 m.m. each) 1 Medical College 1 Director of HS(P) 1 TeRI	3(12 m.m. each) 1 AD(FP) 1 TeRI 1 Public Health	6
8.	Population Control & F.P. Division.	j) Population programme management	pro-MBA with speciali zation in F.P. programme adm.	AD/DD/DFPO of the F.F. Directorate	30 m.m.	-	1(15 m.m.)	1(15 m.m.)	2
<b>Total:</b>					456 m.m.	-	297 m.m.	159 m.m.	30

Short term fellowship

<u>Sl.No.</u>	<u>Name of the Agency</u>	<u>Subject</u>	<u>Background</u>	<u>Man-month</u>	<u>1975-76</u>	<u>1976-77</u>	<u>1977-78</u>	<u>Total</u>
1.	Population Control & Family Planning Division; Population Planning Section, Planning Commission. Ministry of Information.	Research Methodology & Evaluation Tech.	Dy. Director/ A.D./Asstt. Chief/Research Officer/Director/A.P.D./Population Cell, Radio.	42 m.m.	3(6 m.m. each) 2(Research & Ev. Unit. 1 PPS., P.C.	2(6 m.m. each) 1 Research & Evn. Unit. 1 P.P.S.	2(6 m.m. each) 1 R & Evn. 1 Radio Bangladesh.	7
2.	Population Control & F.P. Division, Bureau of Statistics/Census/ISRT.	Computer Programme.	A.D. Research & Ev./Statistical Officer/Lecturer	18 m.m.	1(6 m.m.) 1 R & Evl.	1 (6 m.m.) 1 Bureau of Statistics	1 (6 m.m.) 1 ISRT	3
3.	Population Control & Family Planning Division Ministry of Education.	Curriculum Development	DD/AD/Training Officer/ED/PC & FP curriculum Development officer	6 m.m.	1(3 m.m.) 1 Training unit.	1 (3 m.m.) 1 (Population Evl. Directorate.	-	2
4.	Population Control & F.P. Division; Social Welfare; IRDP.	Community Organization.	AD(IEM)/DFPO/TFPO Social Welfare officer/Thana Project officer	30 m.m.	4(3 m.m. each) 1 DFPO 2 TFPO 1 TPO	4 (3 m.m. each) 1 DFPO 2 TFPO 1 SMO	2(3 m.m. each) 2 TFPO.	10
5.	Population Control & Family Planning Division; Ministry of Information & Broadcasting, Ministry of Education.	Communication, Tech. & Media Production.	Asstt. Director, IEM/Production officer IEM/Asstt. Director, MIB/Asstt. Director PED.	9 m.m.	1 (3 m.m.) AD, OFM.	1 (3 m.m.) AD ITB.	1 (3 m.m.) AD, PED.	3
6.	Population Control & Family Planning Division & Health Division	Management of Family Planning Clinics.	DTO/Direct Lady Doctors Seminar FWW/MO Model clinics.	45 m.m.	5(3 m.m. each) 1 DTO/ 2 SFWW 1 MO Model clinic.	5 (3 m.m. each) 2 DTO 2 SFWW 1 MO, MC.	5 (3 m.m. each) 2 DDMO 1 SLFW 2 MO, MC	15

Short term fellowship

<u>Sl.No.</u>	<u>Name of the Agency</u>	<u>Subject</u>	<u>Background</u>	<u>Man-month</u>	<u>1975-76</u>	<u>1976-77</u>	<u>1977-78</u>	<u>Total</u>
7.	Population Control & Family Planning Division and Health Division	Clinical Training (Tubectomy, vasectomy & M.R.)	AD(SD)/DTO/ DLMO,MO,MC.	18 m.m.	2(3 m.m.each) 1 F.O.M.C. 1 D.T.O.	2(3 m.m.each) 1 M.O. F.R. 1 MFO	2(3 m.m.each) 1 F.O. (MO) 1 AD(SD)	6
8.	Population Control & F.P. Division.	Training Methodology	A.D.,Lecturer, Principal, TeRI.	12 m.m.	2(3 m.m.each) 1 Principal 1 Lecturer	2(3 m.m.each) 1 AD. 1 Lecturer		4
9.	Population Control & F.P. Division.	Nutrition Education.	Nurse Tutors.	6 m.m.	-	(3 m.m.)	(3 m.m.)	2
10.	Population Control & F.P. Division.	Public Health Nursing	Nurse Tutors.	12 m.m.	2 (3 m.m.each)	2(3 m.m.each)	-	4
11.	Population Control & F.P. Division.	Develop-ment of Training materials	A.D.Associate Prof./Asstt. Prof. of pro-posed Training Institute.	9 m.m.	1(3 m.m.) A.D.	1(3 m.m.) Associate Prof.	1(3 m.m.) Asstt.Prof.	3
<b>Total:</b>				186 m.m.	22(69 m.m.)	22(69 m.m.)	15 (48 m.m.)	59

- \* 36 Short term fellowships for population control and Family Planning Division; and the remaining 11 for other Ministries/Agencies.

Study & Observation Trip (for 3-4 weeks)

These are exclusively meant for officials of the government and other concerned organizations whose study and observation on Population Programmes in other countries will be essentially helpful in making decision for improvement of the programmes in the country. Total number of such observations will be 21 to be phased out equally during 1975-78. These should be allocated to the Secretary/Joint Secretary/Deputy Secretary/Director-General/Section Chief/Director/Deputy Director or officers of equivalent posts of concerned agencies or Senior Representative of the Voluntary organizations.

.....

Assistance for 4 Model Family Planning Clinics

No facility exists at present, either for the training of Medical Students in contraceptive technology and modern methods of **sterilisation** or for clinical research activities to facilitate development of up-to-date teaching materials and carrying out clinical research & evaluation on the various contraceptive methods.

IDA credit provides for construction, equipping & furnishing 4 Model Family Planning Clinics at four of the Countries eight Medical Colleges. The following Medical Colleges will have Model F.P. Clinics under IDA Assistance Programme.

