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# ABBREVIATIONS

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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>ARI</td>
<td>Acute Respiratory Illness</td>
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<tr>
<td>AVSC</td>
<td>Association for Voluntary Surgical Contraception (AVSC International)</td>
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<tr>
<td>CA</td>
<td>Cooperating Agency</td>
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<tr>
<td>CBD</td>
<td>Community-based Distribution</td>
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<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
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<td>DFP</td>
<td>Directorate of Family Planning</td>
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<td>DHS</td>
<td>Demographic and Health Survey</td>
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<td>EPI</td>
<td>Expanded Program of Immunization</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>FPHS</td>
<td>Family Planning and Health Services Project</td>
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<td>FWV</td>
<td>Family Welfare Visitor</td>
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<td>GOB</td>
<td>Government of Bangladesh</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>IUD</td>
<td>Intrauterine Device</td>
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<tr>
<td>KAP</td>
<td>Knowledge, Attitudes, and Practice</td>
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<tr>
<td>LIP</td>
<td>Local Initiatives Program</td>
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<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MOHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<td>MR</td>
<td>Menstrual Regulation</td>
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<td>NGO</td>
<td>Nongovernmental Organization</td>
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<td>OR</td>
<td>Operations Research</td>
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<td>ORS</td>
<td>Oral Rehydration Salts</td>
</tr>
<tr>
<td>ORT</td>
<td>Oral Rehydration Therapy</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<tr>
<td>PHN</td>
<td>Population, Health, and Nutrition</td>
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<tr>
<td>QES</td>
<td>Quality, Expansion, and Sustainability</td>
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<tr>
<td>RH</td>
<td>Reproductive Health</td>
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<tr>
<td>SMC</td>
<td>Social Marketing Company</td>
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<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
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<td>TT</td>
<td>Tetanus Toxoid</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>USAID/B</td>
<td>United States Agency for International Development/Bangladesh</td>
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<td>USAID/W</td>
<td>United States Agency for International Development/Washington</td>
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EXECUTIVE SUMMARY

The Bangladesh National Family Planning/Maternal and Child Health (FP/MCH) Program is at a critical juncture. It has experienced substantial success since the early 1980s. Only 15 years ago, the total fertility rate (TFR) in Bangladesh hovered around seven, and the contraceptive prevalence rate (CPR) was less than eight percent. By 1994, fertility had dropped to under four, and prevalence had reached 45 percent. All this happened quickly, despite a social, economic, and institutional environment that many claimed would preclude a dramatic transformation in fertility behavior. Clearly, the National Program's emphasis on the supply side—making contraceptives readily available to as many women and men as possible through a nationwide door-to-door delivery system—has been effective and successful.

There have also been impressive gains made on the maternal and child health side in Bangladesh. In the late 1980s infant mortality began to drop markedly from a level over 100 in the mid-1980s to just under 90 by 1994. This coincides with the program for expanded immunization launched by the Government of Bangladesh (GOB) and its partners. By 1994, 60 percent of the children 12-23 months were fully immunized compared to a rate of less than 20 percent in 1989. This expanded program of immunization (EPI) can certainly take some of the credit for the substantial reduction in childhood deaths.

Today's challenge to the program is to maintain and build on these successes in a sustainable manner. The corresponding challenge to USAID/Bangladesh (USAID/B) is to structure its future assistance package to help the GOB and nongovernmental organization (NGO) partners respond to the new realities. Some of these realities rest in simple statistics:

- The number of married women of reproductive age will increase by almost 40 percent, from 22.7 million to 31.9 million, in the next 10 years.
- Just to maintain current prevalence and fertility levels, the program will have to serve an additional four million users over the next 10 years expanding the number of users from an estimated 10.6 million in 1995 to 14.6 million in 2005.
- To reach the GOB's goal of replacement fertility by 2005, the total number of contraceptive users will have to more than double to 21 million; use of long-acting methods will have to triple; and the number of users of short-term methods will have to double.

Other realities include serious service delivery issues that presently exist despite the program's success:

- A substantial unmet need for contraception coupled with a high discontinuation rate and low rates of use effectiveness
- A rising number of reported menstrual regulation (MR) cases and a declining number of sterilizations
- A supply system that worsens an already unbalanced method mix

1 Population projections are based on Census 1991 figures.
• A substantial unmet demand for high-impact MCH services
• A concern over the quality of services, especially with respect to clinical services

Other factors affecting decisions about future FP/MCH service delivery include an expected doubling of the urban population to over 45 million, the growing enrollment of girls in school, the social transformation occurring in Bangladesh, and the potential impact of HIV/AIDS, which is approaching Bangladesh from all sides.

Clearly, to achieve higher levels of contraceptive use, the costs of the National Program—programmatic, institutional, and financial—will rise to unacceptable and unsustainable levels unless the system becomes substantially more efficient and cost effective.

Recognizing the potential impact of the demographic and socioeconomic changes on the program’s future, USAID/B requested that a team of experts examine the effectiveness and efficiency of the program in the past and identify key issues and strategic options for USAID assistance over the next 10 years. The team was not charged with the responsibility of providing specific details on how the strategic options should be implemented. This will be done over the next several months as USAID/B designs an integrated FP/MCH assistance package in support of the National Program to begin in late 1996. Thus, this report varies from the usual evaluation report by stressing a vision of what can be and suggesting strategy options to guide the formation of future program directions—an intellectual challenge rather than a normative assessment with detailed prescriptions drawn therefrom.

This report summarizes the team's conclusions with respect to issues and strategic options. It provides a framework for building on past successes, refining approaches, and developing innovative ways to meet the emerging challenges, as well as examples of the types of initiatives which USAID should consider supporting. While the team supports continuation of many past initiatives (e.g., social marketing, NGOs), it also introduces some changes consistent with USAID’s current Quality, Expansion, and Sustainability (QES) strategy. Some of the new directions include the following:

• Take advantage of the social transformation underway, especially the greater mobility of women, to encourage them to seek family planning and other health care services in FP/MCH/reproductive health (RH) centers. (This should not be done so precipitously that some hard-to-reach groups—such as newlyweds—cannot avail themselves of doorstep service delivery; nor should it be implemented in areas where prevalence is still relatively low).
• Refine the focus on quality without sacrificing expansion.
• Assist the government in shifting from the role of "retailer" to "wholesaler" in service delivery.
• Assist NGOs to develop special areas of interest rather than create multi-purpose NGOs that all share the same role.
• Encourage greater participation by qualified private practitioners in providing quality FP/MCH/RH services.
• Strengthen the capacity of local administration to plan, coordinate, and implement EPI, FP, and other essential MCH services.

2 See the companion evaluation report by the same team.
• Incorporate greater flexibility in the design of the next assistance package, allowing the program to adjust to environmental and program changes.
• Simplify the structure of the assistance package to reduce the management burden on USAID and the proportion of program funding devoted to administrative costs.

To identify the elements of a successful FP/MCH program that should be put in place now, the team began with a vision of the future in 2005, then focused on USAID/B's role in transforming this vision into reality. In doing so, the team identified a number of strategic options for future USAID/B assistance. In this vision for Bangladesh, the team envisions informed, proactive couples seeking and using appropriate and effective FP/MCH and RH services, fertility approaching replacement levels, and substantial reductions in infant, child, and maternal mortality. Achieving the vision requires a supporting socioeconomic environment and institutional structures (both public and private).

This report focuses on a “package” of health services encompassing family planning and selected maternal, child, and reproductive health interventions. The essential package of interventions should include the full range of contraceptive methods (including sterilization); maternal tetanus toxoid (TT) and childhood immunization; oral hydration therapy (ORT); acute respiratory illness (ARI) case management; and breastfeeding and micronutrient supplementation. In addition, selected antenatal, childbirth, and early neonatal care services and targeted sexually transmitted disease (STD)/RH/HIV interventions are also included.

USAID/B can play an important facilitating role in transforming the vision into reality. But given the demographic realities and the continuing social transformation over the next 10 years, a refocusing of USAID/B's attention and resources will be required. The concepts of quality, expansion, and sustainability provide an ideal and succinct framework for guiding USAID/B's next generation of FP/MCH interventions in support of this vision. The QES framework offers USAID/B clear strategic guidance as well as transparent criteria for selecting among alternative, and sometimes competing, programmatic interventions. It also provides a means for evaluating the impact of future USAID assistance in the FP/MCH/RH field in Bangladesh. In addition, there are several cross-cutting issues associated with ensuring the synergy and feasibility of the QES strategy: IEC, research, policy dialogue, and USAID/B management.

