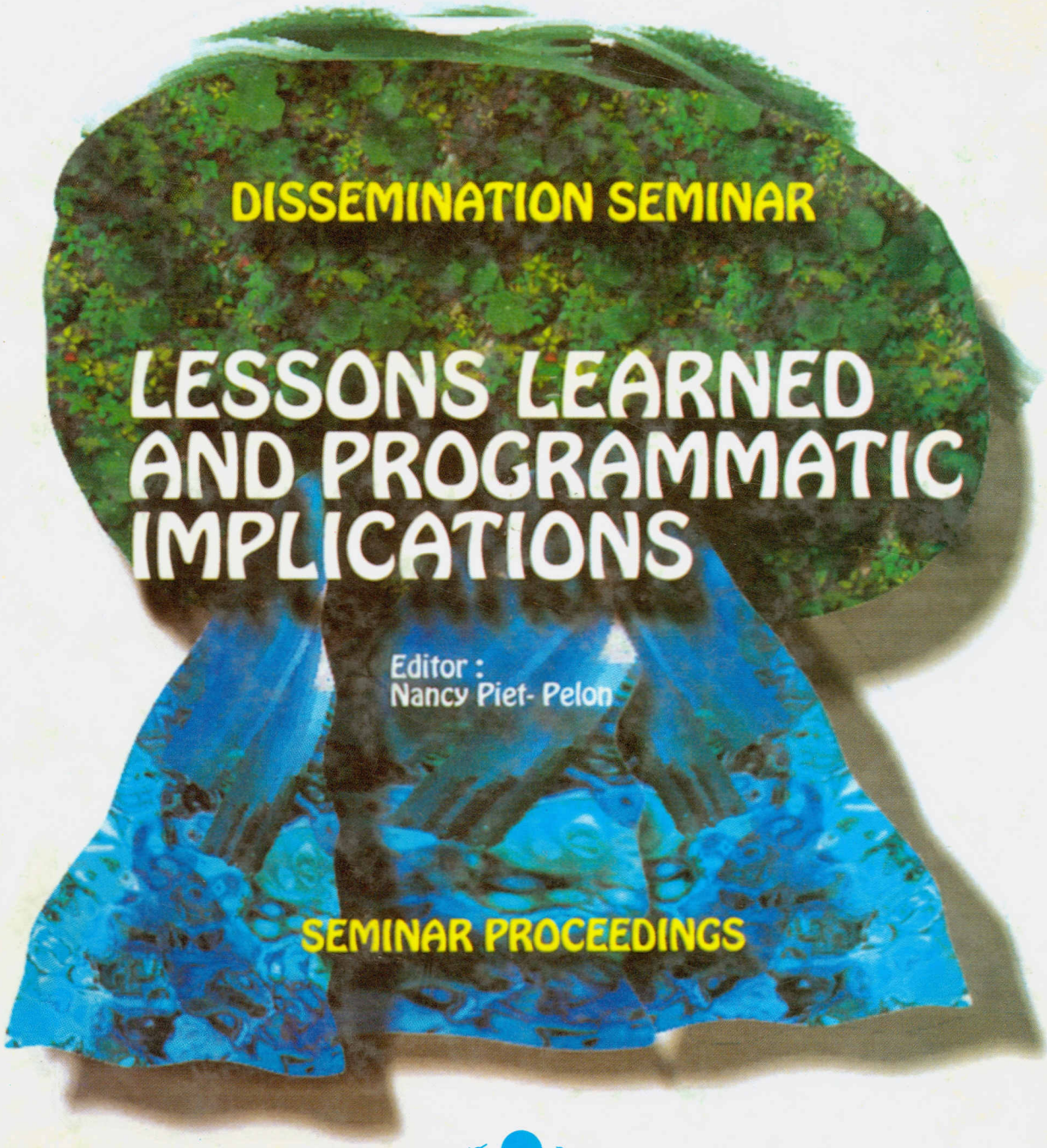

DISSEMINATION SEMINAR

LESSONS LEARNED AND PROGRAMMATIC IMPLICATIONS

Editor :
Nancy Piet- Pelon

SEMINAR PROCEEDINGS

ICDDR,B

CENTRE

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Health an
ICDDR,B:
(HPED)
n Research

DISSEMINATION SEMINAR

LESSONS LEARNED AND PROGRAMMATIC IMPLICATIONS

Editor
Nancy Piet-Pelon

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Secretary,
Ministry of Health & Family Welfare
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FOREWORD

Bangladesh is facing a formidable challenge in its health and population sector. The programme must both sustain the success of its internationally acclaimed family planning programme and break new grounds to achieve its Health and Population Sector Strategy (HPSS). This combination of challenges requires all of us to seek new ways of looking at old problems. The further challenge ahead of us is to determine how to prioritize the delivery of every element of the Essential Services Package (ESP) to which we are all committed.

Consequently, the findings presented at the ICDDR,B MCH-FP Rural Extension Project's Dissemination Seminar are particularly welcome. The Extension Project's various operations research interventions have experimented with those issues which we face in the national programme. With their results, both the positive and negative ones, we have a road map which we can follow as we move forward. I congratulate Professor Barkat-e-Khuda and his colleagues for their excellent work.

The Ministry of Health and Family Welfare faces critical organizational issues. This is, perhaps, our greatest challenge but we must accept it if we are to accomplish the goals we have set ourselves. At the community level, particularly using cluster visitation spots and combining EPI and satellite clinic services, the Extension Project has proven that our health and family planning workers, working together, can serve clients more effectively. This coordination and cooperation will need to be duplicated throughout our system.

ICDDR,B is a valued partner to the Ministry of Health and Family Welfare. I would like to express my appreciation to them, particularly to the MCH-FP Extension Project (Rural), for their contribution to the national programme.

I congratulate Ms. Nancy Piet-Pelon, the editor of this volume, for completing this task in such a short span of time. I recommend this volume to all who work with us and are committed to making the national programme a success.

Muhammed Ali

ACKNOWLEDGEMENTS

The MCH-FP Extension Project (Rural) is a collaborative effort of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) and the Ministry of Health and Family Welfare (MOHFW) of the Government of the People's Republic of Bangladesh, supported by the Population Council. Its purpose is to improve the delivery of maternal and child health and family planning services through the MOHFW programme.

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INAUGURAL SESSION

Address of Welcome
Syed Shamim Ahsan
Division Director, Health and Population Extension Division
ICDDR,B

Mr. Chairperson, Mr. Muhammed Ali, Dr. Richard Brown, distinguished guests, ladies and gentlemen. Assalamu alaikum.

I have the privilege to welcome you all to this two-day seminar of the ICDDR,B MCH-FP Extension Project (Rural). This seminar has been organised to highlight the salient features of various on-going Project activities, and to present two valuable monographs on lessons learned through the Extension Project's operations research and those from the Bangladesh family planning programme as well as an upcoming monograph on Reproductive Health.

The Health and Population Extension Division, known as HPED, is the second largest Division in the Centre. The Division has four projects carrying out research activities in different areas and settings in the health and population field. The Rural and Urban components of the MCH-FP Extension Project work in close collaboration with the Ministry of Health and Family Welfare, Government of Bangladesh, toward improving the management, quality of care, and sustainability of the national programme through applied research, technical assistance, and dissemination. The Environmental Health Programme (EHP) of the Division focuses on multi-disciplinary activities such as environmental engineering, sociology, public health, laboratory science and management. Finally, the Epidemic Control Preparedness Programme (ECPP) carries out investigations into, and monitoring of the cholera epidemics in a cholera-endemic country like Bangladesh.

The ICDDR,B started its Mother, Child Health and Family Planning (MCH-FP) work in Matlab, in 1977. Matlab's success prompted the creation of the MCH-FP Extension Project to test the feasibility of introducing the successful elements of the Matlab Project into the national FP-MCH programme, using government resources, mechanisms and procedures.

At the earlier stages of the national programme, the focus was on increasing contraceptive coverage. Accordingly, the Project identified various key factors that could improve access and effective service delivery. Many of the Project's successful interventions, i.e., satellite clinic combined with EPI (SC-EPI) and emergency obstetric care (EOC) have already been implemented nationally. Based on Project recommendation, Government of Bangladesh recruited 10,000 additional fieldworkers, which increased the fieldworker density considerably. Moreover, the Project also assisted the Government in improving its management information system (MIS), including the FWA registers, client screening checklists, and monitoring tools for frontline supervisors such as the FPI and AHI diaries. The Project also helped in organising logistics and management through the provision of drug and dietary supplement kits to satellite clinics.

USAID has given ICDDR,B the **"sole source"** for the entire operations research portfolio of USAID's **National Integrated Population and Health Program**, known as **NIPHP**. In the new initiative, the Health and Population Extension Division is the designated executing entity for the next seven years, beginning August 1997. The existing Rural and Urban Projects will be merged into one project in the NIPHP to maximize use of skills, expertise and resources, and thereby, operate in a more business-like manner. Please allow me to take this opportunity to express our thanks to USAID for its continued assistance to the work of the Extension Project.

The vision now for the Project and the Government, is to ensure better health for the whole family. The changing needs and priorities of families have prompted the Project to design a number of new interventions to meet the future challenges. They include: providing Essential Services Package (ESP), which comprises wide-ranging health and family planning services; promoting clinical contraception; promoting the involvement of men in reproductive health; and promoting the prevention and treatment of RTI and STDs, including HIV and AIDS. It is worth mentioning that all these Project interventions are in line with the priorities of the Government's Health and Population Sector Strategy and Fifth Health and Population Programme.

I would also like to reaffirm that the Division works very closely with the Ministry of Health and Family Welfare of the Government of Bangladesh. Over the years, many of the valuable findings from different projects operating under the Division have greatly helped the national programme in materialising the objectives of the Government. On this occasion, please allow me to express our gratitude to the Ministry of Health and Family Welfare for its continued support and assistance to the Centre and the Rural Extension Project. Also, I am confident that our existing excellent relationship with the Government will grow even stronger in the days to come.

Let me close by welcoming you once again to this seminar, and I look forward to your active participation in the deliberations.

Objectives of the Seminar
Professor Barkat-e-Khuda
Project Director, MCH-FP Extension Project (Rural), ICDDR,B

Mr. Chairperson, Professor Demissie Habte; Mr. Chief Guest, Mr. Muhammed Ali, Secretary, Ministry of Health and Family Welfare; Mr. Special Guest, Dr. Richard Brown, Mission Director, USAID, Bangladesh; Syed Shamim Ahsan, Division Director, Health and Population Extension Division, distinguished participants, ladies and gentlemen:

Let me begin by extending my very warm words of welcome to all of you.

I will briefly share with you the major objectives of this Dissemination Seminar. The main objectives of this seminar are to: (a) provide the GoB, donors, NGOs, the scientific research community of Bangladesh, and the media, an overview of the major lessons learned and the policy impact the Project has had on the Bangladesh Health and Family Planning Programme over the past 15 years of its existence; (b) share with you some of the key findings, lessons learned and programmatic implications of the Project's most important recent operations research interventions in the areas of management improvement, quality of care, and sustainability; and (c) share with you some of the key results from a number of reproductive health studies and policy analyses carried out by the Project over the past year and a half.

The policy and programme relevance of the Project's work is demonstrated by the translation of many of the Project's research findings into concrete programme policies and actions, not only in the GoB, but by NGOs as well. The widespread dissemination of the Project's results is evidenced by the publication of the study results in international journals, and with replications of some Project strategies and approaches to programme improvement outside of Bangladesh as well (e.g., replication of the Project's SRS in Ghana, Tanzania, Gambia, Uganda and Indonesia).

In addition to the Inaugural Session, the seminar is divided into three scientific sessions: two scientific sessions today after this inaugural session, and another one tomorrow morning. The first scientific session is entitled the **"Broader Reproductive Health Agenda".** This session will be chaired by Professor A.K.M. Nurul Anwar, Director General, Health Services. The three presentations in this session are: (1) **Strengthening Outreach Sites: An Approach Combining Satellite Clinics with EPI;** (2) **Strengthening Maternal and Neonatal Health;** and (3) **Essential Services Package.** These presentations present the preliminary key findings and lessons learned from the respective interventions, each of which has important implications for the reproductive health programme of Bangladesh.

The second scientific session is on the critical issue of **"Sustainable Service Delivery Approaches".** The session will be chaired by Mr. Shirazul Islam, Director General, Family Planning. The three ongoing sustainability-related interventions of the Project presented are: (1) **The Delivery of Maternal, Child Health and Family Planning Services Through Cluster Visitation;** (2) **Charging for FP-MCH Commodities and Services;** and (3) **Networking of Government and Non-government Family Welfare Service Providing Agencies.** Findings from these three presentations have important implications for the service delivery strategies of the national health and family planning programme.

The final scientific session entitled **"Lessons Learned and Programmatic Implications"**, will be chaired by Mr. Muhammed Ali, Secretary, Ministry of Health and Family Welfare. The final session is intended to disseminate the key findings, lessons learned and programmatic

implications from three different research monographs, two of which have been published by the Project and the third will soon be published. I shall be presenting the key findings on policy and programmatic issues from the first two monographs (which have already been published, and copies shared with you). These monographs are: (1) **Bangladesh Family Planning Programme: Lessons Learned and Directions for the Future** by Barkat-e-Khuda, John Stoeckel, and Nancy Piet-Pelon; and (2) **Improving the Bangladesh Health and Family Planning Programme: Lessons Learned Through Operations Research** edited by Barkat-e-Khuda, Thomas T. Kane and James F. Phillips. Dr. Thomas Kane will present a summary of the key findings and programmatic implications of 24 research papers addressing various reproductive health issues, which will soon be published as a monograph entitled **"Reproductive Health in Rural Bangladesh: Policy and Programmatic Perspectives"**. A number of the papers in this monograph have been presented at various seminars over the past year, including the APHA meetings in New York in November 1996; the IUSSP meetings in Islambad in December 1996, and at Costa Rica in May 1997; the Sixth ASCON meeting of the ICDDR,B; and, at the annual PAA meetings in Washington, D.C., both held in March 1997.

Although presentation of our research findings at seminars such as these and at international conferences and in journal publications are important in the process of dissemination of the research results, we believe that our dissemination objectives are not fully achieved unless the relevant study results, findings and programmatic implications are translated into real policies, and then, utilized to improve programme performance at all levels. Therefore, the Project attaches very high priority to organizing this type of dissemination seminar.

The three scientific sessions have been organized in a way that will allow us to get the maximum benefits of valuable comments and suggestions by a number of designated discussants, given their relevance to the national programme -- government, NGOs, and the private sector. In addition, comments by other distinguished participants would be most useful for all of us. I am, however, afraid that all of you may not get enough time to put across all your points within the stipulated time allotted within each session. I would, therefore, seek advance apology from those of you who may not be able to get enough time, but at the same time request you to share with us your comments and suggestions during the breaks as well as after the seminar.