- 1) Sylhet.
- 2) Rangpur.
- 3) Barisal
- 4) Mymensingh

Each of the clinics will have attached to it a ward of 25 beds with facilities for sterilization, abortion and out patient contraceptive services. It is expected that each clinic would annually perform about 2000 male & female sterilizations, 600 to 800 abortions and provide 2 weeks in-service training for 50 qualified doctors, in addition to undergraduate training for the medical students.

Similar clinics are equally needed for the remaining four medical colleges and US assistance is sought to equip & furnish four more Family Planning Model Clinics at the following medical colleges not covered by IDA assistance programme.

- 1) Sir Salimullah Medical College, Dacca.
- 2) Dacca Medical College Hospital.
- 3) Rajshahi Medical College.
- 4) Chittagong Medical College.

It is expected that accommodation for the clinics will be available at the Medical College Premises. If suitable accommodation are not readily available, Govt. will undertake necessary construction.

- 2 -

Cost estimates of equipments & operational costs  
for which US assistance is needed:

A. <u>Equipments</u>	1975-76	1976-77	1977-78	Total
1. 4 Clinical Sets for sterilization.	- \$	53,340	-	\$ 53,340
2. 4 Clinical Sets	- \$	8,940	-	\$ 8,940
3. Clinical sets for vasectomy.	- \$	7,200	-	\$ 7,200
4. 4 sets of additional equipment.	- \$	21,000	-	\$ 21,000
5. 100 hospital beds.	- \$	25,000	-	\$ 25,000
Sub-Total.		\$ 1,14,500		\$ 1,14,500
B. <u>Vehicles</u>				
4 Station Wagons	- \$	22,800	-	\$ 22,800
Sub-Total		\$ 22,800		\$ 22,800
C. <u>Operating Cost.</u>				
1. Vehicle maintenance @ \$ 400 P.M.	\$	4,800	\$ 4,800	\$ 9,600
2. Equipment maintenance 5% of cost	\$	6,000	\$ 6,000	\$ 12,000
3. Office supplies.	\$	800	\$ 800	\$ 1,600
4. Medical/Surgical/ Supplies(details will be provided)	\$ 3000/Per year clinic.	\$ 12,000	\$ 12,000	\$ 24,000
5. In-Patient diet	\$ 3000/per year	\$ 12,000	\$ 12,000	\$ 24,000
6. Per diem for trainees../per year	\$	4,500	\$ 4,500	\$ 9,000
Sub-Total:		\$ 41,300	\$ 41,300	\$ 82,600
D. Salary support		\$ 15,000	\$ 17,000	\$ 32,000
4 Medical officer	- Tk.1300 P.M. each			
4 Female Physician & 8 part-time surgeons	- Tk. 750 " "			
4 Accountant	- Tk. 400 " "			
4 Counsellors.	- Tk. 600 " "			
4 Sister nurse.	- Tk. 500 " "			
24 Nurses	- Tk. 400 " "			
4 Record Keepers	- Tk. 400 " "			
12 Motivators	- Tk. 250 " "			
4 Typists	- Tk. 250 " "			
8 Drivers	- Tk. 250 " "			
12 Nurses Aids.	- Tk. 250 " "			
4 Receptionists	- Tk. 300 " "			
4 Peons	- Tk. 150 " "			
4 Night guards	- Tk. 150 " "			
16 Surgeon (Half-time)	- Tk. 400 " "			
8 Assist. Surgeon(half time)	- Tk. 300 " "			
Sub Total		\$ 15,000	\$ 17,000	\$ 32,000
Grand Total		\$ 1,93,600	\$ 58,300	\$ 2,51,900

Requirement of Consultant from  
US-AID Assistance Programmes 1975-78

<u>Sl.No.</u>	<u>Type of Consultants</u>	<u>Man-months and year.</u>	<u>Programme where consultant will be attached.</u>	<u>Counterparts</u>	<u>Supervising officer</u>
1.	Management Training.	3 months 2 consultants (1976-77)	PC & FP Training Institute.	Professor (Training Institute proposed)	Principal
2.	I.E.C.(Planning & Media production)	18 m.m. (1976-77)	IEM Unit	Director IEM	Director General
3.	Research & Evaluation (Michigan)	as per proposed (Michigan project)	Training, Plg., Statistics, Research & Evn. Unit.	Deputy Director	Director (R & E)
4.	Women's Vocational Training	12 m.m. (to be extended if needed (1976-77)	Women's Rehabilitation & Welfare foundation.	Director	Chairman
5.	Service Statistics.	(12 m.m.)	Directorate of Population Control & F.P.	Dy.Director	Director, Training,Plg. Stat., & Research & Eval.
6.	Training	(12 m.m.)	"	Dy.Director	

Functions of each category of consultants

1. Management training.
  - a) Help develop management training programmes, curriculum & training materials.
  - b) Help conduct training programmes.
  - c) Train local faculties in the conduct of management training programmes.
2. IEC  
Help develop & produce new media, publicity materials and improve on the existing ones.
3. Research & Evaluations:
  - a) Help design research studies & their conduct.
  - b) Train the programme personnel in improved research methodology.
4. Women's vocational training  
Provide consultancy services on programme organization management & evaluation on population control and family planning being integrated with the overall economic programmes of the Women's foundation.
5. Service Statistics:  
Development of Service Statistics & Management Information System.
6. Training:  
Development of Training Programme and materials.