Quality

If the vision of informed and proactive couples seeking FP/MCH/RH services it to be realized, quality services and information must be available and readily accessible to all. The National Program has made impressive quantitative gains in terms of coverage and prevalence, yet these gains have not always been accompanied by advances in the quality of services and information. Recent studies document unacceptably high contraceptive drop-out and failure rates; many women who report wanting no more children are using temporary methods, or worse, no method of family planning; and the dramatic rise in the number of reported cases of menstrual regulation. These facts point to the urgent need to improve the quality of FP (and MCH/RH) services by the public sector, NGOs, and private providers. In addition, it is hard to envision continual rise in prevalence without successfully addressing the widely acknowledged quality shortcomings in the program. Similarly, continued gains in reducing infant and maternal mortality will necessitate the provision of quality FP/MCH/RH services within a tiered but
seamless service delivery system. Therefore, USAID should place high priority on strengthening efforts to provide quality FP/MCH/RH services by the NGOs, the public sector, and private providers. Among the strategic options that USAID/B should consider are the following:

**NGOs**

- Promote greater specialization among NGOs to enable them to concentrate on providing quality services and information in areas they know best.
- Support national NGOs to implement and monitor compliance of quality standards of clinical service delivery.
- Increase the integration of FP/MCH/RH services being provided by NGOs.

**Public Sector**

- Expand the number and use of surveillance teams to monitor the quality of clinical services provided in the public and private sector.
- Promulgate national standards, performance, and monitoring criteria and training to enhance the quality of services, particularly clinical services, in the public sector.
- Increase the role of medical personnel in the provision and supervision of clinical services.

**Private Providers**

- Establish standards and certifications for private providers of FP/MCH/RH services.
- Upgrade the clinical skills of private providers through professional associations.

**Expansion**

While contraceptive prevalence has risen dramatically during the last 10 years, there are areas and populations that have lagged behind; the same is true for child survival and reproductive health services. Areas like the Chittagong division have prevalence levels two-thirds that of the national average. Currently, the rates of contraceptive use among young women are only about half that of older women, yet women under age 25 represent fully 40 percent of the reproductive age women in the country. There is a need for post-MR family planning counseling and services (non-clinical and clinical) provided in a client-sensitive and quality manner. Building on the experience of the urban EPI program, there is a need to strengthen the underdeveloped system for providing quality FP/MCH/RH services to the urban population, especially in the slum areas. While HIV/AIDS is not yet a major public health issue in Bangladesh, the disease is sure to reach the country. Its impact, however, will depend in large measure on how proactive the health system becomes in promoting awareness of the disease and in promoting condom use among high-risk populations. Future USAID/B support and assistance in expanding FP/MCH/RH services should be highly focused and targeted to low prevalence regions and underserved and high-risk populations where quality
FP/MCH/RH interventions are likely to have the largest impact. This includes both door-to-door service delivery as well as new innovative delivery mechanisms. USAID/B should direct its service delivery assistance and support to accomplish the following:

- Expand quality FP/MCH/RH service and information in low prevalence and urban areas.
- Increase coverage and access to underserved and high-risk populations.
- Broaden FP/MCH information and services to include selective reproductive health interventions.

Sustainability

The issue of program sustainability basically involves establishing and maintaining an equilibrium between the demand and supply forces. In the case of FP/MCH/RH, the issue relates to the strength of the public's demand for appropriate and quality FP/MCH/RH services and the organizational capacity to respond to the demand by providing appropriate and quality services at an affordable price (to both the provider and the client). Already the FP program is becoming more programmatically sustainable: witness the increasing desire for smaller families, the rapidly rising contraceptive prevalence, and the substantial remaining unmet need. On the MCH/RH side, programmatic sustainability is manifested by increasing levels of immunization coverage for children and mothers: nearly four million women are making nearly 15 million EPI visits (annually) and over 100 million ORS packets have been sold.

The rising demand for FP/MCH/RH services and information places an increasing organizational and financial burden on the system—a burden that will only increase dramatically in the next decade. Organizational inefficiencies and high costs may have been acceptable in the past because of the priority placed on simply making FP/MCH/RH services readily available to couples. The drag to the system of organizational and financial inefficiencies will only increase over the next decade as the program strives to meet the growing demand for FP/MCH/RH services. Thus it is imperative that all parties (GOB, NGOs, and donors) begin to address the sustainability issue.

It is also important to keep in mind, however, that the goal of attaining FP/MCH sustainability in Bangladesh is well beyond the 10-year time horizon of this report. At best, the donors, the GOB, and other local service providers can take significant, but incremental, steps toward sustainability in the next 10 years. Furthermore, organizational sustainability is likely to be reached earlier than financial sustainability. Nowhere in the world are rural-based family planning organizations self-sustaining financially.

Sharpening the management and technical capabilities of public and private sector organizations is central to achieving any measure of organizational sustainability. USAID/B, through its NGO network, operations research, and support for selected elements of the public sector program, can play an important catalytic role in fostering greater sustainability in the National FP/MCH Program. For example, USAID/B can play a meaningful role in the following:
Promote greater decentralization of responsibility for FP/MCH services to the community level.

Enhance the GOB's willingness and capability to become more of a wholesaler and manager than a retailer and provider of services.

Promote competent and competitive private Bangladeshi organizations to implement elements of the program (e.g., logistics, research, training).

Improve the cost-efficiency of providing FP/MCH services (e.g., rationalizing the use of personnel and facilities to minimize duplication and increase output).

Increase revenue generation in the delivery of FP/MCH services in the public and private sector.

Cross-cutting Issues

There are several key issues which cut across and significantly influence the success of the QES framework: information, education, and communication (IEC), research, policy dialogue, and USAID/B management. All have played pivotal roles in the success of the National FP/MCH Program in Bangladesh. The National Program recognizes the importance of comprehensive IEC activities to promote and sustain demand for FP/MCH/RH services. Similarly, one of the distinguishing features of the Bangladesh program is the empirical foundation on which it is built. Demographic and operations research have played an important role in guiding and evaluating FP/MCH/RH program interventions. There are also a number of critical, and well recognized, policy issues facing the National Program that must be addressed if the vision articulated in this report is to be realized.

IEC, research, and policy dialogue will again play key roles in meeting the challenges of the future and in operationalizing the QES strategy. USAID/B's historic leadership role in these areas places it in an ideal position to test alternative implementation strategies that respond to the changing environment and underserved groups; design and implement IEC efforts to reach these groups and promote quality of services; and continue the dialogue with the GOB on the critical policy issues facing the National Program. For example:

- Target IEC interventions to underserved (and high-risk) groups and by method.
- Use IEC to support and promote providers of quality FP/MCH services.
- Support quick implementation of research findings into program operations.
- Use research to examine the impact, effectiveness, and cost-efficiencies of alternative QES interventions.
- Continue the policy dialogue on key long-term issues confronting the program.

A fourth cross-cutting issue is USAID/B's management of future assistance to the National Program. USAID/B has played an important role in the program's success and has been a major intellectual, technical, and financial contributor. Through its close partnership with external and local implementing organizations, USAID/B has been able to provide substantial support to many aspects of the program including the public and private sector. Yet the current management and administration of the present project design is complex, labor intensive, and cumbersome for all parties involved—USAID, GOB, Cooperating Agencies, NGOs, etc.
There is ample evidence that the large investments made by USAID in the Bangladesh FP/MCH program (most recently the US$300 million allocated between 1987-1997) have paid substantial dividends—witness the increase in contraceptive prevalence and the expansion of immunization coverage. It is equally clear that continued large-scale, but carefully targeted, investments by donors (including USAID) in the program will be needed for the foreseeable future, at least through the 10-year horizon of this report. However, resource constraints and new management structures necessitate that USAID/B adjust its approach to managing, administering, and implementing future FP/MCH/RH assistance and support. Whatever structure and mix of assistance is chosen, it is essential that USAID/B retain flexibility to adjust its programming in response to environmental changes as well as programmatic developments.

- Simplify the structure of future USAID/B support to promote greater accountability of impact and results.
- Identify additional priority areas for proactive donor coordination.