Before I finish, please allow me to express my deepest gratitude to Mr. Muhammed Ali for taking keen interest in our activities and gracing this occasion as the Chief Guest. Sir, we also look forward to your chairing the last scientific session tomorrow morning. We are most indebted to the Ministry of Health and Family Welfare and its two directorates for their continued collaboration with us. Dr. Richard Brown deserves my sincerest thanks for gracing this occasion as the Special Guest. We value the continued support and cooperation from Mr. David Piet and his colleagues at USAID. I am most indebted to Professor Demissie Habte and Syed Shamim Ahsan for their constant encouragement and support. Funding for this seminar has been provided by the Population Council to which I am indebted. My thanks are due to all those who agreed to be the chairperson and discussants of the different sessions as well as to all our distinguished participants, especially our GoB counterparts from the field. Also, our thanks are due to our distinguished colleagues from the donor agencies, NGOs and the private sectors. To our valued friends from the media, a special thank you for coming to this seminar. We hope, through your efforts, the major findings will be disseminated widely. My thanks to various ICDDR,B colleagues, and finally to my colleagues in the Project for their hard work which has made this seminar possible.

Special Guest
Dr. Richard M. Brown
Mission Director, USAID, Dhaka

Mr. Chairman, Mr. Secretary, Mr. Ahsan, Professor Barkat-e-Khuda, colleagues from the Government of Bangladesh, representatives of development partners, colleagues from ICDDR,B; ladies and gentlement.

I am pleased to join you at this seminar organized by the ICDDR,B MCH-FP Extension Project (Rural). This provides an opportunity for these professionals to share lessons learned from their operational research work in rural Bangladesh. As many of you are aware, USAID has been associated with this programme since its inception in 1982. During this time, the programme has achieved many notable successes. The close co-operation between the ICDDR,B, the Ministry of Health and Family Welfare and its two directorates, NIPORT, NGOs, the private sector and USAID has been an example for a true development partnership.

USAID/Bangladesh has long been associated with the Government of Bangladesh in its development efforts, particularly in the area of health and family planning. Our ten-year $300 million family planning and health services project has helped play a role in facilitating and implementing the national FP-MCH programme in all sectors - public, private, and NGO. It contributed to the remarkable success of the national programme during the last ten years - especially in the private sector. It has, for example, greatly expanded the use of NGOs to involve local personnel, supported the development of an excellent social marketing system, and designed a policy and strategy for promoting quality, management, and sustainability across the board through ICDDR,B operations research. These initiatives, among others, have contributed to strengthening the infrastructures for upgrading service delivery programmes and are reflected in the country's impressive contraceptive prevalence rate of 49 percent and total fertility rate of 3.3. in 1997.

Based upon the external evaluation of the family planning and health services project, a USAID-funded sector and strategic options assessment, and a 1995 USAID population and health customer appraisal, the GoB and USAID jointly decided that a new initiative was required to meet the challenges of the next millennium. As a consequence, a seven-year National Integrated Population and Health Program, known as NIPHP, has been designed with seven major components: Rural Service Delivery, Urban Service Delivery, Social Marketing, Quality Improvement, Operations Research (OR), Urban Immunization, and Contraceptive Logistics.

An agreement between the USAID and the GoB in this regard was signed recently agreeing to provide 210 million US dollars for the implementation of the NIPHP. The ICDDR,B Extension Project will be responsible for carrying out operations research for the NIPHP.

The NIPHP attaches top priority to serving the areas of low health performance in Bangladesh. These areas are characterized by high proportions of unmet need, resistance to, and/or unavailability of both family planning and essential health services. Geographically, this means a special emphasis on Chittagong and Sylhet Divisions and urban slums. Also, high priority will be given to under-served pockets and specialized services in higher performing

areas. Furthermore, emphasis will be given to meet the needs of various special groups like newly-weds, post-partum women, and adolescents. Appropriate operations research to find the ways and means to reach the NIPHP objectives will be of critical importance.

The major thrust of the NIPHP is provision of essential services package, particularly to the socioeconomically disadvantaged Bangladeshis. This thrust is in keeping with the Government's health and population sector strategy and will complement the Fifth Health and Population Programme of the World Bank and other donors.

The NIPHP attaches importance to even better co-operation and co-ordination between the GoB and NGOs in the population and health sector. It also addresses the management and financial issues of the service delivery system, and promotes the transition from home-based to static-clinic-based service delivery.

In making the NIPHP a success, the ICDDR,B MCH-FP Extension Project has an important role to play. The vision now for the national programme is to ensure better health for the whole family. It is necessary to look at new, less costly ways, of providing high quality services and to identify ways by which the private sector can develop cost recovery methods to make the delivery process more sustainable, particularly with the doubling of the target group over the next ten to fifteen years. The Project will continue to assist the national programme achieve its objectives by conducting programmatically-relevant operations research and then disseminate the findings of such research to all concerned.

I would like to thank the ICDDR,B for organizing this seminar. I hope that the deliberations during the seminar will highlight various critical issues that need to be resolved to address the future needs of the programme. The sessions on reproductive health and service delivery are important and timely. I commend the ICDDR,B Rural Extension Project for a large number of relevant programmatic research publications, including the two volumes being disseminated at the seminar. I must also say that I find the one page intervention update one of the most useful documents I have used as a development manager. Your comprehensive documents of the lessons learned and directions for the future provide us a useful map. I would like to look forward to the reports on the outcome of these discussions and assure you of our continued support, assistance and interest in the health and population sector.

Chief Guest
Mr. Muhammed Ali
Secretary, Ministry of Health and Family Welfare
Government of Bangladesh

Mr. Chairman, Professor Habte; Dr. Brown; Mr. Ahsan; Professor Barkat-e-Khuda; my colleagues in the Government, representatives of the development partners, colleagues from the ICDDR,B, ladies and gentlemen. Assalamu alaikum.

It is a great privilege to be here at ICDDR,B, an institution of international repute, of which we are justly proud. The Centre and the MCH-FP Extension Project (Rural) has been working in the health and family planning field for several years. It is timely that the Centre has organized this workshop to share its lessons learned on activities that it has been carrying out for over a decade.

All the population programmes under the first four development plans since our independence have been characterized by strong political commitment toward a well-defined, high-impact and high-quality health and population strategy. In the Fourth Five Year Plan, the Government allocated around 5,360 crore Taka to the health and population sector. The overall objectives of the Fourth Five Year Plan were to improve the health status of the population, especially of mothers and children; to integrate population issues within the overall development programme, right down to the community level; to initiate a multi-sectoral population programme; to strengthen and consolidate Primary Health Care; and to work toward the prevention of communicable disease. The draft Fifth Plan also attaches high priority to the health and population sector, since achievements in this sector will greatly determine the overall wellbeing of our people.

We have been able to achieve considerable success in family planning through a gradual shift toward an MCH-based family planning programme, and well-focused IEC programmes. The involvement of the NGOs and the private sector - particularly SMC - in service provision, has proved to be increasingly important as well. Consequently, we have been able to increase the contraceptive prevalence rate from 8 percent in 1975 to 49 percent in 1997.

Bangladesh has achieved a dramatic decline in its total fertility rate, from 7 in 1975 to about 3.3 in 1997. Yet today, we stand at a critical juncture, for the effort which was required in achieving this great accomplishment pales in comparison to that which will be required to reduce fertility still further. The Government of Bangladesh attaches its top-most priority to this sector. The Government recognises the fact that a client-oriented reproductive health approach is the most effective way to reduce unwanted fertility. Moreover, to offset the demographic momentum, our policies need to encourage delays in the age at first marriage, thereby delaying first and subsequent births.

There are five major areas where the Government of Bangladesh is currently focusing in order to materialise its long-term vision. These areas include: 1) designing and implementing the Essential Service Package (ESP); 2) re-organising public sector provision; 3) improving the financial sustainability of the entire programme; 4) paving the way for a greater role of the private sector and NGOs; and, 5) reviewing and updating the National Drug Policy which was commissioned during the early 1980s. All these strategies need to be pursued with utmost urgency over the next five to seven years.

Let me touch upon at least two important principles guiding our vision pertaining to the health and population sector.

1) **Emphasis on the Essential Service Package.** Within this essential package, the Government's highest priorities include: a) interventions having public-good characteristics, and b) interventions related to maternal and child health. It is my pleasure to inform all of you that the ICDDR,B Rural Extension Project has begun fieldtesting this intervention at Patiya in Chittagong and Abhoynagar in Jessore. The Rural Extension Project also deserves our appreciation in putting together a combined IEC flipchart for ESP. Also, it is working, in collaboration with my colleagues, toward the development of an integrated MIS. Ladies and gentlemen, we are all now committed to an integrated approach. The Project is, thus, helping us in critical areas. We look forward to the Project in continued assistance in the process of moving toward an integrated programme.

Within the ESP, the government attaches high priority to reduction of infant and child mortality. In this connection, the Rural Extension Project has undertaken an emergency obstetric care intervention. Being encouraged by the positive results of the intervention, the Government has already decided to introduce Emergency Obstetric Care (EOC) services at the thana level nationwide. As an initial step, the Ministry of Health and Family Welfare will implement it in five rural thanas of the country, taking one from each division, with technical assistance from the ICDDR,B Extension Project.

2) **Equity-based cost recovery and efficient use of resources** to ensure that future demand for health/family planning services are met. I am pleased that the ICDDR,B Rural Extension Project has already begun field-testing its alternative service delivery package known as "cluster visitation" as well as a pricing intervention. Results of these two interventions will be shared at this seminar, and the findings from these interventions will be used by the Government in its future plan.

In realizing our targeted goals, the Government needs a reliable and efficient partner in carrying out necessary operations research (OR). ICDDR,B is one such organization, which has proved itself to be competent enough to test various programmatic interventions through its MCH-FP Extension Project (Rural). The partnership between the Government and the ICDDR,B MCH-FP Extension Project (Rural) has existed for over fifteen years and is quite strong. The Project has, over the years, designed and fieldtested a number of useful interventions to strengthen the management component of the programme, improve quality of care, and strengthen programme sustainability. Several of these interventions, as you will hear from the seminar presentations, have already been replicated in the national programme. I am pleased to say that I am quite impressed with the work of the Project. My impression draws heavily from discussions with the Project staff as well as several field trips to Mirsarai, Chittagong, and Abhoynagar.

I am happy to say that the Project has played a significant role in shaping the mandate of the USAID-funded National Integrated Population and Health Program (NIPHP), the Health and Population Sector Strategy (HPSS) for the Government of Bangladesh, and HAPP-V. I sincerely hope that the Project, working together with the Government of Bangladesh and the NGOs, will test, fine tune and help improve the management, quality and sustainability of the service delivery system during the critical years ahead. I would like to assure my Ministry's continued support to the Project, which I consider as the research arm of my Ministry.

Chair
Professor Demissie Habte
Director, ICDDR,B

Mr. Muhammed Ali, Dr. Richard Brown, Mr. Shamim Ahsan, colleagues from the Government, donor agencies, NGOs, and my colleagues from the Centre, Good morning and a very warm welcome to all of you.

Let me thank you for making time to come to this Dissemination Seminar. We, at the Centre, feel honoured to have so many distinguished guests who have come to participate and share their views with us.

A noted scientist once remarked that all knowledge is useful. He said that it may take some time before that becomes evident but ultimately it will be. In contrast donors and development workers say that one should only aim for generation of knowledge that finds immediate application. The extreme example of this is the farmer who having planted potatoes in his yard gets up every night to dig the soil in order to see how much the seeds have grown! The wisdom must be somewhere between the two. The oft quoted notion that research institutions are ivory towers devoid of awareness of the outside world must surely be wrong now.

Like many other research institutions, the Centre appreciates that research has to be targeted to resolve health problems in the first instance. Such research is now termed strategic research to highlight the relevance of the research to understanding health problems. This then is followed by what is referred to as viz drugs, vaccine, messages to modify behavior health registers etc - to be used directly to resolve the health problems.

The Centre's work in family planning is probably a premier example of strategic research that identifies the obstacles to acceptance of family planning by women, which then, led to the development of health tools and technologies that resulted in acceptance of family planning services nationwide.

Critical in the process of translation of research findings into action is the necessity to empower health professionals, administrators, and policy/decision makers with knowledge of the findings of both strategic research and product development. Hence dissemination of research findings is considered by the Centre as a vital function. Today and tomorrow's meetings have been organized for this express purpose.

ICDDR,B, or "The Centre", was established in 1978 as the successor to the Cholera Research Laboratory, which was created in 1960 to study the epidemiology, treatment, and prevention of cholera. The Centre is an independent, non-profit organisation for research, education, training, and clinical service. The work of the ICDDR,B, is often cited as the authority for important health and population-related decisions taken by multilateral, governments, and development agencies throughout the world.

In the 37 years of its existence, ICDDR,B has evolved into a busy cosmopolitan research centre whose scientists have wide-ranging expertise. Since the mid-80s, the Centre has become increasingly involved in the broader social, economic and environmental dimensions of health

and development, particularly with respect to women's reproductive health, sexually transmitted diseases, and community involvement in rural and urban health care. Future research will be directed toward finding cost-effective solutions to the health and population problems of the most disadvantaged people in the world.

The MCH-FP Extension Project (Rural) began in 1982 in two rural areas of Bangladesh to examine how elements of the Matlab programme could be transferred to the Bangladesh's national family planning programme. The Rural Extension Project is funded by USAID and receives technical assistance from Population Council.

For the last 15 years, the Rural Extension Project has been working closely with the Ministry of Health and Family Welfare, Government of Bangladesh, in improving the management capacity, quality of care, and sustainability of the national programme by designing and field-testing various useful interventions. Many of the Project's successful interventions have already been replicated in the national programme.

The Project is entering a new phase of the USAID-funded health and population programme, known as NIPHP from August 1997. The ensuing NIPHP is a seven-year programme with seven major components, including rural service delivery, urban service delivery, social marketing, quality improvement, operations research (OR), urban immunisation, and contraceptive logistics. ICDDR,B will conduct operations research for NIPHP. The existing Rural and Urban Extension Projects will be merged into one project to maximize use of resources, skills and expertise. Before I conclude, let me record the Centre's sincerest appreciation to USAID for its continued assistance to ICDDR,B, especially the MCH-FP Extension Project.

The Centre has an excellent rapport with the Government of Bangladesh. As a host nation, the Government extends its fullest cooperation to the Centre in its various activities.

As you all know, the Honourable Prime Minister of the People's Republic of Bangladesh visited the Centre recently. The Prime Minister's visit clearly reflects the Government's keen interest in, and commitment to, the Centre's overall activities. I am confident that the existing cordial relationship between the Centre and the Government will be further strengthened in future.

A particular thanks is due to the Ministry of Health and Family Welfare and its two directorates of Family Planning and Health for their continued active collaboration with the Centre and the MCH-FP Extension Project. We will look forward to greater collaboration in the future. My personal thanks are to Secretary Mr. Muhammed Ali for his continued interest in our activities. This interest has been genuine and action oriented.

Finally it is appropriate to thank the very many staff of the MCH-FP extension Projects starting with the Divisional Director Mr. Shamim Ahsan, as well as the two Project Directors Dr. Barkat-e-Khuda and Dr. Abdullah Baqui and their very many staff who have demonstrated commitment to their work and put in a lot of extra effort to make this project a success.

Finally, I would like to thank all the distinguished participants for coming to this seminar. I am more than confident that we would benefit from their valuable deliberations.