PROAG

**PROJECT AGREEMENT**

BETWEEN THE DEPARTMENT OF STATE, AGENCY FOR INTERNATIONAL DEVELOPMENT (AID),  
AN AGENCY OF THE GOVERNMENT OF THE UNITED STATES OF AMERICA, AND

The Ministry of Health and Family Planning

AN AGENCY OF THE GOVERNMENT OF The People's Republic of Bangladesh

FY 1976

The above-named parties hereby mutually agree to carry out a project in accordance with the terms set forth herein and the terms set forth in any annexes attached hereto, as checked below:

- Project Description Annex A     Foreign Currency Standard Provisions Annex  
 Standard Provisions Annex     Special Loan Provisions Annex

This Project Agreement is further subject to the terms of the following agreement between the two governments, as modified and supplemented:

General Agreement for Technical Cooperation    Date: May 21, 1974

Economic Cooperation Agreement    Date: May 21, 1974

(other)    Date: \_\_\_\_\_

1. Project/Activity No. 300-0001    PAGE 1 OF \_\_\_\_\_ PAGES

2. Agreement No. 300-0001-1    3.  Original or Revision No. \_\_\_\_\_

4. Project/Activity Title  
Population/Family Planning

5. Project Description and Explanation  
(See Annex A attached)

6. AID Appropriation Symbol    7. AID Allotment Symbol

8. AID FINANCING	Previous Total (A)	Increase (B)	Decrease (C)	Total to Date (D)
<input checked="" type="checkbox"/> Dollars <input type="checkbox"/> Local Currency				
(a) Total		2,796,600		2,796,600
(b) Contract Services		264,300		264,300
(c) Commodities		2,184,000		2,184,000
(d) Other Costs		348,300		348,300
9. COOPERATING AGENCY FINANCING Dollar Equivalent				
\$1.00 = Tk. <u>11.10</u>				
(c) Total		7,761,000		7,761,000
(b) Technical and Other Services		4,256,000		4,256,000
(c) Commodities				
(d) Other Costs		3,505,000		3,505,000

10. Special Provisions (Use Additional Continuation Sheets, if Necessary)

11. Date of Original Agreement    12. Date of This Revision    13. Estimated Final Contribution Date

14. For the Cooperating Government or Agency    15. For the Agency for International Development

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_    SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
 TITLE: \_\_\_\_\_    TITLE: \_\_\_\_\_

I. PROJECT DESCRIPTION

A. General:

Under this Project Agreement, the United States Government through the Agency for International Development (AID), agrees to provide grant funds for the provision of technical services, participant training, establishment of medical college fertility control clinics, and commodities in support of the Population Control Program of the Government of the People's Republic of Bangladesh (BDG). This assistance will be administered by the Population Control and Family Planning Directorate, BDG Ministry of Health, Population Control and Family Planning (MOHPCFP). Contraceptives supplied under the agreement will be made available to voluntary adopters of birth control methods under the BDG's Family Planning Program, and may also be used in other governmental or nongovernmental family planning programs and projects, as determined by the MOHPCFP.

This project was originally initiated during FY 1973 as Project 388-11-580-001. Beginning with this Agreement the project is renumbered 388-0001.

B. Project Goal:

The project goal is a reduced rate of natural population growth as a critical factor in social and economic achievement.

C. Project Purpose:

The purpose to be achieved during the First Five Year Plan period, resulting from the activities of the BDG and external

donors, is the development of a functioning national institutional structure providing family planning services and population/family planning information and education on a continuing basis to the people of Bangladesh.

## II. ACTIVITY TARGETS:

### End of Project Status:

It is mutually understood that by the end of the project on June 30, 1978 the following conditions are expected that will indicate the purpose has been achieved:

#### 1. Service Delivery--Field Personnel

##### a. Nonmedical Personnel

(1) 12,000 trained male Family Welfare Workers (FWWs) continue to provide, as part of their health services, nonclinical family planning services, related information, and referrals for those wanting clinical means of contraception.

(2) Approximately 13,500 trained female Family Welfare Assistants are making regular home visits in their assigned areas and providing nonclinical family planning/maternal and child health services, related information, and referrals for those wanting clinical means of contraception.

##### b. Paramedical Personnel:

Approximately 1,452 female Family Welfare Visitors (FWVs) are providing contraceptives, related information, maternal child health services, and referrals. In addition, 422 senior Family Welfare Visitors designated as Thana Clinic Supervisors, are giving

technical supervision to the union subcenter F/Ws.

c. Medical Personnel:

(1) 422 Thana Technical Officers are providing clinical services (male/female sterilizations and IUDs), one per thana-level maternal child health/family planning clinic.

(2) 58 District and Subdivisional Medical Officers are providing the above clinical family planning services at the district and subdivisional maternal child health/family planning centers of which they are in charge.

(3) 19 District Technical Officers are giving technical supervision to the entire clinical programs in their respective districts, and are also organizing mobile clinical activities and providing clinical services.

d. Other Supervisory Levels:

(1) Approximately 4,500 Male Union Assistants (MUAs), one per union, are providing nontechnical supervision to the F/Ws in the unions, keeping accurate family planning acceptor records, and providing information and contraceptives among the male population of the unions.

(2) 422 Thana Population Control and Family Planning Officers, each with an assistant, the FP Supervisor, are supervising the MUAs and administering the FP/MCH program in the thanas.

(3) 19 District Population Control and Family Planning Officers are administering the district level FP/MCH program and administratively supervising the district and thana FP/MCH officers and staff.

## 2. Service Delivery - Supply and Logistics System

a. In-country logistics and distribution system ensures adequate warehousing and inventory control of program commodities and their timely distribution in quantities adequate to meet program needs at service delivery points.

b. The BDG system for estimating contraceptive and other FP commodity needs based on anticipated and/or target numbers of contraceptive adopters, for which prior UNFPA/UNICEF and AID assistance has been provided, is operational.

## 3. Service Delivery - Training Facilities

a. 8 model FP clinics are established at the 8 medical college hospitals and are each providing practical undergraduate training to medical students as well as short-term training for doctors already in practice.

b. One college of nursing is training 60 nursing teachers annually who will in turn train F/Ws.

c. 17 training institutes are functioning each with a capacity to train 60 F/Ws annually and to provide periodic refresher training for F/Ws and district and thana officers already in service.

d. One Family Planning Training Institute under the Director-General/PCFP Directorate is training trainers and senior officers, providing policy guidance, and developing and reviewing curricula for M/V and field worker training programs.

e. 8 thana-level rural health centers (with clinical facilities, 25 maternity beds, staff and student housing), each

with 3 union-level subcenters are providing field practice training for medical and paramedical personnel.