The future presents many challenges to the National FP/MCH Program in Bangladesh. This report provides strategic options for USAID consideration as the Agency formulates its approach to assisting the program in meeting these challenges and realizing the vision of proactive couples seeking and using quality FP/MCH/RH services to realize fertility and maternal and child health desires. However challenging this task is, recent improvements in fertility and mortality trends in Bangladesh clearly suggest that the task can be accomplished if all the partners in the program retain their high level of commitment and support to the effort.
1 BACKGROUND

1.1 The Family Planning and Health Services Project

The USAID/Bangladesh (USAID/B) Family Planning and Health Services (FPHS) Project will end August 30, 1997. To ensure continuing support to the Bangladesh National Family Planning and Maternal and Child Health Program, USAID/B is now planning for the next 10-year period. This report is the first step in a larger process which will include the participation of the many partners in the Bangladesh National Family Planning/Maternal and Child Health (FP/MCH) Program (e.g., the Government of Bangladesh [GOB], USAID/B, USAID/Washington [USAID/W], other donors, nongovernmental organizations [NGOs], Cooperating Agencies [CAs], etc.) in the planning and design of the follow-on assistance package. This report is intended to provide strategic options and guidance to the design process by providing a framework for articulating implementation strategies and activities that will consolidate gains to date and accelerate the impact of program interventions. USAID/B has long been a major contributor to the National Program, and its intellectual leadership and diverse technical inputs are well recognized as a significant factor in the program's success. The strategic directions suggested in this report are based on both extensive past program experience and a recognition of the new challenges expected to emerge during the next 10 years. They reflect a vision of the Bangladesh health system in 2005. This vision is informed by the implications for that system of the major socioeconomic transformation already underway in Bangladesh.

1.2 Bangladesh in 2005

Bangladesh will experience profound demographic and socioeconomic changes over the next decade that will have major implications for its National Program. Most directly relevant to the program strategy are the following demographic projections:

1. The number of married women of reproductive age (15-49) is projected to increase by almost 40 percent, from 22.7 million to 31.9 million in 2005.

- The number using contraceptives will have to increase by about four million—from 10.6 million in 1995 to 14.7 million in 2005—just to maintain the contraceptive prevalence rate (CPR) at the 1993/94 level of 45 percent and the total fertility rate (TFR) at about 3.5.

- Alternatively, an additional four million users—a total of 18.6 million—may be recruited, but this will still only reduce the TFR to about 3.0, if the current contraceptive method mix and use effectiveness is maintained.
2. A key GOB goal is to achieve replacement-level fertility (an average of two surviving children per couple) by 2005. Attaining this goal will require the following achievements (see Figure 1):

- The total number of contraceptive users will need to more than double, from 10.6 million in 1995 to 21.3 million in 2005.
- Long-lasting methods will need to nearly triple, from 2.8 million in 1995 to about 7.2 million in 2005.
- The number of users of short-term modern methods will need to increase even more, from 5.8 million in 1995 to 11.9 million in 2005.

No matter which projection is used, it is clear that the cost of the National FP/MCH Program will dramatically increase in the next 10 years unless the system becomes significantly more cost effective. Some savings can be achieved by moving away from home delivery of contraceptives, but increasing the proportion of long-lasting methods in the method mix, particularly sterilizations, is by far the best option to consider. This is not only the most cost-effective strategy but, if properly implemented, can greatly enhance program quality by virtually eliminating the risk of unintended pregnancy. Shifting to longer-acting methods, however, will require a dramatic reversal in the present trends in contraceptive method mix.

The potential for achieving a high level of contraceptive use—even to the point of reaching replacement levels of fertility—is already evident. The 1993/94 Demographic and Health Survey (DHS) showed, in addition to the 45 percent of married women using various family planning methods, another 19 percent have an "unmet need" for family planning. These women were not using any method but said they either did not want any more pregnancies ever, or did not want to have another birth within the two years following the survey. Moreover, about one-third of all births in the three years prior to the survey were unplanned, and 40 percent of those were unwanted. If the unmet need were fully met and unwanted births were completely eliminated, the TFR would already be at replacement level.

This phenomenon is central to the vision and the strategic options contained in this report, as research data clearly demonstrate that by providing Bangladeshi women and men with the means to realize their reproductive intentions the National Program can achieve its objective. In other words, pursuing a strategy of meeting the expressed fertility needs/desires of individuals will result in obtaining the national goal of replacement fertility in Bangladesh. Indeed, the more the Ministry of Health and Family Welfare (MOHFW) and its development partners focus on providing clients what they want—quality FP/MCH/RH information and services—the sooner the national demographic goals will be met. To accomplish this, however, will require a new orientation toward training, supervision, use of evaluation indicators, and carefully structured operations research (OR) to guide the process.

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3 Including 2.8 million users of long-lasting methods, 5.8 million users of short-term methods, and two million users of traditional methods.
4 Male and female sterilization and IUDs
5 Condom, pill, and injectibles
Contraceptive users
Bangladesh, 1995, 2005

Millions

Year

1995 2005

Long term methods

Traditional methods

Short term methods

0 5 10 15 20 25

21.3

10.6
Fortunately there is increasing recognition in the Bangladesh National Program of the actions and issues to be addressed to accomplish a shift in focus toward meeting individual needs. *The Government of Bangladesh's Future Challenges in the FP/MCH Programme: A Plan for Action* identifies many of these critical priority actions and strategic issues.

By 2005 Bangladesh will be reaping the benefits of the fertility decline of the past several years through a reduced burden on its education and health systems. For example:

- In 1995, the population ages 5-14 was 36 million. If rapid fertility decline continues, in 2005 the population ages 5-14 will be 8 million fewer—a remarkable demographic turnaround. This decrease will greatly facilitate GOB efforts to rapidly raise enrollment rates in primary and secondary school for both girls and boys. Large government investments have already raised the primary school enrollment of girls to nearly 70 percent, which is over twice as high as it was 15 years ago.

- In 1995, there will be about four million births. If replacement level fertility is achieved by 2005, there will be fewer than 3.5 million births, even though there will be about 11 million more women of reproductive age. This decrease will significantly reduce the need for health and other services for women, infants, and young children.

Other demographic and socioeconomic changes will pose new challenges to health and development programs. The urban population, currently estimated at 24 million, is expected to almost double in the next decade with nearly one-third of that population (about 15 million) being slum dwellers. The urban FP/MCH/RH needs are dealt with in some detail in the GOB plan of action. USAID's long commitment and success in the urban MCH field points to the urgent need for the Mission to work with involved ministries and other interested donors on integrated urban programs. Indeed, urban areas could well serve as model areas for a new MOHFW role as a manager rather than a provider of services. Growth of the rural population will be slower than urban, but the overall population density is projected to increase from about 850 per square kilometer in 1995 to about 1000 or more in 2005. Pressure for water resources may well become the single greatest stress in both urban and rural areas as Bangladesh tries to industrialize and also feed its growing population.

A great unknown in any projection is the impact of HIV/AIDS which is rapidly approaching Bangladesh from all sides. One thing is certain: the disease will reach Bangladesh. Its magnitude will depend on steps taken now, before the infection is widely disseminated throughout the population.
2 VISION - 2005

2.1 Conceptualization

In conceptualizing the institutional and programmatic elements that must be put in place in Bangladesh in the mid-1990s to improve the health and welfare of the population, it is essential to articulate a vision of what the desirable and attainable socioeconomic and health picture should look like in the foreseeable future, e.g., in 10 to 15 years. Then, knowing the current situation, it is possible to identify many of the critical areas where strategies need to be either strengthened or changed, as well as where innovations need to be developed, tested, and implemented.

Figure 2 illustrates the team's approach to formulating issues and options for the design exercise. The approach begins with the vision itself, presents basic assumptions underlying the reasoning, identifies the specific areas in which USAID/B is best suited to help transform the vision into reality, and defines issues and options within the quality, expansion, and sustainability (QES) framework already established by USAID/B. As indicated, the approach is entirely consistent with the Mission current approved Strategic Plan and will contribute to its achievement.

Certain elements of any vision for a country are essentially predetermined by current environmental constraints (e.g., land area) and demographic realities (e.g., all of the childbearing couples in the year 2010 are already born, as are all of the persons who will be age 65 and above in the year 2060, etc.). While these are important considerations, of far greater significance are the social and economic circumstances reflected in the birth and death rates, the burden of morbidity, the levels of education, the living conditions, and economic opportunities for women and men which can be greatly altered by policy choices and investment decisions made today.

The vision and strategic options contained in this report are consistent with the Plan of Action agreed to at the 1994 International Conference on Population and Development (ICPD) in Cairo. The ICPD emphasized the importance of focusing more on the needs, desires, and concerns of individuals (including their needs for quality reproductive health services) rather than solely on the demographic imperative. The vision the team sees for Bangladesh—that of informed, proactive couples seeking and using appropriate, quality FP/MCH/RH services—is one that simultaneously meets the fertility and reproductive health needs of individuals and will achieve replacement fertility in Bangladesh in the medium term.