SCIENTIFIC SESSION I

BROADER REPRODUCTIVE HEALTH AGENDA

Strengthening Outreach Sites: An Approach Combining Satellite Clinics with EPI

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Problem Statement

Effective functioning of Satellite Clinics (SCs) is important for sustainable MCH-FP services in Bangladesh. Studies show that pregnant women prefer to use the SC over the Health and Family Welfare Centre (H&FWC).

In the early 1980's, SCs were established to support union-level H&FWCs in providing MCH-FP services to community women, as H&FWC was unable to attract faraway women. This resulted in establishment of eight SCs, once a month each, in far-off areas of a union. Since its inception, the SC programme has gone through many developments such as broadening of the range of drugs and equipment, provision of transport allowance and contingencies for the FWVs.

Despite some qualitative changes, there are problems that need attention. Limited access has remained an issue. The distance factor also still exists. On average, an SC serves two villages. One study shows, however, that although an SC provides services for two villages, more than 90 percent of clients attend the clinic from the village where it is located.

Utilization of SC has been affected by proximity and awareness. Low utilization results when these are not proximate and particularly when awareness is low. A study in early 1990's showed that less than half of the women knew about the SC. Ever-visit was 25 percent or less. A survey of providers suggests that FWVs organize half or less of the planned SCs a month. The evidence, indicates that women are not yet ready to travel far, even if there are better facilities and services at H&FWCs and THCs.

Scope of services need to be strengthened. In the mid eighties EPI programme was launched in fixed sites closer to the community. Establishment of 96 spots first, then 48 and finally 24 sites is one of the reasons for success stories of the programme. In contrast to SC, women have almost universal awareness about EPI sites and attendance is also very high there. Along with the proximity, joint SC and EPI might provide a scope for wide range of services and potential to address missed opportunities.

Objectives

The low utilization and missed opportunities might be a reason for low use of family planning services at the SC. Thus, we have set out to increase and combine SCs with EPI outreach sites

to accomplish three objectives: 1) raise accessibility, 2) improve method-mix, and 3) investigate cost-effectiveness.

Intervention Design

In order to combine the EPI spots with the SC, existing two-day per week service delivery approach had to be changed. A new flexible design of four to six-days a week service was developed taking into consideration complexities related to maintenance of cold chain and work routine of field workers and paramedics. Six days a week EPI and SC at Abhoynagar has been provided instead of two days by each previously. Four days per week at Mirsarai instead of two days of EPI and five days of SC instead of two days a week has been set up.

Six days a week service by FWV in H&FWC instead of four days previously was established. An additional FWV was posted by the government in the intervention area to facilitate extended services from the SC sites. The Directorate of Family Planning provides the required number of SC kits. Catchment for each spot was also established.

Methodology

We have followed non-equivalent quasi-experimental design. From high and low performing areas (Abhoynagar and Mirsarai thanas respectively), we selected intervention and comparison unions. The number of SCs was increased from eight SC sites per month per union to a total of 24 sites. All of them were combined with EPI spots at Abhoynagar thana. At Mirsarai thana, the total number of SCs was increased to 20 but only 16 were combined with EPI spots. As a result, three cells were constituted at Mirsarai: i) combined SC+EPI; ii) only SCs; and iii) only EPI spots.

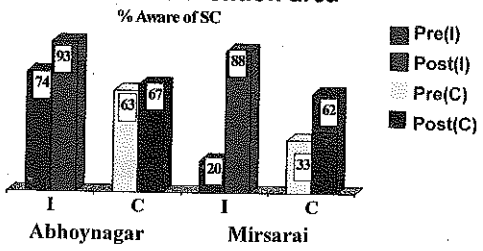
Key Findings

Awareness

At Abhoynagar, a high-performing area in terms of contact by field workers, the contraceptive prevalence rate (CPR), immunization coverage, quality of services and knowledge about SCs were all high before the current intervention began. The intervention began in January 1995. But, we used in-depth survey data which was collected in 1993 for Abhoynagar and 1994 for Mirsarai as pre-intervention data for awareness and visits. In 1993, awareness of MWRA about SCs was 74 percent in Abhoynagar. In December 1996, awareness was almost universal in the intervention area. According to the 1994 base-line survey at Mirsarai, only one-fifth of the rural women knew about the SC in the intervention area. By December 1996, awareness about SC in the intervention increased by about four and half times. The rate of increase is higher in the intervention than in the comparison area (Graph 1).

Graph-1

Awareness about SC has increased, especially in the low performing intervention area



Attendance

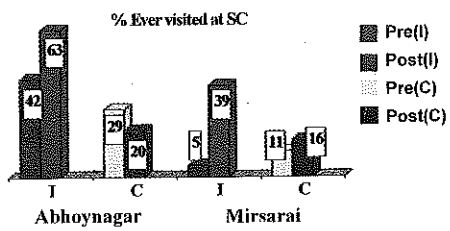
Ever-visits by eligible women to SCs shows a 20 percentage point increase in the high-performing intervention area i.e., Abhoynagar to over 42 percent during the 1993 period. Ever visits by MWRA increased by about eight times by the end of 1996 from only 5 percent in 1994 in the low-performing area, Mirsarai.

The average monthly attendance at SCs has more than doubled at Abhoynagar and increased by almost three-and-a-half times at Mirsarai (Graph 2 and 3).

As mentioned earlier, there was a three-cell intervention at Mirsarai to examine the difference between attendance at combined SC+EPI, only SC and only EPI spots. The average number of attendees per session in these three types of spots were 60, 35 and 17 respectively in December 1996. It is evident that combined spots draw more clients than single spots.

Graph-2

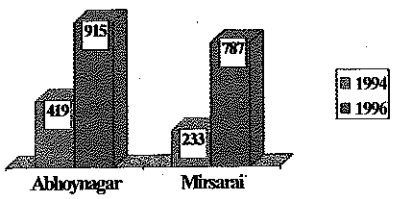
There is a marked improvement in ever visitation to SC, more so in Mirsarai



The objective of increasing the number of SCs and combining them with EPI spots was that it would increase accessibility to pregnant women. In the intervention unions, there was an improvement in the number of visits to SC by pregnant women. About three and half times more pregnant women in Abhoynagar reportedly visited SCs than in the comparison area. In Mirsarai, the difference was seven times greater than in the intervention area.

Graph-3

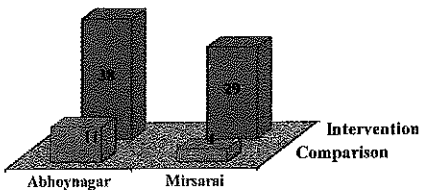
Average monthly attendance at SC+EPI has increased by over two times in Abhoynagar and over three times in Mirsarai



Pregnant women's antenatal care by skilled professionals is always very poor. According to the BDHS study (93-94), only seven percent of mothers received ANC from nurse, midwife and FWV. In Abhoynagar, antenatal care from FWV was 32 percent while at Mirsarai it was 14 percent reflecting a higher achievement than that of national picture.

Graph-4

Visit to SC+EPI sessions by pregnant women is higher in the intervention than comparison area



The SC is the primary source for first level ANC services. In Abhoynagar, out of the pregnant women who visited any facilities for ANC, 70 percent opted for SC while about 40 percent visited in Mirsarai (Graph 4).

Health Care Services Received at Satellite Clinic

Clients continue to associate the combined SC and EPI spots with health care for children, but also seek family planning and MCH services there. In Abhoynagar, nearly half of the clients who visited SC received child health including immunization, while slightly more than one-third received ANC. Sixteen percent received family planning services. Sixty-seven percent of the services provided at SCs in December 1996 in Mirsarai were for child health including immunizations. About 14 percent went to receive some sort of ANC. Only seven percent attended SC for family planning services. A large number of women who went for family planning services were also treated for health problems (Graph 5).

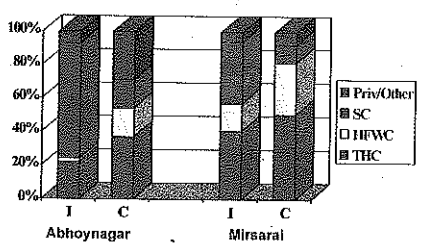
In the intervention area of the high-performing thana, the relative share of SC as a source of family planning methods doubled from February 1995 to December 1996. The FWA's role as a dispenser of family planning methods decreased accordingly, during the same period.

In the intervention area of the low-performing thana, SC has been seen as a potential place to receive family planning methods. SC as a source of family planning methods increased from 3 percent in February 1995 to 20 percent in December 1996. Consequently, H&FWC and FWA as source of family planning methods declined considerably. The intervention picture shows that SC as a source of family planning methods appears to have increased sharply in the areas where performance is low and doorstep service is weak. However, in the comparison area, SC as a source of family planning methods has played a very insignificant role (Graph 6).

Graph-5

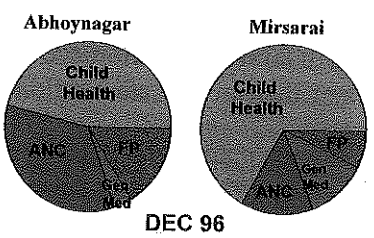
SC is an important source of ANC in the intervention areas

Pregnant women receiving ANC by source



Graph - 6

Most clients go to SC+EPI sessions for child health related services, followed by ANC



Satellite Clinic as a Source of Injectable Methods

Injectable is a dominant method in the method-mix of intervention areas. In Mirsarai thana, the increase in family planning use has been mostly due to injectable contraceptives, since the beginning of the intervention. About 90 percent of the contraceptive users of SCs are injectable acceptors. Among all the sources of injectable, SC alone accounts for more than the contribution of all others.

In Abhoynagar, because of strong doorstep injectable services, proportion of SC is relatively smaller in Abhoynagar. (Intervention March 1995 - 5 percent; FWA 95 percent; December FWC 12 percent; SC 14 percent; FWA 74 percent).

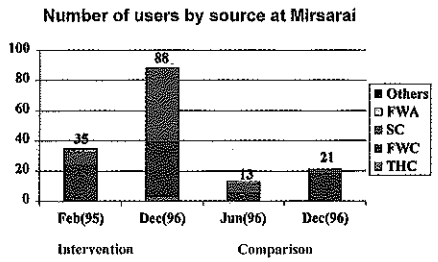
Injectable in Abhoynagar, the high-performing area sustained considerable growth in the SC. SC injectable users have increased from two percent in February 1995 to about 14 percent in December 1996 in Mirsarai (Graph 7).

CPR

Overall, CPR shows higher trends in terms of increase in the intervention areas. Overall performance at SC indicate that if the doorstep service is discontinued, there is a tremendous potential for SC to attract more women for family planning services provided they are held regularly, and in close proximity with EPI.

Graph - 7

In intervention areas, SC+EPI session has become the most important source of injectables



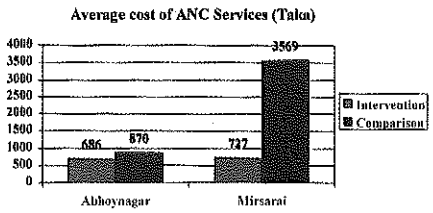
Cost of Providing Services

We have also looked at cost effectiveness of the intervention. Average cost of providing ANC services is low in intervention areas. Also, if we look at family planning services, average cost of pill and injectable are particularly lower in Mirsarai.

We looked at cost of providing services in terms of *cost per birth averted,* which is the cost of a couple year protection of family planning services multiplied by the average birth interval. The cost of quality-adjusted life year refers to a cost of improving the quality of life of pregnant women. The assumption is made that at least 10 percent of pregnant women will develop anaemia or high blood pressure, and treatment of these morbidities can be obtained through antenatal care. The cost of increased quality of life of pregnant women obtained through antenatal care services has been calculated here. Because of the sparsity of data available for IUD at Mirsarai and comparison area, we did not have cost analysis. At Abhoynagar, IUD in the intervention area was lower (Graph 8 and 9).

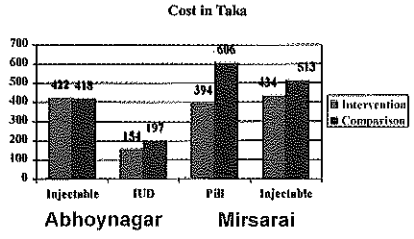
Graph - 8

Average cost of providing ANC services is lower in intervention area



Graph-9

Average cost of providing services is lower in the intervention area



Constraints for the Intervention

IUD insertion was found not to be encouraging because of constraints in terms of privacy, absence of bed, disposal of used cotton particularly in most of the spots in Mirsarai. Also, leave coverage for FWVs/HAs/Porters hampers functioning of combined SC+EPI. The SFWV's role in monitoring and supervision was found to be poor despite education in using monitoring checklist.

Lessons Learned

- Increasing the number of SCs and combining them with EPI spots together with appropriate IEC, has a marked impact on women's awareness about the outreach facilities
- With increased number of spots, women's attendance at SC increases
- Accessibility is particularly important for pregnant women's visit to combined SC+EPI spots
- Combining SC with EPI helps tap missed opportunities
- Based on the above lessons learned, the government has already merged the existing satellite clinic with EPI spots. The government has already facilitated combining SC+EPI by waiving mandatory Monday clinics.

Strengthening Maternal and Neonatal Health

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Dr. Lokman Hekim, Thana Health and Family Planning Officer, Mirsarai

Problem Statement

Bangladesh has a well established health service infrastructure from the community to the district level. The Family Welfare Assistant (FWA) and trained TBA provide preventive services at the community level; at the union level, the H&FWCs and the Satellite Clinics provide curative and preventive care. The Thana Health Complex at the thana level is the first static facility where basic emergency obstetric care services are expected to be available, while the district hospital provides all MCH-FP services and back-up support.

Despite this good infrastructure, maternal mortality ratio in Bangladesh is very high at 4.5 per 1000 live births. Besides, there are at least 16 morbidities for every maternal death and utilisation of health facilities is poor due to low awareness and inadequate referral and linkage.

Almost all deliveries in rural Bangladesh take place at home. Existing research shows that all pregnant women are at risk of obstetric complications. UNICEF states that at least 15 percent of all deliveries will have complications and at least 5 percent will need a Caesarean section. Although FP, ANC and TT immunization all help the individual woman, maternal mortality cannot be substantially reduced unless women have access to emergency obstetric care.

Objectives

With this background, our intervention was designed to improve maternal and neonatal health in rural Bangladesh, with the specific aims of:

- Increasing the knowledge of women regarding complications of pregnancy and childbirth
- Increasing the coverage of antenatal and postnatal care
- Increasing the number of deliveries by trained personnel at different levels
- Increasing management, by trained personnel, of cases with complications of pregnancy and childbirth
- Improving neonatal care and
- Increasing post abortion contraceptive use

The different levels of emergency obstetric care include: 1) First Aid EOC - or offering Ergometrine injection for bleeding, injectable antibiotics for infection, and anticonvulsant injection for convulsions; 2) Basic EOC, which includes first aid EOC, along with assisted vaginal deliveries, and manual removal of the placenta; and, 3) Comprehensive EOC which offers all basic obstetric services, Caesarean section and blood transfusion.