#### 4. Management

a. The Ministerial-level National Population Council is providing broad policy guidance for the HDG's efforts to reduce population growth.

b. The Central Coordination Committee is coordinating the population/family planning efforts of the concerned ministries and private sector organizations. The Committee is composed of the secretaries (highest civil service rank) of the ministries with population/family planning activities.

c. The Population Control and Family Planning Division of the MOHPCFP:

(1) is serving as secretariat for the National Population Council and the Central Coordination Committee;

(2) is planning and implementing the national service delivery program and evaluating its impact;

(3) is providing technical support to other ministries involved in Pop/FP for planning, implementing, and evaluating their population programs; and

(4) is coordinating external assistance in Pop/FP and participating in periodic evaluations of program progress with the various foreign donors.

#### 5. Demand Creation

a. The Information, Education and Motivation Unit of the Directorate of FCFP is established and staffed and is conducting

a communication campaign in support of the service delivery system. The unit is supplying technical support to the information and education programs of other ministries and agencies.

b. 14 pilot schemes (9 with IBRD support; 5 with UNFPA funds) have been implemented and evaluated. These pilot schemes are designed to integrate Pop/FP education into the development programs of the nonhealth development ministries. The ministries involved are Rural Development and Cooperatives, Education, Agriculture, Information and Broadcasting, and Labor and Social Welfare.

c. The Women's Rehabilitation Foundation has incorporated Pop/FP content into their training courses for about 2000 women per year in approximately 30 centers throughout the country.

d. Mass media are being used more extensively for Pop/FP information and education as a result of new and strengthened units of the Ministry of Information and Broadcasting, assisted by IBRD.

e. Work is well advanced on development of population education curriculum materials for introduction in fourth grade through university courses in the formal school system.

f. At the present time, approximately 25 nongovernmental agencies carry on some Pop/FP activities. By end of project, there is a 50% increase in the number of agencies which are involved in promotion of the small-family norm in the context of a variety of development programs.

g. At least one social science research study in Pop/FP is in progress or completed by each of three universities and the Population Study Centre of Bangladesh Institute for Development Studies.

6. Evaluation (Program Impact/Effectiveness Measurement)

a. PCFP Directorate is generating administrative information needed to measure effectiveness of various program components; e.g., delivery of services, training, and IEC, with data obtained from service records and through small specialized studies.

b. A BDG-donors ex post facto evaluation is under way to measure progress towards goal achievement.

III. PROGRESS TO DATE

This project was initiated on May 11, 1973. In the original Agreement, AID indicated its willingness to provide extensive financial support for family planning after BDG approval of the family planning component of the First Five Year Plan; identification of those family planning activities that could best be supported by AID; and a review by AID of the activities proposed. These actions were carried out.

In the first three years of the project AID has helped meet the BDG program priority of building up as rapidly as possible a supply of oral contraceptives and condoms in country sufficient to supply 10% and 5%, respectively, of eligible couples for one year, and a like amount in the pipeline. AID has also helped meet additional program needs in the areas of training, commercial marketing of contraceptives, field research, and establishment of family planning clinics.

During the course of the project the BDG has created a cadre of multipurpose Family Welfare Workers who deliver family planning

information, contraceptives, and a variety of preventive health services through regular visits in rural areas. In addition, a network of thana and urban family planning clinics has been reactivated. The BDG has also created a Population Control and Family Planning Division within the Ministry of Health, Population Control and Family Planning, charged with responsibility to implement a redesigned family planning program. Of particular note in this action is the BDG authorization to employ three women and one man per union as home visitors for maternal child health and family planning, or about 18,000 new full-time employees.

#### IV. FUNDING REQUIREMENTS

##### A. Total Requirements:

The BDG Project Financial Plan indicates total project requirements of \$104,834,000 over the years 1973 to 1978, which includes AID and other donor contributions (in foreign exchange for foreign and local costs) and a BDG contribution in local currency. The projected amount to be expended from all sources during the period from FY 1976 thru FY 1978 is \$82,046,000.

Funding levels and activities shown as USAID and BDG contributions for FY77 and FY78 are illustrative only and do not represent commitments on the part of either Government under the terms of this Project Agreement. They are provided to indicate the nature and level of support under consideration, as a guide to forward planning.

The amounts shown as "Other Donor" costs are not only for the Population Control and Family Planning Division, but include foreign

donor funds distributed to other NEDG agencies for population programs. These amounts in some cases are not yet final.

The following summarizes projected contributions from all sources during the final three years of the project (FY 1976-78):



## B. FY 1976 Requirements (including Interim Quarter):

1. AID Contributions:

a. <u>U.S. Technicians</u>	<u>ML</u>	<u>\$000</u>
Info, Educ & Communications	18	135.3
Women's Programs	6	18.0
Training Instruction	12	111.0
	<u>36</u>	<u>264.3</u>
b. <u>Participant Training</u>	<u>MM</u>	<u>\$000</u>
Prog Mgt/Administration	66	52.2
Demography, Pop Dynamics & Pop Policy	15	11.7
Research & Evaluation, Statistics, and Data Processing	42	63.3
Education & Communication	117	96.6
Social Sciences	18	13.6
Clinical Training	6	14.4
Training Methods, Materials and Development	12	23.8
Short term Observation & Conference Participation	7	16.4
	<u>283</u>	<u>292.0</u>
c. <u>Commodities</u>	<u>Qty</u>	<u>\$000</u>
Orals (Million IECs)	11 1/4	2025.0
IUDs (000 pcs)	200	10.0
IUD Kits (ea)	300	26.0
Vasectomy Kits (ea)	100	8.5
Clinic Equipment		114.5
		<u>2184.0</u>
d. <u>Other Costs</u>		<u>\$000</u>
Local Costs of Establishing 4 new FP Clinics		56.3
		<u>56.3</u>
<b>TOTAL AID FINANCING</b>		<u><u>2796.6</u></u>

2. BDG Contribution:

	<u>\$000</u>
a. <u>Personnel Costs</u>	4256.0
b. <u>Participant Travel</u>	<u>25.0</u>
c. <u>Program Operating Costs</u>	<u>3480.0</u>
TOTAL BDG FINANCING	<u>7761.0</u>
GRAND TOTAL AID/BDG FINANCING	<u>10557.6</u>

V. COURSE OF ACTIONA. Project Inputs:

1. AID: The project inputs to be supplied by AID during FY 1976 are shown in Section IV above. These inputs will be provided through means of Project Implementation Orders issued by AID and countersigned by the Government of Bangladesh.