The concern here is with the health sector, focusing on an integrated approach to fertility change and selected maternal, child, and reproductive health interventions. The essential package of interventions should include provision of the full range of contraceptive methods including male and female surgical sterilization and post-abortion family planning services; maternal Tetanus Toxoid (TT) and childhood immunization; oral rehydration therapy (ORT), and acute respiratory illness (ARI) case management; and breastfeeding promotion and micronutrient supplementation. Additionally, selected antenatal, childbirth, and early neonatal care services and targeted sexually transmitted disease (STD)/RH/AIDS interventions should be initiated based on OR results. This "package" constitutes what is referred to in this paper as FP/MCH/RH interventions.
VISION 2005

ASSUMPTIONS

USAID'S CONTRIBUTION TO THE VISION

ISSUES
- QUALITY
- EXPANSION
- SUSTAINABILITY
- CROSS-CUTTING

USAID'S STRATEGIC OBJECTIVES
This integrated approach is logical for several reasons: fertility levels and trends have an impact most immediately and directly on the health sector, as will the threatening HIV/AIDS epidemic; most of the preventable mortality and morbidity occur in infants, children, and reproductive age women; Bangladeshi women increasingly desire smaller families (women 25 and under desire an average of 2.2 children); and, the primary decision-makers regarding reproductive behavior are the same as the primary providers of maternal and child care—persons of reproductive age, especially women. Finally, there are proven programmatic efficiencies and synergies when selected interventions such as FP and EPI (expanded immunization programs) are delivered together.

The role of the health sector is to assist these decision-makers and providers in making informed choices and taking effective actions by assuring that they are fully counseled and have access to essential health services and technologies. Already this role is beginning to be fulfilled through the family planning, immunization, and diarrhea disease programs. The vision articulated here sets forth goals and objectives with essential components that reinforce and extend this role, strengthening the foundations for a cost-effective and sustainable health system for the 21st century.

2.2 Vision Goals, Objectives, and Components

The vision has three distinct goals, integrally related to one another:

<table>
<thead>
<tr>
<th>VISION GOALS</th>
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<tr>
<td>1. Informed, proactive couples, particularly women, seeking and using appropriate and effective FP/MCH/RH services.</td>
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<tr>
<td>2. Fertility approaching replacement levels.</td>
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These goals lead to two broad objectives. The first is primarily concerned with supporting and facilitating Bangladeshi couples to take informed and effective actions. The second is concerned with establishing and structuring a health system, using both public and private resources, to respond fully to couples' health needs, especially their FP/MCH/RH needs.
VISION OBJECTIVES

1. Supportive social institutions and community-wide educational programs sensitive to the needs and conditions of reproductive age couples.

2. A seamless, coherent, and decentralized health system that promotes and supports the increasingly proactive role of couples in meeting their health and family planning needs.

Attaining each of these objectives over the next decade involves having in place a series of institutional and programmatic components. Some of the major components are identified below, a few of which are the responsibility of other GOB agencies. This report, however, focuses on those areas where the key investments and inputs must come from the health sector.

2.2.1 Social Institutions and Educational Programs

This objective consists essentially of four components, each of which, in turn, is comprised of multiple elements:

Component 1: Supportive family and social norms

- Committed political and religious leaders at national and community levels
- Effective universal education for both sexes
- Nationwide family life education

Component 2: Constellation of supporting community institutions and economic structures

- Community-based advocacy and information, education, and communication (IEC) activities
- Markets and public services accessible to women

Component 3: Supportive legal and regulatory framework

- Gender equality in enforcement of legal rights
Component 4: Couple-sensitive health service systems

- Respect for privacy and confidentiality
- Appropriate constellation of services
- Providers sensitive to and respectful of clients' time and intrinsic worth

2.2.2 Decentralized Health System

This objective consists of five essential components:

Component 1: A tiered/continuum service delivery system

- Readily accessible essential preventive interventions, first aid, and screening/referral services provided at the first tier (community level)
- Appropriately organized and supported second and third tier facilities at the union and thana level
- Involvement of the private sector (profit and non-profit) at all levels

Component 2: Functional linkages among FP/MCH/RH services

- Demonstration of political leadership commitment to an integrated needs-based approach to primary health services
- Appropriate policies and strategies formulated and implemented that coherently support FP/MCH and reproductive health services
- Operational programs at all levels designed to respond to FP/MCH and reproductive health needs of the clients

Component 3: Informed and effective demand for services

- All segments of society well informed about essential, affordable, preventive, and curative interventions
- Qualified providers, private and public, of essential cost-effective services clearly identifiable and accessible to the general public

Component 4: Quality-oriented service delivery systems

- Clearly defined and understood standards set and enforced for clean, regularly supplied, and appropriately equipped and maintained facilities at each level of the continuum
• Well planned and implemented staffing system
• Continuing education of personnel through systematic in-service training (including volunteers and private providers where appropriate) based on properly assessed training requirements
• Well-designed, action-oriented surveillance system throughout the country
• Problem-solving, performance-enhancing supervision
• Information-based and responsive management system

Component 5: Sustainable health service system

• First priority given to assuring universal access to documented essential, cost-effective health care at every level in the health system
• Involvement of civil administrations and local communities in supporting and operating the primary health care (PHC) system
• Government administration skilled in quality assurance, cost-effectiveness analyses, strategic planning, competitive procurement, contract oversight, surveillance, and regulatory action
• Qualified private providers encouraged to deliver discretionary health care
• Competitively selected private contractors used to provide specialized support services

2.3 USAID/B’s Role in Transforming the Vision into Reality

The donors, including USAID/B, will join the GOB in playing important but supporting roles in making this vision a reality. The lead roles will be played by Bangladeshi women and men proactively demanding and receiving quality FP/MCH/RH services through increasingly sustainable local public and private organizations.

USAID/B support has been a major factor in facilitating the very real achievements attained to date by the National Program and has much to contribute in the future. USAID/B’s recently approved Strategic Plan identifies three strategic objectives for the population and health sector: (1) use of modern contraceptives by eligible couples increased; (2) use of high impact maternal and child health interventions increased; and (3) institutional, programmatic, and financial sustainability of FP and MCH programs enhanced.

The vision set forth in this report is consistent with and supportive of USAID/B’s strategic objectives. Many aspects of this vision, particularly Objective 1, Components 1–4, are beyond USAID/B’s areas of comparative advantage and span of influence. There are, however, a number of important elements of this vision where USAID/B’s assistance and support can play important facilitating and catalytic roles. Some that fall clearly within USAID/B’s areas of comparative advantage are technical assistance and training in FP/MCH/RH service delivery (especially clinical training) and support services; assistance to the private sector (including NGOs and social marketing); operations and applied research; policy dialogue; and innovative IEC strategies.
The vision is also consistent with the views of the GOB, as stated in the National Steering Committee's recent report, entitled *Future Challenges in the FP/MCH Programme: A Plan for Action*. The vision does not discuss directly several important long-term policy issues recognized by the GOB and the donor community. These include (1) relations between non-medical and medical officers within the FP wing of the MOHFW; (2) employment status of Directorate of Family Planning (DFP) (and NGO) personnel; and (3) division of labor and coordination between the health and family planning wings of the MOHFW. These issues will directly affect the future role of the GOB in providing FP/MCH services, pertaining, for example, to increased decentralization of FP/MCH services, greater community responsibility and authority in this area, and the willingness of the GOB to become more of a wholesaler and manager of services rather than a service retailer and provider. USAID/B's future program strategies and continuing policy dialogues can substantially facilitate positive movement in these directions.

2.3.1 Assumptions

Any effort to assess what USAID/B's role might be in bringing the vision of the future into reality is premised on many assumptions about USAID/B's activities in Bangladesh over the next decade, as well as the responsiveness of the GOB and other local organizations to USAID/B-supported initiatives. Among the key assumptions underpinning this report are the following:

- USAID/B support to the Bangladesh National FP/MCH Program will remain relatively stable over the next 10-year period.
- USAID/B has sufficient financial and personnel resources to maintain intellectual, technical, and policy leadership in order to implement and monitor the program and to leverage complementary support from other donors.
- USAID/B will continue to support the innovative NGO community, especially in its efforts to become more cost effective.
- FP/MCH services will remain a priority for the GOB and USAID/B.
- The GOB will continue to see NGOs and research institutes as real partners in developing the intellectual underpinning of the National Program and will therefore welcome continuing USAID/B support for them.
- Revenue generation (e.g., fees for service) is acceptable to the GOB, local NGOs, and Bangladeshi couples, and the funds generated remain available to the program.
- The GOB is willing to change its role in the program over time. In principle, it is willing to become more of a wholesale supplier rather than a direct deliverer of FP/MCH services and support systems.
- The GOB will redesign and implement a population program that reflects a genuine concern for the FP/MCH needs and choices of its citizens and will mandate decentralized management and authority (e.g., over personnel and budgets).
- Other donor support and funding to FP/MCH/RH will remain strong.
- Local communities will play increasingly stronger roles in support, supervision, and implementation of FP/MCH/RH programs.
- Decentralization will intensify and promote greater community participation.