Intervention

The present intervention consisted of several activities. The THC maternity facilities were upgraded to provide EOC services. This included strengthening the existing basic EOC services at Abhoynagar THC, which had started in 1993, with more training workshops and the introduction of blood transfusion. Comprehensive EOC was introduced at Mirsarai and a new maternity unit was built. The training and placement of personnel and the procurement of equipment were facilitated.

A Pregnant Women Register has also been introduced for identification and listing of all pregnant women in an FWA's area; referral and linkage is being emphasised to encourage pregnant women to use health facilities; and the thana managers and workers at different levels have been given orientation on the various aspects of the intervention in the form of workshops and refresher trainings.

A pictorial card for raising awareness about the common complications of pregnancy and childbirth has been introduced. This card shows pictures of symptoms of common complications like bleeding during pregnancy; swelling of feet, severe headache and blurring of vision; fever for more than three days; premature rupture of the membranes; prolonged labour; and excessive bleeding. The back of the card shows the different abnormal presentations of the foetus during delivery so that the TBA understands when to take the woman to the THC. The THC is also shown so that the family knows where the mother should be taken in case of an emergency.

Referral and linkage is very weak in the national programme and it is often due to this weak linkage that women cannot reach health facilities in times of emergency. Our intervention attempts to strengthen referral and linkages between the community and higher levels through a series of activities. At the community level, the FWA identifies the pregnant woman and gives her the antenatal and pictorial cards. The FWA also advises the mother to go for ANC to the FWV, and for "normal safe delivery" to the TTBA in her area. She records the woman's name and other relevant information in the Pregnant Women Register. Later, she notifies the respective TTBA about the pregnant woman in her area. The TTBA is asked to take the pregnant woman to the THC in case there is an emergency. The FWA also asks the pregnant woman to go straight to the THC in case there is an emergency. The FWA updates the Pregnant Women Register at the FWC, recording antenatal visits made by the woman. She also records any pregnancy outcome in her area, and updates the FWV's records.

At the union level, when a pregnant woman comes for antenatal check-up, the FWV identifies risk factors and refers if necessary. If a pregnant woman comes with an emergency, she is referred to the THC. Complicated cases from the neighbouring THCs are encouraged to come to Mirsarai THC for comprehensive EOC. In case of Abhoynagar women needing comprehensive EOC services are referred to the district.

Methodology

For the purpose of this intervention three unions each of Mirsarai in Chittagong and Abhoynagar in Jessore were selected. The corresponding comparison areas are two unions each of Satkania in Chittagong, and Keshobpur in Jessore.

Pre-intervention data were collected from the THC maternity registers of 1993 for Abhoynagar and 1994 for Mirsarai. A baseline survey was conducted between May and December 1995. Mid-term evaluation data were collected from: 1) the THC maternity registers during January to April, 1997; 2) the Pregnant Women Registers, exit interviews and observation checklists between January and March 1997; and 3) an evaluation survey conducted between October 1996 and February 1997.

It is too early to show effective impact of the intervention. In Bangladesh, culture, religion and family norms have been influencing the whole process of motherhood for hundreds of years. Many rituals, which have very deep emotional basis, are followed. These in-built behavioural and social patterns are difficult to change. So, although facilities are built, women may not use them. Community education is therefore needed to create awareness about the importance of deliveries by trained personnel. However, change in these age-old practices will take a long time.

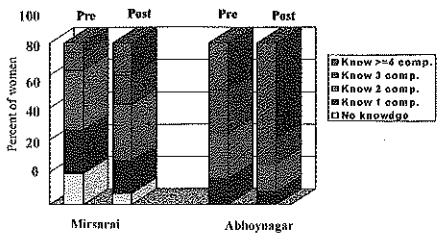
Key Findings

Preliminary findings indicate that women's knowledge about the common complications of pregnancy and childbirth has increased at both field sites in the mid-term evaluation period (Graph 1). The percentage of women knowing about four or more complications increased in both areas. Also, the percentage of women with no knowledge about pregnancy related complications decreased at Mirsarai. Also, there has been an increase in the knowledge of safe and hygienic delivery practices.

Among all the women who delivered during the mid-term evaluation period, half in Mirsarai and three-quarters in Abhoynagar had received the pictorial card. Of them, a majority had retained the cards at the time of interview (Graph 2).

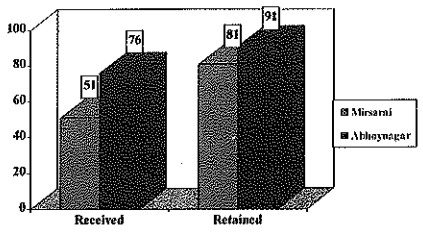
Graph-1

Women's knowledge about complications of pregnancy and childbirth increased in both fields



Graph-2

Retention of Pictorial Card by pregnant women was high in both the areas



There has been a remarkable increase in the number of pregnant women contacted by FWAs in the Mirsarai intervention area. This increase is not so marked in Abhoynagar, where FWA contact was already high in 1993 (Graph 3).

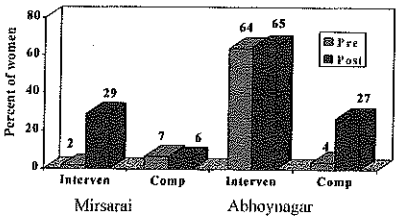
ANC coverage by medically qualified personnel has increased in both intervention areas, more so in Abhoynagar, rising from 38 to 79 percent. This is much more than the national ANC coverage of 26 percent (Graph 4).

The average monthly admissions at the THC maternity has almost tripled in Mirsarai; this also increased in Abhoynagar (Graph 5). In the pre-intervention period only 1.7 percent of the total

pregnancies expected in Mirsarai were admitted to the THC. This rose to five percent in the mid-term evaluation period. For Abhoynagar this was seven percent in 1993 rising to eight percent in 1996.

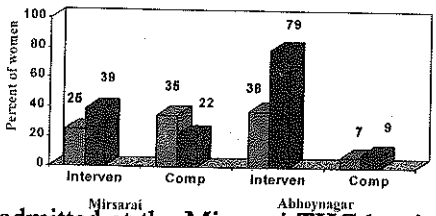
Graph-3

Percentage of pregnant women contacted by FWA for ANC increased, more so in Mirsarai



Graph-4

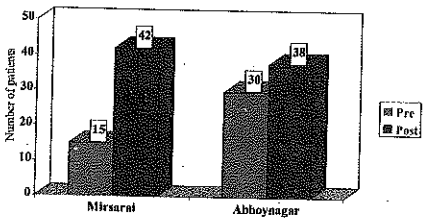
ANC coverage by medically qualified personnel has increased in the intervention areas



The number of cases with obstetric complications admitted at the Mirsarai THC has increased more than three-fold in the evaluation period. This has remained static in Abhoynagar (Graph 6). The common complications recorded are haemorrhage, infection, toxaemia of pregnancy and eclampsia, obstructed or prolonged labour, malpresentation, perineal tear, retained placenta and complications of abortion.

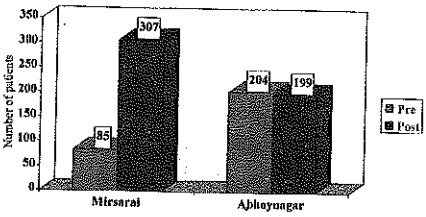
Graph-5

Average monthly admissions have almost tripled at the Mirsarai THC



Graph-6

Number of complicated cases admitted per year at the Mirsarai THC increased more than three-fold

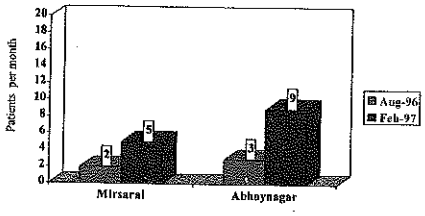


The range of maternity services at the THC has also increased. In the pre-intervention period, both THCs provided only normal delivery services. Following the intervention, Caesarean sections at Mirsarai, while at both THCs blood transfusion, forceps delivery, manual removal of the placenta, management of eclampsia and post abortion contraceptive counseling are available.

The Project takes pride in the fact that the country's first Caesarean section at the thana level was performed at Mirsarai THC on June 22nd, 1996, and six more have been done so far. Although very few Caesarean-sections have been done, this is at least a step forward considering the facts that the service is still new and Chittagong is a very conservative area.

Graph-7

There is an increasing trend in monthly referral from union to the THC

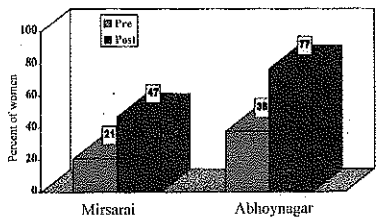


Referral and linkage that we have focused on in this intervention is showing an increasing trend. The number of monthly referrals from the union level to the THC has increased and more than doubled in both areas. Also, referrals to higher centres from the THC has increased from 13 to 17 percent at Mirsarai and 13 to 20 percent at Abhoynagar (Graph 7).

There has been a two-fold increase in the coverage of postnatal care in the intervention areas of both Mirsarai and Abhoynagar (Graph 8). The majority of the women were contacted by the FWA in their homes during the postnatal period and given advice. The use of any modern method of contraception after having an induced abortion increased by nine-fold in Mirsarai, and doubled in Abhoynagar (Graph 9).

Graph-8

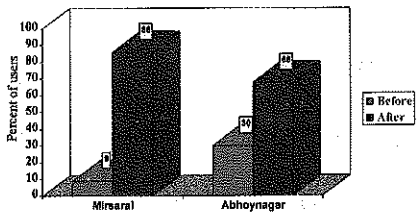
Postnatal visits doubled in both areas



The mid-term evaluation shows that immediate care of the newborn is better at the intervention THCs than is seen in most other THCs in the country. The majority of the newborns were kept warm immediately after birth, and most of them had their airways cleaned. Asepsis for cutting and clamping of the cord was done in 75 percent of the cases in Mirsarai. APGAR score, which is hardly ever done at any THC in the country, was recorded in a few cases both at Mirsarai and Abhoynagar. Birth weight was also taken in more than 30 percent of cases at both THCs. Most new borns were also physically examined. All the neonates observed at Mirsarai, and almost three-quarters in Abhoynagar were given colostrum soon after birth (Graph 10).

Graph-9

Post abortion contraceptive use has increased



Graph-10

Immediate care of the newborn is better at the intervention THCs than is seen in most other THCs in the country

	Mirsarai (%)	Abhoynagar
• Baby kept warm	88	100
• Airway cleaned	79	90
• Sterile cord clamping	75	47
• Apgar score recorded	17	21
• Weight taken	38	32
• Physical examination done	96	74
• Umbilical stump kept open	100	94
• Colostrum given	100	72

In conclusion we can say that, compared to the rest of the country, some progress has been made in maternal and neonatal health in the two intervention areas. More women are coming to health facilities. Also, increase in the range of services at the THC, besides Caesarean sections, is helping to manage other obstetric complications, thereby reducing maternal morbidity. However, there is considerable room for improvement.

Lessons Learned

- ☞ Comprehensive EOC, with effective referral and linkages, can be successfully implemented at the thana level.
- ☞ The pictorial card is an effective tool for improving antenatal coverage and linking pregnant women to service centres.
- ☞ The Pregnant Women Register is an effective tool for monitoring pregnant women.

Programmatic Implications

The success of this intervention has led to the inclusion of EOC as an important intervention in the NIPHP. The government has already adopted the policy of introducing comprehensive EOC nationwide in a phased-in manner. As part of this process, the government will introduce comprehensive EOC in five additional thanas, taking one from each division in 1997. The Project is committed to provide technical assistance in the process.

Essential Services Package

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Problem Statement

Financial and programmatic sustainability is a major concern in the health and family planning programme with a growing resource gap and the burden of additional population. To design a sustainable programme there is a need to address several critical issues and problems.

There is a lack of holistic approach to organizational design and service delivery. A holistic approach would consider coherence of key subsystems of the programme in maximizing utilization of appropriate services to meet the most important needs of population. Despite the development of health and family planning infrastructure in the rural areas, the concept of providing a range of services through a tiered system, limited accessibility and weak referral between the different layers have been a major weakness in the existing programme. Most services are not integrated and of poor quality and are thus of limited effectiveness. Further, the demands and priorities of well-funded vertical programmes have been a serious impediment to the packaging of essential services from a single point.

The concept of the essential service package is based on two ideas. The first relates to the notion that a nation's public health service needs to provide a basic set of essential health services designed to address the most important health problems of the population. Most health services cannot afford to deal with all health problems, hence the need to set priorities. The prioritization of health problems depends on the health care needs of the individual in terms of the disease burden, and important national and global priorities.

The notion of "packaging" services relates to efficiency and cost of providing services as well as client benefits. Packaging profits the client by providing all essential services at one point, and thus reduces client costs. The costs for providing services also goes down through maximum utilization of shared inputs, through synergism between treatment and prevention activities, through improved use of specialized resources, and through the screening of patients at the first level of care to ensure that the small share of high-risk cases can be recognized and appropriately referred. However, these benefits can only be gained when the different services are brought together in a package and blended in a way that at each visit the client needs are assessed, information on available services provided, cross-referrals made and followed through.

Objective

Keeping these issues in mind, the overall objective is to develop a sustainable system for providing a package of essential preventive and curative services through a tiered approach.

The specific objectives are to:

- Provide a broad range of services at locations easily accessible to clients
- Institutionalize health education, screening and referral
- Rationalize support system: IEC, training, logistics, record-keeping, supervision and monitoring
- Foster greater coordination at operational levels

Intervention

This intervention has been implemented in phases. In the first phase of the intervention we have arranged for the provision of reproductive and child health services from fixed sites at community level and provision of services by both HA and FWA from cluster. At the same time, the current services provided at the community level by the HA and the FWA have been widened to provide a more coherent mix of services and current doorstep services has been shifted to fixed points. We have also arranged for the provision of FWV's presence in H&FWC on all working days.

The first phase of the intervention has also involved institutionalization of training on ESP components and job specification of the workers at the community level; development of IEC materials to support the ESP programme; development of a record-keeping system, monitoring and supervisory tools; and institutionalization of a review and planning process.

In the second phase, we plan to introduce First-Aid EOC at H&FWC; strengthen the referral system for EOC services at the THC; strengthen RTI/STI management at the H&FWC; introduce Integrated Management of Childhood Illness (IMCI) at THC and H&FWC; and strengthen the referral system up to the district level.

The activities of the intervention include the development of service modality at fixed spots in the community. A total of 48 spots have been created, of which 28 are limited service centres (LSC - or clusters) with HA and FWA together providing services. Each cluster provides services to a population of 40 to 50 households.

Of the 48 spots, services are provided by FWVs in 20 which are combined with SC+EPI spots. These combined sessions (SC+EPI+Cluster) with larger catchment area are seen as Extended Service Centres (ESC). Both the types of fixed sites are offered on monthly basis at the community level.

An appropriate ESP has been planned to provide broad elements of reproductive health, family planning and child health with support services at the various tiers from the community to the thana level. An individual package was designed to meet the unique needs of each level. We will focus our discussion at the community level as currently our work is concentrated at this level.