2. BDG: Project inputs to be supplied by the BDG during FY 1976 are as shown in Section IV above. Illustrative components of these inputs are such costs as rental, maintenance, office supplies, postage, utilities, furniture, locally procured equipment, vehicle maintenance and POL for Bangladesh Government organizational units. Also included are such other program costs as a portion of in-country training, a portion of international participant travel, publicity and other communications materials, locally purchased medicines, and a portion of construction costs.

B. Project Outputs (relating to A.I.D. inputs):1. Service Delivery--Supply and Logistics System

a. Contraceptive supplies are deployed throughout the country and are readily accessible to field and clinic program personnel. Based on projected user estimates, in-country supply levels sufficient for one year's use are being maintained, with an additional year's supply on order, i.e., in the pipeline. The following are contraceptive requirements to meet these supply/pipeline considerations:

<u>Commodity Type</u>	<u>Est. In Country</u>				<u>Est. In Pipeline</u>			
	<u>FY75</u>	<u>FY76</u>	<u>FY77</u>	<u>FY78</u>	<u>FY75</u>	<u>FY76</u>	<u>FY77</u>	<u>FY78</u>
Orals (million monthly cycles)	11.80	15.50	16.75	20.00	11.50	17.25	31.25	46.15
Condoms (000gross)	786	923	675	463	217	0	52	352
IUDs (000 pcs)	200	140	240	290	0	200	200	500
IUD Inserters(000)	20	14	24	29	0	20	20	50

b. Seven hundred union-level FP/ICM clinics are equipped with IUD Insertion Kits. Clinics will be equipped with USAID-supplied kits on the following schedule: FY76-300 clinics; FY77-200 clinics; FY78-200 clinics.

c. Three hundred clinics, hospitals and physicians are supplied with equipment sets to perform vasectomies at the rate of 100 sets per year from FY76 through FY78.

## 2. Service Delivery--Training Facilities.

Four medical college hospitals (Dacca, Sir Salimullah, Mymensingh, and Rajshahi) have established, by converting available space, family planning clinics capable of providing medical students with practical training in advanced methods of fertility regulation. These clinics will become operational during FY77.

## 3. Other Cutout Categories

a. Program personnel, whose knowledge and skills have been upgraded through training in the U.S. and third countries, have been assigned in staff positions. Persons trained, based on present estimates of need, are the following:

<u>Broad Area of Study</u>	<u>Numbers of Personnel Trained, by Year of Completion of Training</u>						
	<u>(FY)</u>	<u>76</u>	<u>77</u>	<u>78</u>	<u>79</u>	<u>80</u>	<u>Total</u>
a. Program Management/ Administration		5	8	9	3	-	25
b. Demography, Population Dynamics, -Policy		-	-	1	2	1	4
c. Research & Evaluation, Statistics, Data Processing		4	3	4	1	-	12
d. Education, Communication		7	11	11	2	-	31
e. Social Sciences		-	-	1	2	1	4
f. Clinical Training		2	2	2	-	-	6
g. Training Methods, Materials Development		4	4	1	-	-	9
h. Short-term Observation, Conference Participation		7	7	7	-	-	21
							<u>112</u>

Length of training: 32 long term (12 mo. or more) - 456 m/m  
 59 short term (under 12 mo.) - 207 m/m  
 21 observation, conferences - 21 m/m

Inasmuch as the new national family planning organization is only partially staffed at present and implementation of the recast program has not yet begun, the above training outputs are subject to later revision and refinement based on program experience.

b. Consultant services have produced the following:

(1) A capability has been established in the national-level Family Planning Training Institute to plan and direct management training for appropriate categories of program officers. A training program has been planned, based on identified needs, and a curriculum and training materials have been developed, in the course of which the Institute faculty have benefitted from on-the-job training. This will be accomplished by the end of FY77. Quantifications will be determined by the consultant(s).

(2) The Information, Education and Motivation Unit of the PCFP Directorate has developed the capability to plan and direct the communication aspects of the family planning program. By the end of FY77, a communication campaign has been designed and is in progress, materials have been produced, and technical inputs are being provided to the nonhealth ministries with population programs. Quantification will be determined by the consultant.

(3) Program staff of a large national organization with activities aimed at improving the status of women have gained the understanding and skills to incorporate family planning information and counselling into their program by the end of FY77.

(4) A system has been designed for the recording, reporting, and analysis of the program's service statistics. The staff of the concerned Directorate unit and field personnel at various levels are receiving on-the-job training in its use by mid-FY77.

(5) The capability to plan and manage the training function has been established in the PCFP Directorate. This includes the training of field, clinic, and supervisory personnel in the 17 regional training institutes and at district and thana offices.

### C. Implementation Plan:

The implementation schedule presented below includes major activities supported by USAID, the BDG, and some by other donors. This is done because combined inputs are required to accomplish project purpose.

<u>AID Grant</u>	<u>BDG/Other Donors</u>	<u>Target Date</u>
	Approval of BDG Pop Program Plan	Dec 75
Transmittal of Project Paper to AID/W		Dec 75
	Recruit and begin training 4,500 female field workers and 1,500 supervisors	Jan 76
	Staffing of Pop Control & FP Directorate substantially complete.	Jan 76
Approval of project paper by AID/W, including identified SPA waiver		Feb 76
Negotiate and sign Proj, PIC/Cs, PIO/Fs and PIC/Ps for first year project support		March 76
Resident hire women's program advisor available for project on part-time basis		March 76
AID/W approval of Mich/USA project	Agreement reached on W of Michigan technical support for research and evaluation	March 76
TDY of AID/W training advisor to conduct review of BDG staff future training requirements and alter training schedule as necessary		March 76