2.3.2 QES as the Framework for Achieving the Vision's Goals

Achievement of the vision's goals, coupled with the realities of population characteristics and continuing socioeconomic transformation during the next 10 years, requires refinement of interventions and a refocusing of attention and resources to maximize the return on USAID's future investments in this sector. The QES framework is ideally guiding the next generation of programming. Overlaid on the vision, it offers clear directions as well as inherent criteria for selecting among programmatic options. It also offers a means for assessing the impact of future USAID/B investment in FP/MCH/RH in Bangladesh.

The remainder of this report presents design issues and options within the QES framework. It also highlights several key cross-cutting concerns related to all three QES areas. In addressing the issues and options, it is crucial to consider the synergistic relationship between quality, expansion, and sustainability (see Figure 3). Efforts to expand services must not focus on quantity alone but on the expansion of quality services. Similarly, managerial and financial sustainability objectives do not stand alone. Sustainable services must also be quality services. Thus, while design issues and options appear in the QES components below for ease of presentation, the team urges the design team and other readers to consider the issues and evaluate options with a full understanding of their critical inter-relationships and the need to enhance sustainable, accessible quality services within the Bangladesh National FP/MCH Program.
FIGURE 3

THE QES FRAMEWORK

Expansion

Quality

Sustainability
3 DESIGN ISSUES AND OPTIONS

3.1 Quality of Service

The vision for 2005 foresees more informed couples actively seeking affordable services that will effectively meet their FP/MCH and RH needs. If this vision is to be realized, quality services must be available and accessible to all couples.

Quality is multi-dimensional. In the case of FP, at the minimum a quality care system will include the following:

- Sensitive counseling that is client-centered, taking into account the life cycle stage of the couple and the concerns of each partner, and fully explains the advantages and disadvantages of all options

- Technically skilled and client-sensitive providers of clinical services, equally concerned with safety, efficacy, and the follow-up services that produce satisfied users as well as gain new acceptors

- Appropriate service integration with active links to other providers that may offer related services where needed

These same principles, in fact, apply in the case of MCH and RH services, even though each activity may have its own technical and logistical requirements (e.g., maintaining a cold chain and sterile technique with immunizations).

Moving from a service delivery strategy driven by quantitative goals toward one equally concerned with quality and meeting individual needs requires the introduction and implementation of four program elements. Three of these are essentially technical; the fourth, and most important, involves a transformation in the operating principles of most organizations. These program elements are the following:

- Emphasizing the importance of the use of well understood national standards for quality performance drawing from existing models such as those developed for all sectors by the Association for Voluntary Surgical Contraception (AVSC) and Pathfinder.

- Introducing competence-based training of staff persons so that they have the requisite skills to implement a quality program.

- Instituting supervision and surveillance systems that monitor performance quality and respond to and correct deficiencies in a timely manner.

- Transforming the worker performance incentive system so that quality is rewarded and active recognition and self-correction of substandard performance are encouraged.
The record of Bangladesh's National FP Program performance over the past 15 years has two major lessons for the future. First, it graphically illustrates the power of incentive systems to shape the structure and organization of the service delivery system. This is seen first in the dramatic rise in male and female sterilizations in the early 1980s when strong programmatic and financial incentives were available, and then in the equally dramatic decline in these procedures beginning in the mid-1980s (and continuing until the present) when certain incentives were withdrawn and when an increasing percentage of younger couples not ready for a permanent method entered the system (see Figure 4). Correspondingly, in the late 1980s there began the major increase in acceptors of pills (and later injections) that was linked to the massive home-based service delivery system with incentives (e.g., no cost or effort for the client) designed to maximize the couple acceptance rate (see Figure 5).

While this latest strategy has resulted in impressive quantitative achievements (see Figure 6), some adverse consequences of the inattention to quality are beginning to appear. Specifically, recent studies are documenting unacceptably high contraceptive drop-out and failure rates with the non-clinical methods; many women wanting no more children are reporting non-use because of real or perceived adverse effects of modern methods, many of which are non-specific (headaches and weakness). The increasing number of women resorting to menstrual regulation (MR) in recent years is also indicative of the need to improve the provision of quality family planning services. These current programmatic trends, if unchanged, could lead to the virtual disappearance of sterilization and more and more couples having poor experiences with non-clinical methods. Recognizing these problems, the GOB put the issue of increasing the use of clinical methods as the number one priority designated for its Future Challenges: Plan of Action.

USAID/B must put a high priority on strengthening current efforts to promote quality FP/MCH/RH services by the public sector, private providers, and NGOs. Clearly, USAID/B cannot and should not do everything. Nevertheless, there is high potential for designing a follow-on program with impact in all three subsectors, building on past successes, taking advantage of new opportunities, and stressing quality FP/MCH/RH services.
Sterilization and IUD
Bangladesh, 1973 - 1993

Thousands

- Tubectomy
- Vasectomy
- IUD

Year

Source: MIS Unit, Directorate of FP
Non-clinical Methods
Bangladesh, 1973-1993

CYP (Millions)

- Pills/15
- Condoms/150
- Injections/4

Year

Source: MIS Unit, Directorate of FP
CPR in Bangladesh
1975-1993

Percent MWRA

Any Method
Injectable
Pill
Condom
IUD
Tubectomy
Vasectomy

Year

3.1.1 Promoting Quality FP/MCH/RH Services Provided by NGOs

Years before USAID/B had a bilateral agreement with the GOB, it was making grants to indigenous NGOs in Bangladesh to support their family planning efforts. The grants, now cooperative agreements, have continued. During the past two years of managing the QES framework, USAID/B has accelerated efforts to improve the quality of family planning services at every level on the delivery continuum, including the public sector, through the AVSC training program for doctors and Family Welfare Visitors (FWVs) and the development of national standards for quality practice throughout the country. These efforts are beginning to pay off. For example, from 1993 to 1994, among all USAID/B-supported NGOs the percentage of clinical users has increased by at least two points. The increase was twice as high among those USAID/B-supported NGOs that put the greatest effort into increasing quality services. In contrast, the national percentage of acceptors using clinical methods has fallen during the same period. Given the high priority the GOB has put on increasing clinical methods, USAID/B support to improving the quality of service through the NGOs, and eventually in the public system, can have an important programmatic impact. Currently, lack of a fully functioning system of supervision impedes quality improvement efforts in the public system.

The government, at the highest levels, has recognized the importance of its partnership with NGOs and has granted them a rightful place in deliberating on and influencing the course of future policy and implementation decisions. It will be at this level that NGOs can have their greatest impact, serving as catalysts advocating for the importance of quality improvement as a direct means of increasing clinical CPR and reducing costly drop-out rates.

USAID/B is ideally situated to support the intellectual rigor and programmatic leadership that the NGOs can bring to policy discussions with GOB and other donors that are just beginning to understand the programmatic implications of quality. Continuing USAID/B support to NGOs will enhance their capacity to advocate for focused efforts to achieve a full quality service continuum of integrated FP/MCH/RH care over the next 10 years.

In the next 10 years, it is imperative that NGOs consolidate their gains by further developing their special skills and exploring alternative delivery mechanisms rather than adhering rigidly to the traditional community-based distribution (CBD) model. USAID/B can facilitate this transformation by targeting its support more finely and helping NGOs identify and enhance their unique strengths.

Options:

1. **Promote the quality of FP/MCH/RH services provided by NGOs by supporting NGO services based on each NGO’s area of expertise (e.g., clinical, MCH/RH, CBD).** While past USAID/B support has to some extent fostered specialization among NGOs, it has generally addressed the NGOs as a homogenous community, promoting parallel capacity development among them. Greater attention is needed to promoting specialization, where it makes sense, rather than multiple (and duplicative) capacities, e.g., IEC materials production.
2. **Continue to promote the quality of FP/MCH/RH services provided by NGOs by working with national NGOs to implement and monitor compliance of quality standards for all aspects of clinical service delivery.** Efforts at standardization have fallen short of national implementation. During the next 10 years, USAID/B can help NGOs refine quality standards and monitor and reward compliance to support the GOB's objective of increasing the use of clinical methods.

3. **Further increase the quality of FP/MCH/RH services provided by NGOs by instructing NGOs to strengthen and report on integrated quality FP/MCH/RH services.** USAID/B can promote more effective service integration by strengthening the terms of its agreements and removing bureaucratic barriers to increased involvement of FP NGOs in providing MCH/RH services through their facilities and outreach operations.