The service elements are delivered by the HAs and FWAs considering their basic capabilities and the technical competencies that can be attained with short locally organized training. In order not to overburden any individual staff member, a rational distribution of these services

between HAs and FWAs was done at the local level. (For example, FWA was not given the task of malarial treatment and HA was not given the task of contraceptive pill distribution.)

Under the ESP intervention, the FWA provides family planning methods to female clients, iron and folate tablets and anti-scabies medication and de-worming tablets for children. HAs provide the remaining services, including ARI management, ORS, and limited medication for malaria, and night blindness. In the Extended Service Centre (ESC), FWV strengthens the elements offered at the cluster or LSC by providing mostly of the services available at SC. EPI is also offered at ESC.

The ESP Matrix shows components with service delivery points and type of providers available for the ESP (Graph 1). While implementing this intervention we have tried to address all sub-systems like Training, IEC, Logistics, record keeping, monitoring and supervision, planning and coordination. The programme managers needed to readjust their work area to establish cluster spots.

Graph-1

ESP MATRIX

SDP: Limited Service Centre (LSC)

Provider: HA, FWA

Child Health:
- Vitamin A Capsule
- Diarrhea management
- Curative care of scabies and worm infestation

Maternal Health :
- Iron tablets to pregnant women

FP & Reproductive Health:
- Oral pill, Condom and injectable contraceptives
- Referral to HFWC & THC

Health Education:
- Breastfeeding, nutrition
- Reproductive Health

A training of trainers (TOT) was provided to thana managers on procedures to set up fixed sites and modes of service delivery. The fieldworkers also needed training about the concept of ESP, how the services are to be delivered, recorded and reported. After review of existing standards and protocols a training curriculum and a manual were developed to facilitate short training to the supervisors and workers. The intended beneficiaries also needed information about the new service delivery strategy as well as where from, when and what services can be obtained. In the absence of relevant IEC we have designed bill board with information like - where to get the service, exactly when, at what time, what services available and who are providers of the services.

There are multiple flip charts available in the current programme of the government and NGOs, like family planning, ARI treatment, diarrhoea, maternal health etc. None of them provide complete information to meet the community health needs. The workers had also difficulties in carrying a number of them. Considering all these problems the Project, in collaboration with the MOHFW, developed a single flip chart to address all the issues relevant for the ESP.

Considering the new strategy of services from fixed spots instead of doorstep service delivery by HA and FWA at different monthly round, it became important to inform the community about location and types of services available. Community meetings at the ward level involving local formal and informal leaders created awareness in the community about location of services.

MOHFW has five different cards, such as EPI, injectable, IUD, TT and Vit-A, and EOC. The project has developed an ESP card called MCH-FP card to record the information of all those cards. Moreover, this pictorial card is helpful to clients not only as a IEC material but also to keep a record of services given. It can also be used as a referral slip to the higher facility.

All of the drugs for the ESP components are available to provide services at the cluster and SC+EPI level except new components like scabiol and alben. Folfe tabs were available to the FWAs from the HFWC. Additional SC kits were provided by the government to hold additional SC+EPI spots. House owners of the ESP sites were made depot holders for ORS with 50 packets initially given and provision of monthly replenishment. In the aftermath of a very recent cyclone, in Chittagong, it was observed that depot holders played a very good role in treating diarrhoea with ORS.

ESP, because of the service delivery from single spot, would require a record keeping system not fully congruous with the existing one. Considering services of two sets of workers and the reporting requirement of the government, an HA Register and a modified FWA Register were introduced to record the services provided by them from ESP spot. Now that both the workers are operating from the same sites and offering ESP, there is a need to have a unified record keeping system. An MIS committee has been established at the thana level to develop a unified record-keeping and reporting system.

Monitoring and supervision are the weak links of the government programme. Under the existing system, there is a front line supervisor for each category of workers, called AHI and FPI. Two sets of monitoring tools called diaries have been introduced for two sets of supervisors taking into consideration current organizational and political situation. Now that two types of workers are offering services from one spot, it may be possible to provide an unified front line supervisory tool to replace the existing diaries.

Planning and coordination is viewed as an important activity, particularly form the point of view of different lines of authority to control supervisors, paramedics and workers, distribution of logistics, and identification of field problems. A monthly review meeting for thana managers, to systemize plan of activities and performance review, was developed.

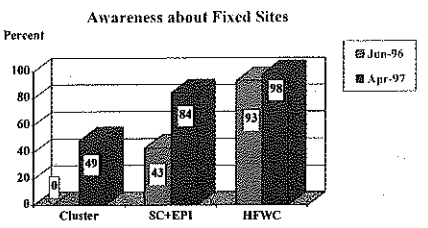
Key Findings

The preliminary findings are based on survey and observation data. The intervention period is not long enough to give any clear indications of effects of the intervention. While the analysis of data is in progress, particularly in Abhoynagar, we will be sharing with some preliminary results for Patiya only.

We were particularly interested to know about clients' awareness on ESP sites. Awareness about cluster and SC+EPI, shows marked increase because of the intervention during last six to eight months (Graph 2). In contrast, there was very low awareness in the comparison area about SC+EPI spots and THC. Accessibility might be an issue for low awareness in the comparison area.

Graph-2

Awareness about fixed sites in intervention area has increased

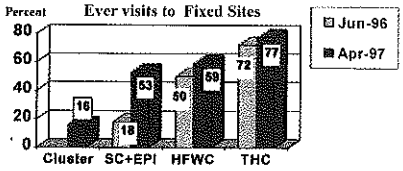


Ever visit to SC+EPI spots in intervention area has increased by three-fold (Graph 3). CPR in modern methods has increased by five percentage points in the intervention area in comparison to three percentage points (Graph 4). However, the interesting

point is that largest increase in the intervention area was due to increase in injectable and sterilization (Graph 5). If we look at the source, there is a seven-fold increase (4% to 28%) in the use of outreach sites (SC+EPI+CS) as a source of FP methods in the intervention area (Graph 6). Immunization rate is higher than comparison area (Graph 7).

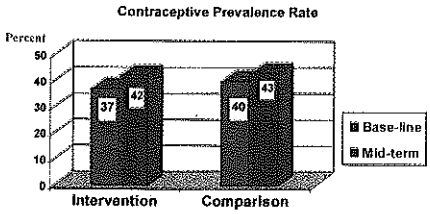
Graph-3

Ever visit to SC+EPI spots in intervention area has increased three-fold



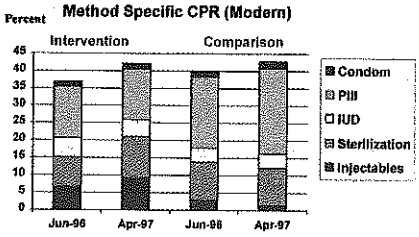
Graph-4

CPR (modern method) rise is higher in intervention area



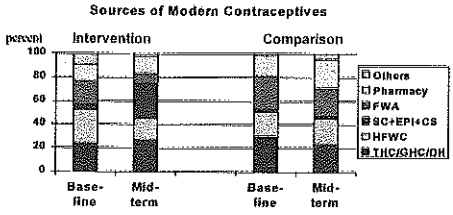
Graph-5

There is a noticeable increase in use of sterilization and injectables in the intervention area



Graph-6

There is a seven- *fold* increase (4% to 28%) in the use of outreach sites (SC+EPI+CS) as a source of FP methods in the intervention area

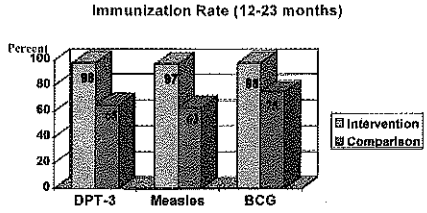


ESP spot is a source of ORS for treatment of 38 percent of those women who reported receiving from any source. ARI is predominantly treated by qualified private practitioners. HA normally refers ARI cases to higher level facility as acute conditions can be rarely treated in a monthly spot.

Thirty percent of under-5 children of the total children of LSC visited for deworming in last six months. Six percent of total under-5 children visited for scabies in last two months.

Graph-7

Immunization rate is higher in the intervention than comparison area



Thana health and family planning managers jointly review performance. Fieldworkers' attendance to spot has become regular because of easy accessibility to spots by supervisor and use of monitoring tool for supervision. Holding of ESP by FWA and HA jointly is almost regular.

Lessons Learned

Considering the current ESP strategy, coordination and cooperation between health and family planning managers is critical. There is a need for decentralization to readjust the work area

as the process has to consider the work unit of each worker with areal variation, size of population and work routine such as monthly and bi-monthly rounds. As such it would require efforts from thana level managers for which they should be given authority for readjustment. It is easier to supervise the fixed sites than door-step services.

There is a need to incorporate disposable needles and syringes in the programme as current management of sterilization is cumbersome in the field. FWAs are capable to provide services like deworming and treatment of non-infected scabies.

Vacancy of either FWA or HA of a unit/ward impedes functioning of ESP. If any of the workers are absent from an ESP site, then clients have to get services from next sites in the following day as one can not do others work under current design. But it has been observed where both HA and FWA are female, they compliment each others work informally when one is on leave. Special tasks required by the government such as population registration and GR update may hamper holding of fixed sites.

Programmatic Implications

Future programmatic research could potentially address the following questions:

1) Should there be one or two categories of workers? The perspective of the proposed beneficiaries of the ESP, organizational scenario, and the political sensitivity should be considered in making any decision. However, the capability of workers, availability of logistics from a single source, a separate IEC strategy, simple mechanism of supervision, coordinated structure - all should be taken into consideration when deciding such matters.

2) Should there be single/dual record-keeping, supervision and logistics? Currently there are duplications in collecting vital events such registration of population, birth and death data. A need for critical indicators of ESP at each level, monitoring and feedback formats are essential.

3) What should be the new roles for fieldworkers? Besides skills in deciding roles, should we consider the gender issue? A review of FWA and HA tasks is also required for a better coordination of their tasks so that different services are delivered through a coherent strategy at the fixed sites. Rescheduling of the work routine and reallocation of area is also essential for coordinated services from the same sites.

Summary of Discussion for Scientific Session I

The designated discussants, as well as the participants who spoke from the floor, highlighted several important elements from the presentations. The principal comment was that the packages of services which were described -- combining satellite clinics with EPI services, strengthening maternal and neonatal health, and experimenting with ESP -- followed the strategies of the national programme. In addition, the timing of the seminar is appropriate because it coincides with the planning of the GoB programme, NIPHP and HAPP V. Thus, the lessons learned and programmatic implications presented here are of particular importance.

The combination of satellite clinic and EPI services creates opportunities to overcome some currently missed opportunities. Women who come for family planning injectable services can be checked for their own tetanus toxoid status. Their children, who often accompany them, can receive their EPI services. These are important linkages which can be made through the combined set up.

At the same time, cautionary notes were raised. It is particularly important to realize that satellite clinics cannot deliver all ESP services. Some services require more privacy or a level of infection prevention which cannot be managed in outreach facilities. Thus, an important priority for the GoB is to determine which of the ESP services will be provided in fixed clinical sites and which can be provided through outreach services. Standards which can guide the work of both GoB and NGOs need to be developed to ensure uniform quality of ESP services.

The coordination of health and family planning services is a difficult task, yet the preliminary results of these operations research projects show that it is not only possible but highly desirable for coordination to occur. The combination of satellite clinics and EPI is a particularly effective entry point for coordinated services.

The important intervention in maternal and neonatal health was lauded by the discussants. At the same time, they took the opportunity to describe other EOC interventions which are being developed concurrently and to describe the success of those interventions to date. Concerns were raised that none of the EOC interventions were effectively reaching all women in need of services. EOC interventions require good teamwork at the service site and effective referral from the community to be successful. The experimental work of Mirsarai THC's EOC interventions will need to be complimented by others. It will be essential to work together to refine and revise these services. Thus, a coordinated effort of all organizations who work on safer motherhood issues could enhance the success of the programmes.

In order to deliver the services described in the first scientific session, organizational reform is essential. Without a resolution of the problems of the structure of the programme, the delivery of ESP will falter.

SCIENTIFIC SESSION II
SUSTAINABLE SERVICE DELIVERY APPROACHES

The Delivery of Maternal, Child Health and Family Planning Services Through Cluster Visitation

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Ms. Dilara Islam, Thana Family Planning Officer, Abhoynagar

Problem Statement

The impressive achievement that has been made by the Bangladesh Family Planning programme during past two decades are well-known. More than 30,000 field workers, employed by the government and NGOs, are major contributors to this impressive achievement. These fieldworkers, are the major actors in stimulating and maintaining the demand, acceptance and continued use of contraception. According to Bangladesh Demographic Health Survey (BDHS 96-97) report, which has been released very recently, the current CPR is 49 percent with variation among the divisions. Despite such impressive achievements, there is a sustainability concern about doorstep delivery of services. Thus, experimentation with alternative modes of service delivery are necessary. Different scenarios such as, including more fieldworkers and supervisors or maintaining current eligible couple to FWA ratios with their cost implication, are portrayed. Different organisations and professionals are making various recommendation such as, cost recovery, cost containment or design alternative service delivery approaches. Some NGOs are also testing alternative approaches. However, they were often criticised for resource dependency.

Intervention

This alternative service delivery intervention is called, "The Delivery of Maternal Child Health and Family Planning through Cluster Visitation". It has been tested as a transitional strategy to move from doorstep delivery to fixed sites under the normal government setting.

Before describing the intervention, let me share some of the key findings of research focussing the cost aspect of the Bangladesh programme that has been carried out during recent years by Family Health International (FHI), Associates for Community and Population Research (ACPR), Population Council and Population Development and Evaluation Unit (PDEU) of the Planning Commission. These findings illustrate the severity of the problem and concluded changes in service delivery would have to occur, "in order to meet the demand of increasing number of Married Women of Reproductive Age (MWRA) and to maintain an acceptable CPR in next ten years."

The costs of home service delivery will increase substantially. Therefore, there would be a need to increase programme resources to meet the rising cost. To maintain the current programme structure 32,500 FWAs and 6,500 FPIs will be needed.

There is a decreasing likelihood of increased external resources on a per capita basis. Given the sizable cost and sustainability concern of the present system, there is a need for an alternative mode of service delivery system. We have tested this alternative approach in two unions each of Mirsarai thana of Chittagong district, a low-performing area and of Abhoynagar thana of Jessore district, a high-performing area.

Objective

The overall objective of this intervention is to develop MCH-FP service-seeking behaviour among the eligible women through cluster visitation approach and increase service coverage. The specific objectives are to reduce dependence on doorstep service delivery, sustain and increase contraceptive acceptance rate in high and low performing areas. I will discuss how we developed the intervention and what have we learned while implementing it.

As a first step, the intervention design was extensively reviewed and discussed with government colleagues in the field. Time was spent orienting the fieldworkers and their supervisors, and establishing cluster spots. A field guide was provided to the fieldworkers and supervisors. Routine monitoring and performance review was introduced

Considering the number of FWAs available, 178 cluster spots in Abhoynagar and 182 in Mirsarai were established. The field guide provided a guideline and basic principles needed for the establishment of a cluster spot, a detailed description of various steps involved for providing services, record-keeping and reporting.