<u>AID Grant</u>	<u>BDG/Other Donors</u>	<u>Target Date</u>
Select intermediary for hospital fertility clinic review and complete plan design. Intermediary to implement.	BDG assign counterpart for planning and implementation	Mar/Apr 76
	Agreement reached on training of medical students in hospital fertility clinics	April 76
	Recruit and begin training of 4,500 female field workers and 1,500 supervisors	June 76
	Establish and post staff to 300 union subcenters	June 76
Arrival of IE&C advisor for 18 month assignment	BDG provides office and admin support	Aug 76
Arrival of training advisor for 12 month assignment	BDG provides office and admin support	Aug 76
Departure of long-term participants		Sept 76
TDY of AID/W logistics consultant to review supply/distribution activity		Nov 76
	Recruit and begin training of 4,500 female field workers and 1,500 supervisors	Dec 76
Joint AID/USAID/BDG review of program progress		Jan 77
Negotiate and sign Proj, PIO/Cs, PIO/Ps, and the PIO/T for management training consultant for second year project support		March 77
Arrival of management training advisor(s) (short-term)	BDG provides office & admin support	June 77
	Establish and post staff to 365 subcenters	June 77
	4 fertility clinics operating in medical college hospitals	Sept 77

<u>AID Grant</u>	<u>EDX/Other Donors</u>	<u>Target Date</u>
Departure of long-term participants		Sept 77
TDY of AID/W logistics consultant to review supply/distribution activity		Nov 77
Joint AID/USAID/BDG review of program progress. Decide upon additional consultant requirements. Determine future year assistance.		Jan 78
AID/W provides demographer and statistician to assist BDG in analyzing program accomplishment and in designing study to measure progress towards goal achievement at end of FYP.		Jan 78
Negotiate and sign ProcAg, PIO/Cs and PIO/Ps for third year project support. Issue PIO/Ts as required based upon January review		March 78
	Establish and post staff to 365 subcenters	June 78
Departure of long-term participants		Sept 78

#### D. Monitoring and Reporting:

The project will be monitored by the Health and Population Division of USAID in conjunction with the Population Control and Family Planning Division of the Ministry of Health, Population Control and Family Planning and the relevant Directorate.

The Commodity and Logistics Section of USAID will monitor the arrival of all USAID-supplied commodities at port and will furnish the Health and Population Division with reports on problems of port clearance and information on spot-checks on commodities distributed throughout the country. This information will be compared with information that will be made available to USAID from the commodity/logistics advisor posted to Bangladesh under the UNFPA/UNICEF logistics project.

The four fertility clinics to be established at the medical college hospitals will be designed and implemented through an intermediary, such as The Pathfinder Fund, with funds provided under the Project Agreement. This intermediary shall have the responsibility to monitor these clinics through an on-site review at least once a year for three years from start of implementation.

Technical advisors requested by the BDG will be assigned counterparts and supervisors by the BDG. The need for top quality advisors is recognized.

Beneficiaries of this project assistance are ultimately the end-user of the birth control services. Reports from several large voluntary agency field projects and reports that result from USAID field visits and discussions with PDG program personnel will form the basis for obtaining the views of the beneficiaries. On the national level, continuing review of the activities of the technical advisors and discussions with their counterparts and supervisors as named by the BDG will provide feedback on the quality and usefulness of the assistance provided.

In addition to the above, the standard USAID yearly project evaluation will be conducted with the assistance of the USAID Research and Evaluation officer to provide necessary feedback for project correction or modification.

#### VI. CONDITIONS AND COVENANTS

- A. The BDG will furnish regular monthly reports to AID on:
  1. the receipt, clearance, and distribution to the districts throughout the country of AID-financed commodities; and
  2. acceptors of contraception, by method and by district.
- B. AID reserves the right to use the services of a training consultant to review, with the BDG, the staffing and prior training and experience of incumbents to identify training needs for the programming of participant training.
- C. The BDG agrees to finance the air travel of participant trainees to the furthest points served by the national airline.
- D. AID population program support in FY77 and FY78 is contingent upon satisfactory progress towards full staffing of field worker positions with trained workers.
- E. An annual joint PDG/AID review of program progress will be made as a necessary step in negotiating the second- and third-year Project Agreements.
- F. Final details of the support to be given for the establishment of four family planning clinics will be worked out by an intermediary agency and the concerned host country agencies.
- G. Project Agreements will designate by title the counterparts and the supervisors of consultants to be supplied under the project.

H. The BDG reserves the right to review and approve consultant nominations.

I. The contribution of the host country shall be equivalent to at least 25 percent of the total cost of the program during the life of the project.

J. None of the A.I.D. funds made available under the project shall be used to pay for the performance of abortions, as a method of family planning, or to motivate or coerce any person to practice abortion.

VII. PERIOD OF THE AGREEMENT

This Agreement may be modified, altered or amended by mutual consent of the parties in writing at any time. Unless otherwise agreed to, subject to the availability of AID funds and legislative authority, this agreement shall continue through three years from date of signing.

The terminal disbursement date for obligations made under such Agreements and amendments thereto shall be three years from date of signing the agreements and amendments. Procedures for the disbursement and/or reimbursement of grant funds will be provided by USAID/Bangladesh prior to such disbursement or reimbursement.

DRAFT

ANNEX F

ACTION MEMORANDUM FOR THE DEPUTY ADMINISTRATOR

THRU: ES

FROM: AA/PHA

SUBJ: Approval of FY 1976 Project Paper for Bangladesh Population/  
Family Planning

Problem: The attached Project Paper increases the total cost of a project by more than \$2 million over the amount stated in the original PROP and therefore requires your approval.

Discussion: This project was initiated during FY 1973. Through FY 1975 it has financed the provision of contraceptives adequate to ensure sustained delivery of contraceptive supplies in support of the Bangladesh Government's (BDG) family planning program. For FY 1976 it is proposed that the project be expanded to incorporate technical assistance for the government's Population Division, training for staff personnel and field workers, local costs of establishing four new family planning clinics, plus continued provision of contraceptives. Of the total \$2.8 million being requested for FY 1976 approximately \$1.8 million will finance the new activities proposed, with the balance to be used to procure contraceptive needs. For the final 2 years of the project (FY 1977-78) an additional \$12.5 million is proposed for continued support and development of the Bangladesh Government's nationwide family planning program.

The basic need for population/family planning assistance to Bangladesh is reviewed in Part II.A. of the Project Paper; details of the project's components are found in Part II.B. The additional funds being requested are a specific response to a proposal made by the BDG Ministry of Health

and Family Planning. The USAID Mission to Bangladesh has carefully reviewed the request and selected those components for financial support which address the most crucial constraints within the Population/Family Planning sector of Bangladesh.