### 3.1.2 Promoting Quality FP/MCH/RH Services Provided by the Public Sector

The government remains the largest single provider of family planning services in Bangladesh. As such, USAID/B should continue to support improvement of the quality of those services. Experience with the Local Initiatives Program (LIP) demonstrates that improved quality provided in the context of decentralized government services increases clinical CPR. The challenge to USAID/B is to stimulate broad-scale quality improvement in the public sector. This can be done through a strong focus on improved supervision and surveillance; facilitating the temporary use of NGO expertise, if necessary to help develop public sector operations; and pilot/demonstration and OR projects in the public sector that document the importance of equal investments in FP and MCH, a more equitable access to a wide range of methods, and collaborative involvement of medical and non-medical staff in effectively meeting the full needs in a client-centered FP/MCH/RH program.

All of these initiatives should be considered in the context of an ongoing policy dialogue with the GOB and interested donors about the revisions in the motivation structure and programmatic investments to more effectively promote a balanced FP program providing clinical and non-clinical services and a range of related FP/MCH/RH services.

**Options:**

4. **Continue to promote the quality of clinical FP services provided by the National Program by urging the expansion of surveillance and supervision mechanisms to monitor the quality of clinical services provided in the public and private sectors.** Currently, one major constraint to improving quality in both public and NGO sectors is the paucity of surveillance teams to monitor clinical FP services. National surveillance responsibility falls naturally to the GOB. On an urgent basis, USAID/B needs to press for more teams, including the use of an independent contractor if government personnel systems cannot accommodate further increases.
5. Encourage the quality of FP/MCH/RH services provided by the public sector by supporting NGOs, in selected circumstances, to assist in establishing clear standards, developing performance objectives, and providing training to upgrade the quality of GOB personnel and equipment to provide clinical services. Working through selected NGOs, USAID/B can assist in strengthening government services in critical areas. This activity should be linked to a comprehensive strategy involving restructured incentives as noted earlier. NGOs need to employ adequate numbers of physicians to serve in the NGO system. Various mechanisms to resolve this situation should be sought, pilot tested, implemented, or abandoned.

6. Promote the quality of FP/MCH/RH services provided by the public sector by increasing the role of medical personnel in the supervision and provision of clinical services. USAID/B could be in a leadership position regarding this issue through engagement of NGOs in service delivery demonstration projects dealing with this issue, as well as encouraging GOB experimentation with alternative delivery strategies through NGO-supervised pilot/demonstration projects.

3.1.3 Promoting Quality FP/MCH/RH Services Offered by Private Providers

For years, USAID/B has been the sole supporter in developing private sector FP/MCH service delivery. Its success with the Social Marketing Company (SMC) has been so great that other donors are now providing significant levels of support to SMC. Projected numbers of users mandate an increased role for private physicians and other providers of FP/MCH/RH services. In fact, in urban areas, most users of FP, as well as parents with sick children and mothers seeking pregnancy care, are using private providers of uncertain qualifications. USAID/B can play a leadership role here, drawing on its significant experience in similar efforts elsewhere in the world and building on its investments in urban-based activities in Bangladesh. It can support innovative NGO projects that demonstrate effective use of a full range of private providers that may be providing FP, MCH, and/or other RH services to strengthen the quality of care or referral services they provide. Associations of health professionals may also be enlisted to provide continuing education and possibly technical support to their providers of FP/MCH/RH services. USAID/B should also coordinate with other donors supporting improvement in medical and nursing education to assure that all graduates have adequate knowledge and skills in the areas of FP/MCH and RH.

Options:

7. Promote the quality of FP/MCH/RH services provided by the private sector through technical input for the establishment of standards and certifications for private providers of clinical services. USAID/B may support NGO projects that demonstrate how to identify private providers of FP/MCH/RH services in a community and effectively upgrade their skills and performance.
8. Promote the quality of FP/MCH/RH services provided by the private sector by upgrading the clinical skills of private providers through professional associations. Strong professional associations can be important advocates for reaching the public with higher quality FP/MCH/RH health care. Often these groups can also be instrumental in curriculum reform in medical and nursing schools. USAID/B can consider supporting leadership in this area.

3.2 Expansion of Quality FP/MCH/RH Services

To reach higher levels of contraceptive prevalence and to provide the quality FP/MCH/RH services that couples want, the program will have to make a concerted effort to expand the coverage of quality services provided by the public and private sectors. Expansion is broadly defined as horizontal, i.e., further geographic coverage, and vertical, i.e., reaching out to new unserved groups in the same geographic area. Expansion can also include new technologies and modes of delivery, e.g., greater use of the cluster approach and depot holders. Expansion especially includes improving coverage in low prevalence regions and urban areas; increasing coverage among underserved and high-risk populations; expanding the number of types and upgrading the quality of FP/MCH/RH services (e.g., greater integration of FP and EPI services); and promoting greater use of qualified private providers. The need to expand coverage of and access to quality FP/MCH/RH services to ensure continued growth of the program and avoid plateauing is recognized by the GOB. (See MOHFW, Future Challenges in the FP/MCH Programme, 1994).

While contraceptive prevalence has risen dramatically during the last 10 years for the whole country, there are areas in the country that lag behind—especially the Chittagong division. The Chittagong division, which contains 5.6 million couples of reproductive age, has a CPR two-thirds that of the national average and only about half that of the Khulna and Rajshahi divisions. To effectively provide couples in low prevalence regions such as Chittagong with quality FP/MCH/RH services, the National Program will have to focus and concentrate resources in these geographic regions as a follow-on to the pioneering penetrations currently being undertaken by the large NGOs.

Another area meriting greater FP/MCH/RH attention is the urban population. The size of the urban population is expected to increase tremendously over the next 10 years; yet the system for delivering quality FP/MCH/RH services is relatively underdeveloped especially compared to the rural areas of the country. This is particularly true with respect to the urban slums. For example, a large city like Chittagong, which operates a major municipal hospital, has only 25 positions for medical officers, compared to a much smaller rural thana health complex with eight positions. Prior to NGOs’ arrival to provide FP, and more recently EPI, most urban areas had no functioning primary care services. A major thrust of the National FP/MCH Program in the past has been toward the rural areas where most people lived. The whole CBD focus of the public sector, and to some extent among NGOs, has been to extend FP/MCH services to women in rural areas, and this effort has been largely successful in increasing CPR nationally.

The present doorstep method of delivering FP services seems not well suited or cost effective in providing effective services in urban areas where many private providers exist; alternative strategies need to be developed, including service sites with night hours for the growing number of women employed in the formal economy.
An additional element in expanding quality FP/MCH/RH services involves expanding the number of types of FP/MCH/RH interventions provided by the National Program and the delivery mechanisms used to provide these quality services. Among the types of public health services needed is a more integrated approach to FP and MCH/RH. The key element here is the integrated delivery of FP and immunization, which has been shown to enhance both programs in several settings around the world, including Bangladesh. Another important integrated approach is one that includes the provision of quality reproductive health services such as family planning counseling and services for postpartum/post-MR clients and diagnosis and treatment of STDs.

To date, the private sector involvement in the National FP/MCH Program has been limited primarily to NGOs and the social marketing of selected contraceptive methods and oral rehydration salts (ORS). Over the next 10 years, it seems reasonable to anticipate the private non-NGO sector will become more active in the provision of selected FP/MCH/RH services, especially in urban areas. While private providers are not likely to provide FP/MCH/RH services to large segments of the Bangladeshi society, they are likely to serve an important niche among the urban population. To the extent that private practitioners increase their provision of FP/MCH/RH services, particularly clinical methods and services, it is important that these clinical services be delivered in a quality fashion.

Women under age 25 comprise over 40 percent of the women of reproductive age in Bangladesh. Yet contraceptive use among these young women is only about half that of older women. These young, and generally lower parity, women are not well served by the current system. Recent and successful efforts by some NGOs to provide FP services to newly married couples suggest that there is considerable demand for quality FP/RH services among this population, and this group will have a tremendous influence on prevalence and fertility during the next 10 years. Furthermore, the most recent DHS findings indicate that women under age 25 have a lower ideal family size (2.2 children) compared to older women (2.5 children). Without special efforts, including a strong postpartum program to reach younger couples, however, their fertility preferences will not be met.

In addition to the young and newly married, another large underserved population are post-abortion clients. The dramatic rise in the reported incidence of MR over the last few years is a clear indication of a large unmet demand for quality FP services. Estimates are that the current number of MR procedures are probably over 500,000 annually. While the actual number of MR procedures performed is unknown, it is on the increase and represents a population clearly in need of quality family planning services. Of greatest concern, abortion-related deaths are now recognized as the second highest cause (21 percent) of maternal deaths in Bangladesh.