Under the current service delivery structure, the FWA makes a house-to-house visitation to an average of 800 MWRA for motivation and contraceptive supply on a bi-monthly basis. Under this new intervention the FWAs did not make house-to-house distribution rather she served the women from a fixed site, called cluster spot.

The cluster spot is a service site consisting of a fixed household in the community (cluster household), where the FWA provides services. Each FWA is required to arrange an average of 16 spots on a monthly round. Each cluster spot is designed to serve up to 43 women, providing counseling on family planning, contraceptive methods, child immunization, ANC and PNC, and supplies of oral pills, condoms and injectables.

Methodology

Data sources include:

- Longitudinal data from the Project's sample registration system (SRS)
- Service statistics reported by the FWAs
- Unscheduled observation at cluster spots by project staff
- Survey.

Key Findings

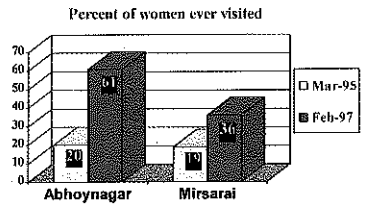
This intervention has been tested under a normal GoB setting. During past two years we have experienced some encouraging results while testing this intervention and would like to present some of the key findings for which data from varied sources have been used.

As a part of this intervention, FWAs were mandated to inform the married women of reproductive age (MWRA) about the new service delivery approach and the name of cluster spot from where they could collect contraceptives. The awareness of CS has become universal in all intervention areas. However one area which remains inaccessible much of the year in Mirsarai, it was almost 50 percent, which can be considered as encouraging.

Ever visit to cluster spot has increased three-fold (from 20% to 61%) in Abhoynagar and two- fold (from 19% to 36%) in Mirsarai (Graph 1). Such increases indicate the potential for organizing and delivering services from field sites. Now it would be interesting to know who the women are, that have made all these visits. What are their socio-economic and demographic characteristics? We have taken two most commonly used socio-economic variables such as education and land holding to understand the characteristics of these women.

Graph-1

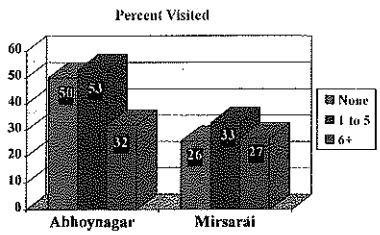
Ever visit to cluster spots has increased three- fold in high performing and two-fold in low performing area



In Abhoynagar these visits are largely made by women with no or low education, while in Mirsarai no major variation has been observed. Now we will see other economic indicator i.e. land holding status of these women. Ever-visits to cluster spot are largely concentrated among those with little or no land-holding. In Mirsarai this is higher among the landless (Graphs 2 and 3).

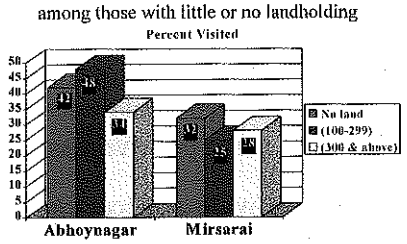
Graph-2

Ever visit to cluster spots are largely made by women with little or no education



Graph-3

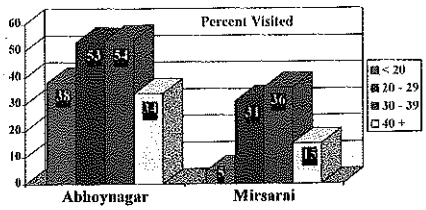
Ever visit to cluster spots are largely concentrated among those with little or no landholding



To understand the influence of demographic variables we have used only age-group to assess their visit pattern. Ever visit to CS is largely concentrated among the prime age group (20-39 years) in both areas. In Mirsarai, it was quite low among the women under 20 years of age (Graph 4). However, there has been very little increase in the visit by non-users and pregnant women. This is a dilemma which is also faced by the national

Graph-4

Ever visit to cluster spots are largely concentrated among prime target group



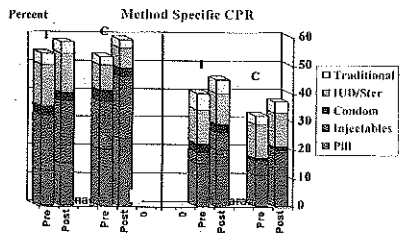
programme under current service delivery strategy. The project is currently working on a new IEC strategy involving houseowners of cluster spots in the next phase to increase the attendance.

In order to measure the impact on performance we have used three prominent indicators for this presentation: Contraceptive prevalence rate; comparison between CAR and CPR, and sources of contraceptive.

Method specific CPR during doorstep service delivery and cluster visitation intervention are available from projects SRS for both areas. Despite introduction of cluster approach as an alternative to door-step delivery, there has been no negative impact on overall performance. Contraceptive prevalence rate continued to increase both in intervention and comparison areas (Graph 5). We have also reviewed the difference between CAR and CPR. Comparison between CAR and CPR shows that the gap between MIS and SRS has declined over time which indicates data quality has improved in the intervention area.

Graph-5

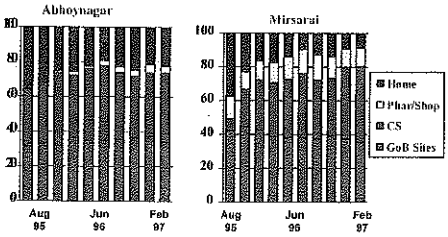
Despite the introduction of cluster approach as an alternative to doorstep delivery, CPR has continued to increase in the intervention areas



Now, let me share what happened to the source of contraceptive as a result of discontinuation of door-step delivery. The relative share of cluster spot as a source of contraceptive supply has increased in both areas. The growth of CS as source of contraceptive over time. Receiving contraceptives at home has been declining (Graph 6).

Graph-6

Relative share of CS as source of supply has increased in the intervention areas



Lessons Learned

So far, we have discussed the problem of current programme structure and its future implication and also seen some encouraging results which should provoke our thinking process. There are some positive lessons to be learned from this intervention:

- FWAs can provide services on a monthly basis instead of bi-monthly, through the cluster approach.
- Women are willing to go out of their homes to receive services.
- Special IEC is needed to attract more women.
- Needs of special groups (newly-wed/non-user/low parity) have to be addressed by utilizing available FWA free days each month. With the cluster approach, FWAs do have more time to visit these groups with special needs.
- House-to-house recording of FWA register and monthly reporting requirements need review.

- ☞ Supervision of FWAs by FPIs has become easier.
- ☞ Workers' fear of job loss hinders implementation of the intervention.

The workers feared that if this intervention succeeded many FWAs would be retrenched and the government would be able to provide services with less number of FWAs.

Programmatic Implications

Cluster visitation is an approach to shift away from door-step which looks promising in terms of: 1) relative share of supplies; 2) contraceptive prevalence rate; 3) as a transition from doorstep to fixed sites; and 4) as a potential to provide additional services included in Essential Services Package (ESP).

Policy impact, so far, has included:

- Several NGOs have already replicated the cluster approach intervention.
- National Integrated Population and Health Programme (NIPHP) funded by USAID has adopted the policy of gradually phasing out from doorstep to fixed sites.
- The concept of "one-stop-shopping" has been adopted by the government in the Health and Population Sector Strategy (HPSS).

We have completed almost two years and are currently working on deficiencies of the past, making modifications in the intervention design. Testing to increase the coverage to make it cost effective is continuing.

Charging for FP-MCH Commodities and Services

Ms. Dilara Islam, Thana Family Planning Officer, Abhoynagar
Dr. Ann Levin, Health Economist,
MCH-FP Extension Project, ICDDR,B
Mr. S.M. Khairul Amin, Thana Family Planning Officer, Mirsarai

Problem Statement

At present, the contraceptive prevalence in Bangladesh has risen to close to 50 percent. The family planning programme is now at a point where it can concentrate on improving its cost-effectiveness and recovering some of its costs as well as improving demand for its services. This is particularly important because programme costs are rising as more clients adopt family planning. Programme costs increased from $97 million in 1990 to $132.8 in 1995, and are estimated to increase to as much as $220 in 2005.

A second factor is that there is a high dependency on donor funds since 60 percent of revenues are coming from donors. These funds are expected to decline over the next decade. Even if the absolute amount does not decline, the per capita amount will decline over time as the population increases. A third factor is that the service delivery strategy of doorstep delivery of services is costly due to the large number of fieldworkers and supervisors required.

There are three mechanisms that can be tried to improve financial sustainability of family planning and MCH service delivery: the first is to increase recovery of costs for commodities and services, the second is to improve the cost-effectiveness of service delivery through alternative service delivery approaches such as cluster approaches, and the third is to lower costs through improving programme efficiency. This presentation will deal specifically with the first option, improving cost recovery.

What fees are currently being charged for family planning and MCH services? At present the government outlets charge only for condoms and not for other methods or MCH services. NGO outlets, on the other hand, are charging nominal fees, 50 paisha to one Tk. for most contraceptive services.

In addition, other outlets, pharmacies and shops, are charging higher prices, although still subsidized, for commodities and services (3 Tk. for a dozen condoms and Tk.15 a cycle of pills). The cost of condoms ranges from 1-16 Tk. for a dozen, and 3-60 Tk. per cycle of pills.

Objectives

The objectives of the intervention are two-fold: 1) to accustom clients to pay user fees for FP-MCH services; and, 2) to increase the clients' use of service outlets outside of the home.

Intervention

This intervention has two phases. During the first phase of the intervention from August 1996 to December 1997, differential pricing at different service delivery points is being introduced. Charges have been introduced for resupply methods - pills, condoms and injectables, and are highest at the home. Lower prices are being charged for clients at satellite clinics since clients may incur travel costs going to the satellite clinic and are being encouraged to seek services outside of the home. No fees are being charged at the fixed site clinic, the H&FWC, so that there will be a safety net for users unable to pay.

Based on the lessons learned from Phase 1, regarding affordability of higher prices, during the second phase of the intervention, beginning in January 1998, fees for family planning commodities will be increased. Secondly, fees will be introduced for selected MCH services. The fee structure will be based on assessments of willingness to pay and operating costs, and will be determined in collaboration with MOHFW officials.

During the first phase of the intervention, the fees at the doorstep are Tk. 2 for 2 cycles of pills, 2 dozen condoms, or 1 dose of injectable. At the Satellite Clinic, the fees are half of those at the doorstep since users are incurring travel costs. At the H&FWC, all prices are free except for condoms since prices were already in effect for these commodities.

A simple revenue management system has been introduced so that service providers can record their receipts from contraceptive sales. The FWA first records the amount paid by the client in the FWA register. She then writes the quantity and amount received on a form developed by the project in collaboration with thana managers to record revenues received each month.

A separate form was developed for the FWV (Family Welfare Visitor) for her to record revenues from contraceptive sales at the Satellite Clinics. The revenues are deposited at the end of the month to the Thana Family Planning Assistant on 'Salary Day'. Then the TFPO deposits the revenues into a special bank account at the beginning of the following month.

Methodology

The intervention is being introduced in two unions: Rajghat Union in Abhoynagar, a high-performing area, and Dhum Union in Mirsarai, a low-performing area. The interventions will be evaluated in two ways: before-after and intervention-comparison unions will be compared. The data sources include periodic surveys, bimonthly SRS reports, and monthly monitoring data.

Key Findings

The total revenues that have been collected at Abhoynagar are approximately 10,000 taka, with the mean monthly revenues about 1,100 Taka. At Mirsarai, the total monthly revenues were about 3,000 Taka, with month revenues of about 375 Taka. More revenues were collected at Abhoynagar because its intervention union is large and the contraceptive prevalence is higher there.

During the nine months that the intervention has been in effect, no adverse effects have been found on contraceptive use. The contraceptive prevalence has been sustained in the union in Abhoynagar and has increased in Mirsarai (Graph 1). These findings suggest that when users become habituated to contraceptives, nominal prices are not a deterrent to use. The thana managers and service providers have reported that the additional time required to record the receipts is not lengthy.

Because differential pricing has been introduced and prices are lower at Satellite Clinics and H&FWCs, we examined whether the use of service outlets outside of the home has increased. In both sites, the use of the Satellite Clinic has increased although the results are mixed for the H&FWC. An unexpected finding was that the use of the FWA increased in Mirsarai, probably due to the increased regularity of these workers after the intervention began (Graph 2).

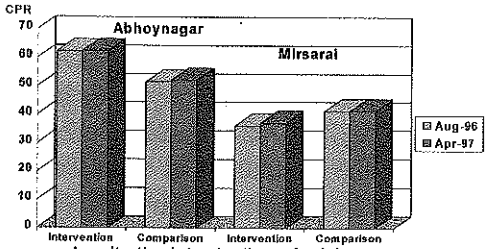
Several studies have reported that there is considerable deferred payment in places where prices are being charged for FP-MCH services. Our data indicates that 90 percent of users are paying for the commodities with cash. Slightly under ten percent are going to the H&FWC or THC to obtain contraceptives. Only one to two percent are taking contraceptives on credit (Graph 3).

Most users who are paying for contraceptives stated that they felt the fees were reasonable (Graph 4). It's worth mentioning that prices are quite nominal. It's encouraging to note that 75 percent of respondents in the baseline stated that they are willing to pay Tk. 5 or more, and that there should be potential for charging higher prices. Another indication that fees had no detrimental effect on contraceptive use is the method mix. During the intervention period, the share of resupply methods on which prices were introduced, increased (Graph 5).

A secondary objective of introducing prices is to improve accountability in the system.

Graph-1

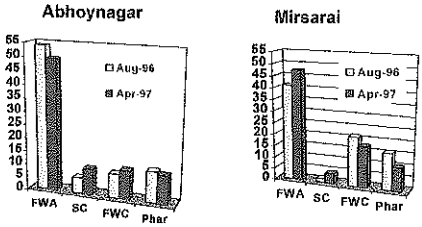
CPR has been sustained/increased...



...despite the introduction of pricing

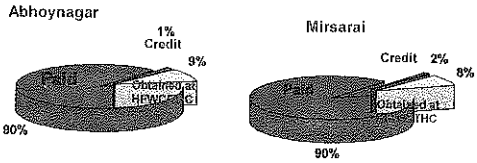
Graph-2

Use of SC as a source of supply has increased.



Graph-3

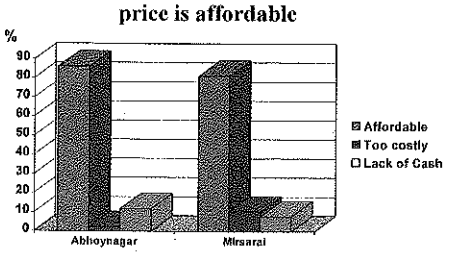
Most clients are paying for contraceptives...



in both high and low performing areas.

Graph-4

Vast majority of respondents say price is affordable

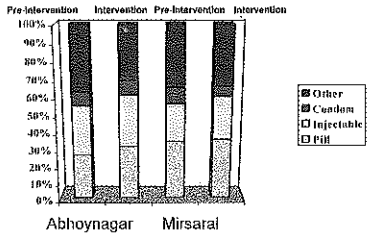


After prices were introduced, the gap between the contraceptive acceptance rate of the Project decreased to below five percent (Graph 6).