Recommendation: That you approve the attached Project Paper authorizing an additional \$2.8 million for the FY 1976 Bangladesh population/family planning program and \$12.4 million during the remainder of the project (FY 1977-78).

Approved \_\_\_\_\_

Disapproved \_\_\_\_\_

Date \_\_\_\_\_

PROJECTED OTHER DONOR INPUTS AND AID/W CENTRALLY FUNDED  
GRANTS AND CONTRACTS, BY YEAR (\$000)

ANNEX G  
Page 1

Donor	Prior FY75	FY75	FY76	FY77	FY78	FY79	FY80	Total
IBRD/IDA & Associates <u>a/</u>		287	7,057	8,955	17,390	10,564	1,451	45,704
UNFPA	92	1,477	3,042	1,951	1,429	+ unprogrammed bal.		7,991 2,009
Ford Foundation	474	589	500	?	?			1,563
AID/W Central Grants and Contracts <u>b/</u>	876	1,698	410 <sup>c/</sup>	100 <sup>c/</sup>	?	?		3,084
	<u>1,442</u>	<u>4,051</u>	<u>11,009</u>	<u>11,006</u>	<u>18,819</u>	<u>10,564</u>	<u>1,451</u>	

a/ Includes BDC contribution of \$5,647,000 to IBRD project. Bilateral donors are Australia, Canada, Federal Republic of Germany, Norway, Sweden, and United Kingdom.

b/ Excluding centrally funded contraceptives.

c/ Incomplete.

ANNEX G  
Page 1

INPUTS OF OTHER DONORS AND AID/W CENTRALLY FUNDED GRANTS AND CONTRACTS,  
BY EOPS CATEGORY (\$000)

ANNEX C  
Page 2

<u>EOPS Category</u>	<u>IBRD/IDA &amp; Associates a/</u>	<u>UNFPA</u>	<u>Ford Fndn</u>	<u>AID/W d/</u>
1. Service Delivery - Field Personnel	3,320	400 2,136 <u>b/</u> 379 <u>c/</u>	12	617
2. Service Delivery - Training Facilities	33,046			187
3. Service Delivery - Supply and Logistics		1,079 504 <u>c/</u>		213
4. Management	220		154	
5. Demand Creation	7,504	476 2,002 <u>c/</u>	1,069	1,585
6. Evaluation	1,584	600 415 <u>c/</u>	328	482
7. Unprogrammed		2,009		
	<u>45,704</u>	<u>10,000</u>	<u>1,563</u>	<u>3,084</u>

- a/ Includes BDG contribution of \$5,647,000 to IBRD project.  
b/ Revisions in progress, necessitated by BDG reorganization.  
c/ Under negotiation.  
d/ Excluding centrally funded contraceptives

AID/W ASSISTANCE TO BANGLADESH POPULATION PROGRAM  
THROUGH CENTRALLY FUNDED CONTRACTS AND GRANTS

<u>Contractor/Grantee and Fiscal Year</u>	<u>Purpose</u>	<u>Status &amp; Duration</u>	<u>Financial Assistance Programmed</u>
<u>Pathfinder Fund</u>			
FY73	National Population Seminar	Completed 1 year	\$10,000
FY74	Postpartum Program and Model Clinic	On-going	170,000
FY75	-ditto-	On-going	42,000
<u>Family Planning International Assistance</u>			
FY74-75	Support voluntary organi- zation population projects	On-going	133,000
<u>Association for Voluntary Sterilization</u>			
FY75	BAVS activities	On-going	162,000
<u>World Fertility Survey</u>			
FY75	Bangladesh survey (funded through International Statistical Institute)	on-going 2 years	181,897
<u>Johns Hopkins University</u>			
FY74	Fertility research projects in Dacca and Matlab	on-going 3 years approx.	300,000

AID/W Centrally Funded Grants and Contracts, page 2

<u>Contractor/Grantee and Fiscal Year</u>	<u>Purpose</u>	<u>Status and Duration</u>	<u>Financial Assistance Programmed</u>
<u>Cholera Research Laboratory</u>			
FY75	Contraceptive saturation project in Matlab Thana	On-going 3 years	approx. \$300,000
<u>Population Services International</u>			
FY75	Develop and implement contraceptive commercial marketing project.	On-going 3 years	approx. 920,000 initial funding
<u>University of Michigan</u>			
FY76	Assist Population Control and Family Planning Directorate with service statistics system and action research	Proposal 3 years under review in AID/W; BDG has approved	approx. 450,000

AID/W also provides program support to UNFPA, IPPF, and Population Council.

Note: Above activities are approved by the BDG. Specific project details are available with the Population Control Division of the BDG, with the intermediary funding organization, and with the respective project monitors in PHA/POP, AID/W.

IN-COUNTRY, PIPELINE AND USAGE PROJECTIONS - ORAL PILLS (million monthly cycles)

<u>FY75</u>	<u>FY76 &amp; IQ</u>	<u>FY77</u>	<u>FY78</u>	<u>FY79</u>
A. 11.80				
FY75 U. -1.80				
Bal. 10.00	→ 10.00			
O. <u>15.50</u>	→ 5.50			
	A. 15.50			
	07/75 U. -4.75			
	to 09/76			
	Bal. 10.75	→ 10.75		
O. <u>16.00</u>	→ O. <u>16.00</u>	→ 6.00		
		A. 16.75		
		FY77 U. -8.00		
		Bal. 8.75	→ 8.75	
	P. (11.25)	→ O. <u>11.25</u>	→ 11.25	
			A. 20.00	
			FY78 U. -12.00	
			Bal. 8.00	→ 8.00
		P. (20.00)	→ O. <u>20.00</u>	→ 20.00
				A. 28.00
				-17.25
				Bal. 10.75
			P. (26.15)	→ <u>26.15</u>
<u>Summary:</u>				
In Country:				
(A) 11.80	15.50	16.75	20.00	
In Pipeline:				
(O. + P.) 11.50	17.25	31.25	46.15	

LEGEND

A.--Available for use.

U.--Usage, estimated.