There is also a critical need to initiate a more proactive IEC and condom campaign to prevent the spread of HIV/AIDS especially among high-risk populations and areas (e.g., port cities, truck routes, etc.). While HIV/AIDS is not yet a major public health issue in Bangladesh, the health system needs to become proactive in this area. By actively promoting awareness of the HIV/AIDS disease and promoting condom use among high-risk populations in the country, Bangladesh may be able to escape or minimize the HIV/AIDS crisis confronting other countries in the region.
Options:

9. **Increase expansion of quality FP/MCH/RH services by focusing and directing GOB and NGO efforts toward urban areas and low prevalence areas.** USAID/B can continue to make a significant contribution to the National Program by working with GOB, NGO, and donor partners on policy and planning for FP/MCH/RH delivery in urban and low prevalence areas and by carefully targeting its future FP/MCH/RH assistance efforts to these areas. This may mean redirecting the attention of NGOs toward these areas and designing, testing, and implementing new and innovative models for delivering quality FP/MCH/RH services. It may also mean a much expanded role for the private sector including certified private practitioners.

10. **Increase coverage and access to quality FP/MCH/RH services among underserved and high-risk populations.** Future USAID/B population and health assistance could be targeted to provide quality FP/MCH/RH services to various underserved and high-risk populations. This will likely require identifying priorities among these populations and selecting the most appropriate FP/MCH/RH service interventions to reach these groups. Since many of the underserved and high-risk groups are not adequately served by the current delivery systems, new and innovative means of reaching these groups in a cost-effective/efficient manner will have to be designed, tested, and implemented. USAID/B can play an important catalytic role in this area.

11. **Increase the types of FP/MCH services to include selective reproductive health interventions and encourage the provision of quality services by private practitioners.** Future USAID/B assistance in the population and health sectors will increase its leverage by promoting the more effective use of selected reproductive health services within the context of integrated FP/MCH/RH services. This could include the provision of FP/RH counseling and services to post-MR clients as well as a targeted HIV/AIDS awareness and condom promotion campaign. In the short term, USAID/B may wish to explore the feasibility of other selected RH activities that are affordable to and appropriate for the Bangladesh environment. Finally, USAID/B may wish to examine the feasibility and mechanisms for more actively engaging the private sector as effective providers of quality FP/RH services in selected markets. One option could encourage NGOs and/or medical associations to engage and/or upgrade the skills of private practitioners in clinical FP through a quality and competency-based referral system, particularly in urban areas.

### 3.3 Sustainability

Program sustainability fundamentally involves the demand and supply issues found in any market system. In the case of FP/MCH/RH, the issues relate to the strength of the public demand for appropriate preventive and curative care and the institutional capacities to meet these demands effectively with quality technologies and services that are affordable in the long run, both for the provider and the recipient.
Already, the social and FP and MCH investments by the GOB, USAID/B, and other donors over the past decade are generating a rapidly growing demand for FP, MCH, and RH care. This is expressed in many ways. For example:

- In the case of FP, there is a well documented increasing desire for smaller families, directly expressed in the rapidly rising contraceptive prevalence and in a substantial remaining level of unmet demand.

- For MCH, effective demand is expressed annually, among other ways, by nearly four million women making nearly 15 million visits to EPI centers for immunizations and by the sale of over 100 million ORS packets.

These achievements, however, have brought their own problems that impinge on sustainability. First, the demand still is outstripping the capacity to supply quality FP/MCH/RH services. In family planning, this is seen by the continuing high level of unmet need reported in recent surveys and is manifest in the rapid increase in the numbers of women who are resorting to MR to control their fertility. In the case of MCH/RH, unmet demand is manifested by the very high rates of infant, child, and maternal mortality from preventable diseases still seen in the rural areas and urban slums.

The second and related problem is the rising cost of providing for this growing demand for health services. This is driven by multiple factors. Some, like the growing numbers of reproductive age couples, are inevitable in the short run; but more important are others, such as the rapidly escalating costs of bureaucratic and operational inefficiencies that were tolerable as a program rapidly expanded, but are not sustainable in the long run.

3.3.1 Increasing Institutional and Organizational Sustainability

It is well recognized worldwide that no government can realistically afford to supply all the health care that every individual might demand. At the same time, there are essential preventive and curative services that provide wide social benefits (e.g., immunizations, FP, tuberculosis treatment, STD/HIV control) that not every individual can afford or will be willing to purchase. This requires governments with limited resources to take two interrelated actions:

- First, set priorities on which services to subsidize, choosing those interventions that will provide the greatest benefit to the most citizens and the lowest cost (FP, MCH, and related RH services are clearly in this category).

- Second, learn how to provide these services in the most cost-effective manner so that they can be affordable for the providers as well as the recipients.

While these actions involve technical and managerial considerations, they are very much in the political arena. Thus, these actions require committed leadership, as well as competent management and high-quality technical support. In democratic societies that must be responsive to public demands, like Bangladesh, the record clearly shows that leadership commitment appears most effective through locally elected civil administrations responsible for the general welfare of the public. Government authorities, however, will never possess all of
the high-level competencies required for any operational activity and thus must learn how to access and use professional and technical expertise in the commercial and voluntary sectors of society.

Options:

12. **Increase institutional/organizational sustainability by promoting leadership and management capabilities in the rural and urban civil administrations and local committees.** USAID/B will achieve multiple objectives by moving in this direction. First, promoting local "ownership" of the FP/MCH/RH programs will encourage investments of local resources to increase sustainability. Continuing efforts should be made to promote the lessons learned about local ownership and political and fiscal support from the LIP project. Second, strengthening program management that is closer to operations can reduce bureaucratic and operational inefficiencies. Third, developing mechanisms for closer oversight and decentralizing responsibilities at the local level can better improve technical quality. Finally, encouraging decentralized, responsive elected administrations can promote democratic institutions.

13. **Increase institutional/organizational sustainability by enhancing the GOB's capacity to act as a wholesaler.** Future USAID/B assistance could be instrumental in identifying opportunities for and exploring the feasibility of GOB contracting for selected FP/MCH/RH and support services (e.g., distribution, urban services, IEC, training). There are a number of activities now being implemented by the GOB that could, over the next 10 years, be performed by private organizations (including NGOs), for example, contraceptive distribution, provision of FP/MCH/RH services in urban slums, in-service training, and IEC activities. To accept this idea, the GOB must be willing to adjust its role within the National Program to become more of a manager and financer of selected FP/MCH/RH services and support systems than a full-scale provider of all such services. There is an important policy dialogue and analysis role for USAID/B in helping the GOB embrace the concept of "contracting for selective services" as a viable means of achieving greater institutional sustainability.

14. **Increase institutional/organizational sustainability by promoting technically competent and competitive private Bangladeshi organizations (e.g., professional organizations and associations, NGOs, private companies, universities) to support elements of the program (e.g., training, logistics, research).** USAID/B, through its credibility with professional groups and its ability to relate to the private sector, both for-profit and non-profit, should continue to play a major role here, building on many linkages and capacities already developed, as well as exploring new opportunities.

### 3.3.2 Increasing Financial Sustainability

Included in financial sustainability are issues related both to revenue generation and improving cost efficiency. These two are intimately intertwined and, in fact, cannot be separated from issues of quality and effectiveness. People will not purchase services or commodities that are
not affordable or that they do not perceive as effective or at a level of quality commensurate with the price.

In terms of strategic issues, four points must be emphasized:

- First, the MOHFW will not be able to afford to supply the entire population of Bangladesh with even a limited package of critically essential services if every effort is not made to maximize operational efficiencies. Even an annual expenditure by the GOB of one taka (US$0.025) per person comes to nearly US$3 million.

- Second, and following on the first, not only must there be management improvements with existing strategies but also research to develop even more efficient operations in the future and ones that are at least equally effective.

- Third, given the many intrinsic inefficiencies of any governmental bureaucracy, competitive private sector alternatives should be encouraged wherever possible.

- Finally, sustainability is a long-term goal that is well beyond the 10-year horizon of this report. At best, the GOB and other local FP/MCH/RH service providers can take significant but incremental steps toward sustainability. It should also be pointed out that institutional/organizational sustainability—if measured by strong leadership and management capabilities—is likely to be achieved earlier than financial sustainability, which remains one of the most difficult challenges in all population programs, especially in poorer countries like Bangladesh. Nowhere in the world are rural-based FP organizations fully self-sustaining financially.