Due to the increased accountability of use of supplies, there has been a substantial decrease in pill wastage (Graph 7). The number of cycles distributed by service providers declined by 40 percent after the intervention began in Abhoynagar, and by 54 percent in Mirsarai. These figures agree with the findings from the URC study by Barkat *et al,* on pill wastage. We also examined the distribution of injectables but the difference in distribution before and after the intervention began was not great.

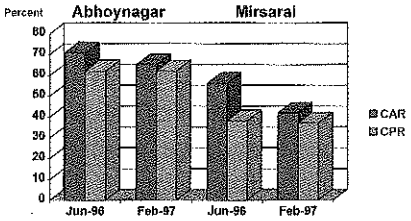
Graph-5

The share of pill and injectable use has increased.



Graph-6

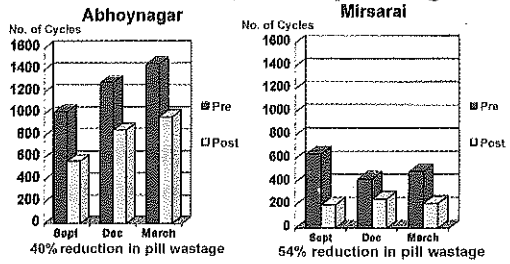
The CAR-CPR gap has decreased



We also calculated the potential savings from pill wastage if the intervention was to be introduced nationwide. When the data from the project areas was applied to the number of MWRA pill users in each region using data from the 1996 DHS, the savings from a reduction in wastage ranged from $2,500,000 if there were 30 percent reduction in wastage to $4,000,000 if there were 50 percent reduction in wastage. The savings from a decrease in wastage would be considerable (Graph 8).

Graph-7

Since pricing introduction, there has been a substantial reduction in pill wastage



Graph-8

Annual savings from pill wastage reduction will be considerable.

(in $ US)

Division	Pill Users in Rural Areas	$ Savings if 30% Wastage	$ Savings if 40% Wastage	$ Savings if 50% Wastage
Barisal	314,895	186,331	248,441	310,550
Chittagong	626,243	370,583	494,084	617,600
Dhaka	1,206,071	713,661	951,548	1,189,435
Khulna	622,819	368,537	491,382	614,230
Rajshahi	1,283,939	759,736	1,012,984	1,266,230
Sylhet	120,524	71,317	95,090	118,860
TOTAL	4,174,491	2,470,146	3,293,529	4,116,910

Programmatic Implications

The findings indicate that contraceptive prevalence can be sustained or even increased, despite the introduction of pricing. A nominal charge for contraceptives is acceptable to majority of users. There is a potential for charging higher prices. Significant reductions in contraceptive wastage can lead to substantial savings.

User fees may be a viable option to recover costs of the health and family planning programme in Bangladesh.

Networking of Government and Non-government Family Welfare Service Providing Agencies

Mr. Ajoy R. Barua, Thana Family Planning Officer, Sitakunda
Dr. Mizanur Rahman, Demographer, MCH-FP Extension Project (Rural), ICDDR,B
Dr. Sk. Keramat Ali, Thana Health and Family Planning Officer, Abhoynagar

Problem Statement

In this presentation we describe our experience of working with various GOB family welfare service providing agencies in one union of Chittagong district. We will present background, methodology, and some very preliminary findings of our network approach to service delivery.

Individual and family welfare enhancement is the prime goal of any development programme. Health and family planning services are components, among others, that positively affect quality of life. Ability to earn income that ensures basic food and nutrition, education, and a woman's ability to appropriately exercise her role, are all very important factors that need to be considered in the development effort. It has been observed that even without formal economic development it is possible to improve quality of life. Examples are Sri Lanka and Kerala where quality of life is very high in terms of life expectancy, fertility, educational levels. It has been possible to achieve such a high quality of life through affordable, efficient and equitable distribution of family welfare services. The national family planning programme in these places has made remarkable success with careful attention to the efficient service delivery of family welfare services having a positive impact on health, family planning, and other aspects of quality of life.

Seven government agencies provide family welfare services at the community level in rural Bangladesh. These are: health, family planning, agricultural extension, Bangladesh Rural Development Board (BRDB), social welfare, education, Ansar and Village Development Party (VDP). NGOs also provide family welfare services. The focus of these agencies is the family. Their mission is enhancement of family welfare and quality of life. The village- and union-level service providers of these different agencies, however, often work independently without any inter-agency coordination. There is no or little effective mechanism at the operational levels by which various agencies can work together.

Objective

This intervention is an attempt to develop effective coordination among various GoB agencies and NGOs that provide family welfare services at the community level. This intervention has great potential for improvements in management, as well as programme and institutional sustainability. It is expected that through the combined effort of all the agencies, new ideas, such as small families, better health and availability of appropriate technologies, will empower women and men through information. Without increasing workload, a representative of one agency can supplement and complement the work of another agency.

The ultimate objective of this intervention is to improve quality of life. This objective can be achieved by increasing awareness, accessibility, and utilization of services. Experiences

from operations research of this Centre and of others, clearly indicate that utilization of any services can be increased through improved and appropriate accessibility. Once services are in place, clients should be made aware of services through effective awareness-raising activities.

Methodology

The network intervention includes several GoB agencies. Consequently, it was necessary to set-up common forums for managers and workers at district, thana, and grassroots levels. Each and every district manager liked the idea of the network and agreed to set up a forum at the district level. With the permission of the respective district managers, thana managers also set up thana forums. Similarly, union forums were established.

The next step was to prepare terms of reference for the forums at each level. One important issue emerged on leadership. Who would lead each forum? It was decided that the chairmanship of the forum would rotate in alphabetical order, using the first letter from the name of each agency.

The union and thana forums each meet once a month. All the activities are planned and proposals are made at the union forum and are forwarded to thana forum for approval. Upon the approval of the thana forum, the union forum initiates activities. In monthly meeting, activities and progress are reviewed. The district forum meets biannually. Whenever approval of new initiative is required from the district managers, arrangements are made accordingly.

The intervention has two phases: the first phase aims to increase awareness of and accessibility to services of the participating agencies. In this phase, initiatives started in May 1996 at Sitakunda and in October 1996 at Abhoynagar. These activities will continue until December 1997.

The second phase will begin in January 1998 for another two-year period. This will involve introduction of depot-holders of health and family planning services. Efforts will be made to recruit depot-holders from the beneficiaries of other agencies like BRDB, social welfare, Ansar and VDP, and NGO members. NGOs like the Grameen Bank, BRAC, and other local NGOs, which are devoted to social and economic development, will be brought into the network. This network will be an effective delivery system that will help make services available to the poor, particularly poor women.

Awareness-raising activities and dissemination of information are important parts of the intervention. The general principle is that a worker of one agency, during his/her routine activities, will disseminate information on the activities of other agencies. For example, an agricultural extension worker motivates a farmer to keep his family small, so that per capita food production, and thus, availability of food will be higher. This leads to savings, and thus, greater access to resources that improve quality of life, such as health, and education. Agricultural workers also motivate farmers to raise quality children rather than a large number of children.

Awareness-raising efforts are made by workers of various agencies. Agricultural extension, BRDB, and social welfare workers visit the SC+EPI spots to discuss the services offered by their respective organization. Agricultural, social welfare, BRDB,

family planning and health workers give lectures at schools about their services. During their routine work, service providers motivate parents to send their children to school. These workers also make an effort to link enterprising women with credit providers. Non-health and family planning workers inform and motivate villagers to avail health and family planning services from the neighborhood fixed-site service centers.

Inter-sectoral workers serve from a common place, usually the SC+EPI spot. Meetings of agriculture, social welfare, BRDB, and Ansars are held in the neighborhood of the SC+EPI spot so that clients can receive various services at a single visit. This is an innovative approach that will invariably involve men in reproductive health primarily because all workers are making effort to motivate men on health of children, women, and small family.

There are several activities that are undertaken in the intervention unions. Health and family planning workers encourage mothers to send their children to school, particularly at the beginning of the year. Kitchen gardens are demonstrated in the courtyards of the SC+EPI spots and at primary schools. Fuel-efficient stoves are exhibited at SC+EPI spots, BRDB, and social welfare meetings where training is given on their use and manufacture. This stove has been popular among workers. Training is given on poultry raising, pisciculture, and the use of new varieties of fertilizer among villagers. A local NGO is providing technical assistance to the training activities, and also, NGOs will provide support to the trainees so that they can utilize their knowledge effectively.

The intervention is being carried out at Muradpur Union of Sitakunda Thana and Sreedharpur Union of Abhoynagar Thana. The effect of the intervention is being evaluated in a before-after and treatment-comparison scheme. There are two comparison unions; one at Sitakunda and one at Abhoynagar. Information was collected prior to the intervention, it is being collected during the intervention and will be collected after the intervention. Client surveys, checklists, exit interviews, and focus group discussions are used for data collection. Effect is measured by using various indicators of awareness, accessibility, and utilization.

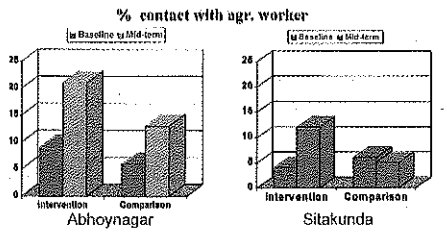
Key Findings

Preliminary findings are presented here. We compare results of baseline and mid-term surveys which were conducted four to six months apart. The respondents of these surveys were women of reproductive age. The observation period, however, has not been long enough to discern a definite effect of the intervention.

Graph 1 shows one indicator of agricultural awareness represented by the percentage of respondents reporting to have information from agricultural workers. There is a noticeable increase in the dissemination of agricultural information in the intervention area while there is only a small increase at the comparison union of Abhoynagar. Relative changes at the Sitakunda intervention union are appreciable.

Graph-1

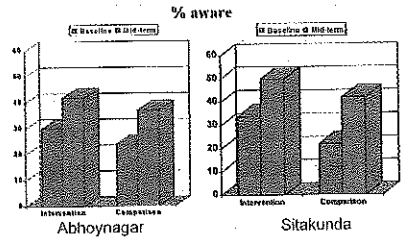
There is a larger increase in dissemination of agricultural information in the intervention area



Graph 2 shows the percentages of respondents who were aware of BRDB credit services. There are some indications of changes in awareness of BRDB credit services. Increases are noticeable in all areas. Further investigation is necessary to explain such changes. The percentages of respondents who reported that they were aware of social welfare services is shown in Graph 3. Awareness of social welfare services has increased in the intervention areas of both thanas. Note that awareness of Social Welfare services is quite low at Sitakunda Thana.

Graph-2

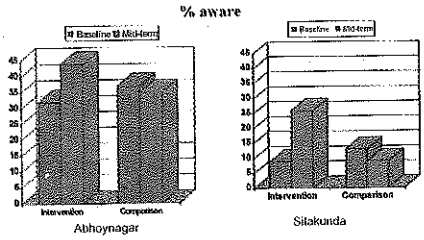
There is an increase in awareness of BRDB credit services



Graph 4 shows the percentages of mothers receiving information on kitchen gardening from their school-going children. It is very encouraging to note that the proportion of mothers receiving information on kitchen gardening from their school-going children has increased. At Sitakunda this is quite pronounced. One reason may be that the intervention started earlier at Sitakunda than it did at Abhoynagar.

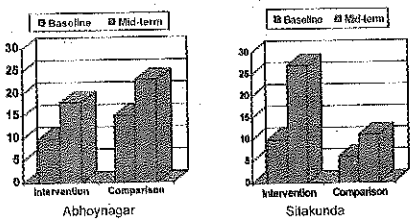
Graph-3

Awareness of Social Welfare services has increased in the intervention area



Graph-4

Percent of mothers receiving information on kitchen gardening from their school - going children increased



There were several challenging issues related to the intervention. Are all the agencies willing to work together? Will there be increased in workload of individual workers? Which agency will have the leadership of the forum? We have rewarding experience during our work with grassroots-level workers and with thana and district officials. All from the grassroots to district levels have responded favorably to the network concept. The bottom-up approach is appreciated by union-level workers. Despite initial concerns, workload has not increased, because of more efficient working arrangements. Rotating leadership will ensure common ownership of the achievement. This rotating leadership also helps prevent tensions between agencies. A circular outlining the responsibilities of each inter-sectoral agency will be useful at the time of scaling-up.

Programmatic Implications

It is too early to make conclusions from the findings that have programmatic implications. However, the potential of this intervention deserve mention. One-stop service delivery for family welfare can increase accessibility and use of services. If service providing agencies can be effectively linked, clients will be motivated to take advantage of a wider variety of services from one spot. Moreover accountability of work can be increased through networking with local government agencies. The network intervention promises to be a platform through which community representatives and service providers can become effective partners in social development.

Summary of Discussion for Scientific Session II

Enthusiastic discussion ensued following the presentations on sustainability issues. Clearly this is an area of great concern to the programme. The discussants both appreciated and re-emphasized the positive findings. Foremost among those findings were:

1) Women were coming out of their homes to attend services. This represents a substantial social change from the early days of the programme when women could only be reached through household delivery.

2) Women are willing to pay for contraceptives. Though the amount which is being paid is still nominal, the fact that women are willing and able to pay is actually a surprising finding. The GoB, based on the evidence presented, can consider payment as long as there is a safety net for those who cannot pay. In fact, payment of services is not new in other sectors of the programme. A proportion of clients have been purchasing socially marketed contraceptives (pills and condoms from SMC) and another proportion are reached through NGO services which charge for household delivery.

3) The introduction of payments had a beneficial effect on the reduction of wastage of contraceptives. This finding confirms the belief that when services are offered at a price, the value is enhanced.

While these dramatic changes were occurring, the use of the cluster visitation spots increased and, most importantly, CPR was maintained. Based on these findings, one discussant concluded that pricing appeared to carry few risks for the programme.

This session was enriched by personal observations described by the designated discussants. They mentioned recent field trips where they met women in cluster spots who willingly pay for services. While they mentioned they hardly believed it could be possible, they were convinced when they observed and talked with the women directly.

The strategy reflected in HPSS of "one-stop shopping" for services is predicated on the findings of these operation research programmes on sustainability and cost containment. Both the GoB and NGOs are committed to this concept.

At the same time, there were cautions. Among those were: the full costing of ESP is not yet known and pricing options for contraceptives also require further testing. The programme will have to experiment with a variety of ways of developing cost effective services -- particularly for ESP. It will require further experimentation to determine how high the charges can be.

SCIENTIFIC SESSION III
LESSONS LEARNED AND PROGRAMMATIC IMPLICATIONS

Improving the Bangladesh Health and Family Planning Programme: Lessons Learned Through Operations Research

Barkat-e-Khuda, Thomas T. Kane, James F. Phillips

BACKGROUND

We have heard in preceding presentations about the success of the Bangladesh family planning programme, with contraceptive prevalence rising six-fold, resulting in a considerable decline in fertility. The above success is due to a number of factors: (a) strong political will and commitment; (b) a sizeable programme; (c) generous donor support; (d) and high-quality programmatic research. In this presentation, I shall be focusing on ICDDR,B research and its utilization in its national programme.