O.--On order and arriving in country.

P.--Programmed.

IN-COUNTRY, PIPELINE AND USAGE PROJECTIONS - CONDOMS ('000 gross)

ANNEX I  
Page 2

<u>FY75</u>	<u>FY76 &amp; IQ</u>	<u>FY77</u>	<u>FY78</u>	<u>FY79</u>
A. 786				
FY75 U. -80				
Bal. 706	-----> 706			
O. <u>217</u>	-----> 217			
	A. 923			
	FY76 & IQ U. -248			
	Bal. 675	-----> A. 675		
		FY77 U. -212		
		Bal. 463	-----> A. 463	
			FY78 U. -250	
			Bal. 213	-----> 213
		P. (52)	-----> O. <u>52</u>	-----> 52
				A. 265
				FY79 U. -265
				Bal. 0
			P. (300)	-----> O. <u>300</u>
<b>Summary:</b>				
<b>In Country:</b>				
(A.) 786	923	675	463	
<b>In Pipeline:</b>				
(O. + P.) 217	0	52	352	

LEGEND:

A.--Available for use.

U.--Usage, estimated.

O.--On order and arriving in country.

P.--Programmed.

ANNEX I  
Page 2

POPULATION & FAMILY PLANNING PROJECT  
FINANCIAL PLAN  
(\$000)

Annex J  
(Page 1)

PROJECT COST	ACTUAL								Proposed	PROPOSED							
	Actual Total	FY 73		FY 74		FY 75		Total		FY 76		FY 77		FY 78		TOTAL	
		In	US \$	In	US \$	In	US \$			In	US \$	In	US \$	In	US \$	In	US \$
\$	Eqv. \$	US \$	Eqv. \$	US \$	Eqv. \$	US \$	\$	Eqv. \$	US \$	Eqv. \$	US \$	Eqv. \$	US \$	Eqv. \$	US \$		
<b>AID Grant</b>																	
<b>Mission Programed</b>																	
Clinic Construction Centrally Funded	-	-	-	-	-	-	-	229	-	56	-	58	-	115	-	229	
Contraceptives	4489	-	1167	-	1671	-	1651	13540	-	2025	-	4470	-	7045	-	18029	
Training Cost	-	-	-	-	-	-	-	685	-	292	-	268	-	125	-	685	
Other Commodities	857	-	709	-	148	-	-	248	-	159	-	37	-	52	-	1105	
Consultant	-	-	-	-	-	-	-	581	-	264	-	167	-	150	-	581	
	<u>5346</u>	-	<u>1876</u>	-	<u>1819</u>	-	<u>1651</u>	<u>15283</u>	-	<u>2796</u>	-	<u>5000</u>	-	<u>7487</u>	-	<u>20629 4/</u>	
<b>AID/W</b>																	
Intermediatory Grant	2574	-	245	-	631	-	1698	510	-	410 <sup>3/</sup>	-	100 <sup>3/</sup>	-	-	-	3084	
AID Sub-total	<u>7920</u>	-	<u>2121</u>	-	<u>2450</u>	-	<u>3349</u>	<u>15793</u>	-	<u>3206</u>	-	<u>5100</u>	-	<u>7487</u>	-	<u>23713</u>	
<b>Other Donor</b>																	
IBRD/IDA & Association	287	-	-	-	-	-	287	33402	-	7057	-	8955	-	17390	-	33689	
UNFPA	1569	-	-	-	92	-	1477	6422	-	3042	-	1951	-	1429	-	7991	
Ford Foundation	1063	-	-	-	474	-	589	500	-	500	-	-	-	-	-	1563	
SIDA 1/	371	-	371	-	-	-	-	-	-	-	-	-	-	-	-	371	
DANIDA 1/	715	-	715	-	-	-	-	-	-	-	-	-	-	-	-	715	
UK-ODM 1/	72	-	-	-	72	-	-	-	-	-	-	-	-	-	-	72	
Sub-total	<u>4077</u>	-	<u>1086</u>	-	<u>638</u>	-	<u>2353</u>	<u>40324</u>	-	<u>10599</u>	-	<u>10906</u>	-	<u>18819</u>	-	<u>44401</u>	
<b>Total Donor Contribution</b>	<u>11997</u>	-	<u>3207</u>	-	<u>3088</u>	-	<u>5702</u>	<u>56117</u>	-	<u>13805</u>	-	<u>16006</u>	-	<u>26306</u>	-	<u>68114</u>	
<b>BDG Contribution</b>																	
F.P. Projects Personnel Cost	10791	3060 <sup>2/</sup>	-	3300 <sup>2/</sup>	-	4431 <sup>2/</sup>	-	-	-	-	-	-	-	-	10791	-	
Travel (Participant)	-	-	-	-	-	-	-	15732	4256	-	5436	-	6040	-	15732	-	
Estab. & Other	-	-	-	-	-	-	-	65	25	-	25	-	15	-	65	-	
Total BDG Contribution	<u>10791</u>	<u>3060</u>	-	<u>3300</u>	-	<u>4431</u>	-	<u>10132</u>	<u>3480</u>	-	<u>3317</u>	-	<u>3335</u>	-	<u>10132</u>	-	
GRAND TOTAL	<u>22788</u>	<u>3060</u>	<u>3207</u>	<u>3300</u>	<u>3088</u>	<u>4431</u>	<u>5702</u>	<u>82046</u>	<u>7761</u>	<u>13805</u>	<u>8778</u>	<u>16006</u>	<u>9390</u>	<u>26306</u>	<u>36720</u>	<u>68114</u>	
<b>ALL-YEAR TOTAL</b>																	

\$104834

POPULATION & FAMILY PLANNING PROJECT  
FINANCIAL PLAN

FOOTNOTES:

- 1/ Latter years the proposed amount included in IBRD/IDA and Associates.
- 2/ Break-down of Family Planning Costs are not available.
- 3/ Incomplete.
- 4/ Total amount in log frame summary also includes over \$2 million estimated requirement to pay for unpaid balance of 11.5 MCs of oral contraceptives ordered in FY 74.

The BDG amount calculated on present exchange rate i.e. Taka 14.00 = \$1.00.