Options:

15. Increase financial sustainability by improving the cost efficiency of providing FP/MCH/RH services (e.g., rationalizing the use of personnel and facilities to minimize duplication and increase output). USAID/B can facilitate this process, particularly through supporting NGOs that can lead the way in developing and implementing managerial and operational strategies that improve cost effectiveness, as well as through support of operations research (see below).

16. Increase financial sustainability through increasing revenue generation in the delivery of FP/MCH/RH services in the public and private sector. USAID/B already has a successful track record in initiating financial sustainability efforts with the development of the SMC. This can be extended in the private sector by supporting programs that encourage private providers, particularly in urban areas, to offer selected FP and MCH/RH services (e.g., sterilizations) at a quality that will attract paying clientele. In the public sector, USAID/B can encourage the GOB to recover nominal costs for many services in high demand. USAID/B could also undertake a more systematic examination of health care financing, paying particular attention to FP/MCH/RH.
3.4 Cross-cutting Design Issues and Options

There are several key implementation and management issues associated with ensuring the synergy between the quality, expansion, and sustainability initiatives, namely IEC, research, policy dialogue, and USAID/B management. These issues are ones with which USAID has considerable experience and expertise, and they are critical to carrying out successfully the options discussed earlier. USAID/B has recognized the importance of comprehensive IEC, research, and policy dialogue activities in support of the National Program as a whole. It has been a major player in focusing attention on the need for these broad-scale activities, bringing international expertise to the Bangladesh National Program and stimulating the development of national expertise. Past experience and successes now place USAID/B in an ideal position to refine its implementation strategies in response to the changing environment, meet the challenges of reaching underserved populations, use IEC to enhance quality of service, target usable, practical research on issues germane to the next generation of programming, and continue the policy dialogue/research.

The GOB and its partners, including USAID/B, have long recognized the contribution of IEC activities in support of the National Program. The IEC activities have contributed to the changes in fertility behavior that have occurred during the past decade in Bangladesh. Effective communication technologies and strategies will be equally important to continued success in the future. A comprehensive IEC effort will be essential to implementing the QES options by making sure that Bangladeshi women and men have an informed choice among contraceptive methods (quality); expanding the messages to encompass essential MCH/RH services and targeting messages to underserved and high-risk populations (expansion); and promoting greater capacity of Bangladeshi organizations to design and implement IEC campaigns (institutional sustainability).

One of the hallmarks of the National Program in Bangladesh is the empirical foundation on which it is built. Bangladesh is unique in the extent to which research findings, pilot projects, and field experiments are used to guide large-scale program implementation and test alternative strategies to delivering FP services and increasing contraceptive prevalence. The operations research conducted in Matlab and through the Urban/Rural FP/MCH Extension Projects provided the empirical basis for many of the program’s achievements to date (e.g., the importance of outreach and follow-up in increasing CPR). These efforts need to continue, though the focus of future research may shift to addressing how to deliver more effectively and efficiently FP/MCH/RH services within the QES framework discussed above.

There are a number of important policy issues that the GOB program will have to confront over the next 10 years including the role of medical personnel within the FP wing of the MOHFW, the employment status of DFP personnel, decentralization of FP/MCH/RH services, and the willingness of the public sector to become as much a manager of services as a provider of services. The GOB has already identified many of these issues as critical to the future success of the National Program, and it is essential that USAID/B continue to assist the government in addressing these issues through policy dialogue and policy research.

There are also organizational and bureaucratic constraints facing the GOB that impinge on the implementation of the National Program. In addition to the policy issues listed above, there is the looming “talent crisis” that will confront the program as senior Ministry officials at all administrative levels retire over the next several years. In addition, there is also the question
of the allocation and accountability of GOB resources—human, capital, and financial—that need to be committed to the FP/health sector. It is important that the GOB increase its contribution to the resources being committed to achieving further reductions in mortality and fertility. USAID/B should continue to engage the GOB (and other donors) in policy dialogue and policy research on these issues.

USAID resource constraints and new management imperatives demand that USAID/B adjust its approach to overall program administration, establishing new strategies for oversight and stimulating and measuring impact. USAID/B is distinguished among donors for its close partnership with CAs, its concern for performance and accountability, and its attention to measuring the impact of its FP/MCH/RH investments. The challenge now is to continue this partnership and concern with fewer resources.

3.4.1 IEC

Options:

17. Make IEC explicitly support and promote QES by (a) promoting the use of contraception and MCH services together as a means to ensure healthier families; (b) targeting messages to underserved groups and by method (including men and male methods); and (c) increasing advocacy activities with political and community leaders to build a stronger national and local government commitment to providing FP/MCH/RH services. Past IEC activities have been very successful in promoting awareness and increasing prevalence. While these general objectives need continuing attention, it is also important to formulate IEC programs that now encourage couples to seek MCH and RH as well as FP services. This will be especially effective in reaching low-parity women. Additionally, IEC is essential to reach specialized groups such as newlyweds and men. Sustainability can be supported through more effective advocacy among leadership groups. In addition, greater sustainability can be achieved by continuing to build and institutionalize within local organizations the capacity to implement effective IEC programs and design materials using standard and innovative communication technologies.

3.4.2 Research

Options:

18. Stimulate more rapid implementation of relevant research findings. USAID/B and others have supported massive amounts of FP/MCH/RH research in Bangladesh. Much is known about the knowledge, attitudes, and practice (KAP) of Bangladeshi families, as well as about the effects of various program strategies. In view of the new strategies that will be needed in response to the social transformation, as well as the general need to do more with less, new mechanisms are needed to ensure that research findings are rapidly available to those who need them and that findings and lessons learned are applied more quickly in the field.
19. **Focus research on impact and cost-efficiency issues.** Program needs are rapidly outgrowing program resources, and this trend will continue. Simply maintaining gains achieved to date is now problematic; expansion of sustainable quality services is even more so. It is critical that USAID/B-supported research address impact and cost-efficiency issues in FP, MCH, and especially RH, in order to help the National Program identify and use those interventions that take best advantage of available resources and have the greatest impact on achieving FP/MCH/RH objectives.

3.4.3 **Policy Dialogue**

Option:

20. **Continue policy dialogue on key long-term issues confronting the program.** Policy dialogue and analysis is an area where USAID/B support has been effective and where continued assistance is needed. The GOB has identified nine priority policy issues that must be addressed if the program is to achieve its objective of replacement fertility within 10 years. These policy issues are both structural and programmatic. Among the structural issues are several that concern the MOHFW as an organization: the relations between the two wings of the Ministry; relations between the medical and non-medical personnel within the Ministry; and the employment status of the large number of temporary personnel. On the programmatic side are the issues of reversing the downward trend in the use of clinical methods; continuing need for training among Ministry personnel; effective GOB-NGO collaboration; sustainability; provision of FP/MCH/RH services in urban areas, especially slums; and utilization of research findings. Ultimately, these policy issues will have to be resolved by the GOB itself. USAID/B, in concert with other donors, can facilitate the policy dialogue by assisting the GOB to identify policy options and assess the costs and programmatic implications of alternative options. It is important that alternative options be evaluated in terms of both cost and program performance before they are implemented nationwide.

3.4.4 **USAID/B Management**

Options:

21. **Simplify the structure of the next USAID/B population and health (PH) project and promote greater accountability of impact and results achieved by USAID/B-supported organizations.** During the last 10 years, USAID/B has managed an increasingly complex program with fewer personnel resources. During the next 10 years, as human and financial resource constraints continue to grow, USAID/B will need a simpler project structure that requires less administrative level of effort and focuses available resources on monitoring impact and quality. This also implies the need to establish a limited number of clear, manageable impact and quality measures applied across the board, allowing USAID/B to assess the relative effectiveness and impact of its activities and adjust its support accordingly. The future USAID/B assistance package needs to permit flexible allocation of resources to maximize QES impact on the National FP/MCH Program.
Identify additional priority areas for proactive donor coordination at the policy and operational levels. Effective and coherent cooperation and coordination among donors is essential to the realization of the vision. Individually, no donor can provide the external assistance and resources needed to support implementation of the vision, but working together and in concert the donors collectively can provide critical backing at the policy and operational levels. The timing could not be better: the two largest donors in the National FP/MCH Program (USAID/B and the World Bank Consortium) will be developing their follow-on assistance packages over the next several years. In addition, through the Common Agenda with the United States, the Japanese government has identified population and HIV/AIDS as priority assistance areas and is anxious to work in Bangladesh. These developments create an ideal opportunity for collaboration among donors to develop truly complementary assistance strategies and identify policy issues where there is common agreement. This report projects a vision of a FP/MCH/RH program in Bangladesh built around proactive couples throughout the country receiving quality services that are increasingly sustainable. The donor community has an important supporting role in transforming this vision into reality, but only if all parties work in concert with one another.