That latent demand for FP exists was demonstrated from Matlab, and therefore, investments in supply-side activities were considered to be fundamentally sound. Matlab success, therefore, prompted the GoB to ask the ICDDR,B to find a mechanism for testing the successful elements of the Matlab Project in the national programme.

Thus, in 1982 the MCH-FP Extension Project was set up. The Project is funded by USAID, and receives technical assistance from the Population Council. There is a National Steering Committee, headed by the Health Secretary and comprising senior officials from MOHFW, DFP, DGHS, NIPORT, USAID and the Project. The Committee provides overall guidance to the Project and reviews its activities.

The MCH-FP Extension Project was initially set up to test replicability of successful elements of the Matlab Project. Subsequently, the Project has been assisting the national programme in terms of improvements in management, QOC and sustainability, through applied research (diagnostic and OR), TA and dissemination.

OR is carried out in selected field sites, both in the high performing and low performing areas. The Project uses a variety of data sources, including its longitudinal surveillance system (SRS), as well as other quantitative and qualitative sources such as special surveys, in-depth interviews, situational analysis, exit interviews, observations, etc. The Project uses a quasi-experimental OR design.

Although research is generated by the Project, all service activities, field management/supervision, and research utilization activities are the responsibility of MOHFW. Concerned MOHFW and directorate officials, both at Dhaka and in the field, are involved at all stages of the intervention from design, implementation, monitoring, evaluation, and scaling-up. Also, the GoB provides resources in terms of time of several counterpart staff, both at Dhaka and in the field, as well as office space in the field, etc.

POLICY IMPACT

The Project has developed and tested many innovative interventions and approaches in its field sites to improve home-based service delivery, enhance utilization of static centres, and help achieve programme sustainability. Several of the Project interventions have significantly influenced the policy decisions of the GoB and the major donors; and have resulted in appropriate changes in the national health and family planning programme.

An edited volume giving detailed historical overview of lessons learned over the 15 years of the Project life, with several chapters contributed by several Project colleagues, has been completed and disseminated. Here, I shall briefly run through some of the major thematic areas of policy impact in Management, QOC, and Sustainability.

The breadth of the thematic areas demonstrate the systemic impact of the Extension Project approach. No single finding, component or activity characterizes the Project's role and design. Rather, the general MOHFW system, its problems, and interlocking components are the subjects of investigation. The systemic approach has required the Project to adapt its design to changing programme needs. As such, it is an evolving initiative managed by a team of investigators who shift their attention as changes require new priorities.

Management

Increasing density of field workers (FWs): The research from Matlab and the Extension Project areas found that the size of work area and population served by worker are important determinants of the frequency and quality of FW contact. There were critical factors in raising contraceptive prevalence. Thus, the Project recommended to the GoB in 1986-87 to increase the density of FWs by recruiting an additional 10,000 FWAs. The Project assisted the MOHFW by developing a recruitment strategy, providing necessary assistance to the MOHFW in implementing that strategy, and subsequent training of the FWAs.

Management Information System (MIS): The Project contributed to the development of the national MIS in a number of ways:

(a) **Record Keeping System for Field Workers:** Based on the lessons learned from Matlab and the Extension Project areas that the fieldworkers record keeping helps systematize her work and helps her record data more accurately, the Project developed, in collaboration with the MIS Unit of the DFP, what is known as the FWA Register. The Register was adopted in the national programme in 1989. The Project assisted the DFP in subsequent modifications and simplifications of the Register (2nd generation register in 1991 and 3rd generation in 1996). Likewise, the Project started working on the development of a register for grassroots health workers -- the HA Register. The Register was

finalized in collaboration with the DGHS and MDU. The MOHFW decided in November 1994 to introduce the HA Register nationwide. As part of nationwide implementation, the Register has been introduced in the Project field sites. The introduction of the registers has systematized the work of the fieldworkers, improved contact rates, and reduced the CAR-CPR reporting gap.

(b) **Monitoring tools for frontline supervisors and managers:** The Project realized the weakness in monitoring and supervision at the field level. Therefore, it started addressing the problem by developing monitoring tools for frontline supervisors and managers. The Project developed the FPI and AHI Diaries in the early 1990s and mid-1990s. More recently, the Project has developed monitoring checklists for thana health and family planning managers. The introduction of the supervisory tools has improved supervision at the field level.

Satellite Clinic (SC): operational problems: The Project has been actively striving to bring clinical contraceptives (Injectables, IUD) and MCH services closer to the homes of women through clinics located at the community (SC). However, the Project identified a number of operational problems in the effective implementation of SC activity:

(a) Inadequate transportation allowance for paramedics: The Project, experimented with a rickshaw van scheme to enable the paramedic and the aya to go to SC. This was found to be very helpful. The GoB accepted the idea, and introduced Tk. 100 per SC session to meet travel and contingency costs for the FWV and the aya.

(b) Inadequate/irregular supply of drugs and other kits (kerosene).

(c) Absence of formal linkage between paramedic (FWV) and FW (FWA).

(d) Mandatory Monday SC creating logistics, supervision and monitoring problem. The Project was able to convince the MOHFW of these problems, and was able to first obtain MOHFW waiver on mandatory Monday SC in the Project areas in August 1994 and subsequently throughout the national programme in October 1994.

Logistics Problems: The following Project recommendations were adopted by the MOHFW to improve the logistics and supply situation in the field:

(a) both the quantity of DDS (drug and dietary) kits and the amount of drugs in the kits have more than doubled, from 3/4 in the 1980s to 8 now;

(b) increase in the types of drugs in DDS kits; and,

(c) provision for a separate SC kit.

Quality of Care

Expanding contraceptive choice (doorstep injectables)

Based on the experience from Matlab and the Extension Project areas, it was decided by the MOHFW to expand the doorstep injectable programme. The first phase expansion involved 8 additional thanas with technical assistance from the Project.

The provision of doorstep injectables led to a significant increase in the CPR. Nationally, it is the third most popular method, after the pill and female sterilization. Also, the relative share of injectables in the method mix has increased, accounting for one-seventh of modern method mix in 1996-97, up from one-eighth in 1993-94. Furthermore, field workers accounted for more than one-third of injectables (1996-97 BDHS).

The positive findings led the MOHFW in 1995 to adopt a policy of nationwide expansion of injectable programme, not necessarily confined to homes of clients but also at other service delivery centres, such as cluster and satellite clinics. The most important lesson learned from this particular Project intervention is that the FWAs, with proper training and supervision, can safely administer injectables.

EOC - Maternal and Neonatal Health

To address the problem of high maternal and neonatal mortality, the Project set up basic EOC at Abhoynagar in 1993. This led to several positive findings, including increase in number of maternity cases admitted at the THC. The lesson learned from Abhoynagar, that only basic EOC intervention is not enough, led to the Project to design a comprehensive EOC intervention at Mirsarai Thana. This resulted in a three-fold increase in maternity admissions. The first Caesarean-section in rural Bangladesh at the thana level took place at Mirsarai in June 1996 and since then several more Caesareans have taken place.

Based on the encouraging findings of the Project's EOC intervention, the GoB has adopted a policy of phased-in expansion of comprehensive EOC nationwide, beginning with 5 thanas in 1997. The Project is involved in the scaling-up process.

Clinical Waste Disposal at THC

Disposal of clinical waste is a serious problem at all THC. There has been no safe mechanism for disposal of contaminated waste. The Project built a low-cost incinerator (US$ 550) at Abhoynagar in 1993, which has attracted the attention of the DGHS. The incinerator has now been replicated at Mirsarai Thana and at another thana of Jessore.

Safe disposal of needles and syringes used for injectable

Reuse of unsterile needles and syringes is a major cause of hepatitis and can transmit HIV/AIDS. With the introduction of injectables, the risk of infection of these diseases

through used syringes has increased. As a result, disposable syringes are used. However, if the used needles and syringes are not destroyed, these can be reused, and thereby, infect healthy people. To avoid this public hazard, the Project tested a system of destroying used needles and syringes. This was then recommended to the MOHFW, and adopted in the national programme in 1994.

Screening checklist for FWAs and FWVs

Checklists were developed by the Project that help FWAs and FWVs to properly screen new method acceptors, particularly pill and injectable acceptors. This has been a very important tool that helped maintain quality of injectable services.

Sustainability

Seeking Services outside of home -- Cluster Visitation

The existing labour-intensive CBD system is quite expensive. While this service delivery strategy was certainly needed and justified in the 1970s and 1980s when the programme was still weak, there is a need to think of alternative service delivery approach(es) as the programme matures (with the CPR of 49%) and with rising costs of the programme. Furthermore, positive social changes (e.g., increased female mobility) are favourable to the design of service delivery approaches where women no longer have to remain dependent on the field workers visiting them at their homes. Accordingly, the Project designed an alternative service delivery approach "cluster visitation". Under this approach, field workers provide services to the women from a neighbouring house "cluster house". Contrary to initial fears that women may not go out of their homes to seek supplies and services and that therefore the CPR will decline, the findings of the fieldtest show that the CPR has been sustained/increased. The positive findings of the intervention led to its replication by some NGOs.

SC + EPI

Stand-alone programmes operated separately by the two directorates are unable to tap missed opportunities. An SC can be turned into a more viable facility with a wider range of services if held jointly with EPI. The Project, in collaboration with the Directorates of Health and Family Planning, designed and fieldtested this intervention at Mirsarai and Abhoynagar beginning January 1995.

The initial findings are encouraging: (a) Client attendance has tripled; and (b) grassroots health and family planning workers find it convenient to operate as a team, supplementing and complementing each other's work.

The intervention of combined SC with EPI has been replicated in the national programme in October 1995.

ESP

The proven effectiveness of both health and family planning workers providing coordinated services from one spot (SC+EPI) and the increasing need in the community for a broader range of RH services has led the Project, in collaboration with the GoB, USAID and World Bank, to the development of a high-impact ESP.

FP and RH	**Health**
➥ Contraceptive services	➥ Immunization
➥ S/E and complications	➥ Vit-A
➥ ANC	➥ ARI
➥ TT	➥ Diarrhoea
➥ PNC	➥ Malnutrition
➥ STD, RTI, HIV, AID	➥ Scabies
	➥ Worm infestation
	➥ TB
	➥ Leprosy

The package provides both family planning and reproductive health services as well as health services for children.

The fieldtesting of this package began at Patiya in Chittagong and Abhoynagar in Jessore in late 1996. The results of the fieldtest will be used in the design of the country's next programme. The concept of "one-stop shopping" in the HPSS has originated from this approach. Also, the NIPHP has adopted the policy of phasing out from doorstep service delivery to fixed sites.

Charging for FP-MCH

One of the ways of achieving programme sustainability is through cost-recovery. Charging for MCH-FP commodities and supplies is being tested at Abhoynagar and Mirsarai, primarily with two-fold objectives: 1) to accustom users to paying for MCH-FP commodities and services; and 2) to encourage users to seek services outside of their homes. The initial findings show that: 1) the CPR can be sustained/increased, despite the introduction of nominal charges; 2) a nominal charge for contraceptives is acceptable to most users, and there appears to be a potential for charging higher fees; and 3) there appears to be considerable potential for savings due to reductions in contraceptive wastage.

Networking of Family Welfare Agencies

There are several intersectoral agencies with the mandate of promoting the health and population programme, in addition to their own sectoral activities. However, most of those agencies take little or no interest in health and population activities. Thus, there are missed opportunities for tapping the resources of all concerned agencies in order to make the programme more sustainable. An intervention has been designed to network activities of seven service providing agencies (Agriculture, Ansar and VDP, BRDB, Education, Family Planning, Health, and Social Welfare). This intervention addresses issues beyond health and family planning and will help achieve better quality of life of people. This is a promising intervention from programme and institutional sustainability points of view.

LESSONS LEARNED

Influencing government policy decisions in a bureaucratic system in a South Asian country by itself is a difficult task. There must be a full ownership of the policy community with the Project activities through:

- involvement of all concerned at all stages of the research: from design of intervention to fieldtesting, monitoring and evaluation, review of lessons learned for scaling-up and replication of the OR lessons in the national programme and policy
- joint field trips with senior government officials
- joint field trips with donor representatives
- participation of Project staff in high-level GoB/NGO committees
- regular meetings of various Project committees
- ongoing dissemination of Project findings by organizing workshops at Dhaka, and more so in the field sites; and other methods of disseminating Project findings such as through intervention update flyers, working papers, and journal articles.

What is critically needed is to sustain an ongoing two-way interaction between the researchers and the policy community, so that with collective wisdom of all actors the benefits are maximized.

Reproductive Health in Rural Bangladesh: Policy and Programmatic Perspectives

Thomas T. Kane, Barkat-e-Khuda, James F. Phillips

Following the International Conference on Population and Development (ICPD) in Cairo in 1994, the Extension Project has continued to broaden its scope of research on reproductive health issues beyond family planning. Some key issues in reproductive health that continue to challenge the Bangladesh Health and Family Planning Programme are in the following areas: contraception, abortion, fertility/infertility, RTI/STD/HIV/AIDS, maternal mortality and morbidity, and infant and child mortality.

This last category on Infant and Child Mortality is added because of the particular interest in how reproductive dynamics, such as length of birth intervals, birth order, gender, and number of siblings impacts infant and child mortality. There is also a unique dynamic between maternal reproductive health and its affect on infant health. For example, pregnant women having STDs and HIV/AIDS can have potentially serious health consequences for the fetus and infants.

In each of these key areas of reproductive health, important research and programmatic work is underway. But more research is still needed concerning men and women's awareness and knowledge of reproductive health issues; their sexual practices and health-seeking behaviour; provider knowledge and practices; current prevalence and trends in RTIs/STDs; determinants and health consequences of various reproductive health behaviours; and on the issues of quality of care and sustainability of various reproductive health services in Bangladesh.

Consequently, the Project research staff have been working hard over the past year and a half conducting research that addresses some of the reproductive health issues. The result of this effort is two dozen priority research papers on reproductive health topics which have policy and programme relevance to the Bangladesh health and family planning programme and have potential importance internationally as well.

This research complements some of the Project's intervention-related operations research. The reproductive health research papers more fully exploit the rich body of data produced by the Project in its field sites. The culmination of this effort is a two volume monograph entitled "Reproductive Health in Rural Bangladesh: Policy and Programmatic Perspectives" which will be published later this summer. The principal authors are senior national and international staff of the MCH-FP Rural Extension Project and several colleagues of the Population Council and Australian National University. The research presented here includes the efforts of researchers from a number of different disciplines. The research papers are primarily based on data from the Extension Project's sites in Abhoynagar, Sirajganj, and Mirsarai thana, and selected other thanas. Data sources include information from the longitudinal sample

registration system for the 1983-1996 period, as well as several population-based sample surveys. Qualitative data (including focus group discussions, observations of client-provider interactions, and in-depth interviews with key informants, clients and providers) is also used. Methods of analysis were: crosstabulations, qualitative data analysis, life table methods, and multivariate statistical procedures, including logistic regression and proportional hazards models.

The papers have been grouped into five thematic areas. These are:

(1) Reproductive Health Knowledge and Behaviour (5 papers);

(2) Contraceptive Use Dynamics (7 papers);

(3) Demand, Cost and Utilization of MCH-FP Services (5 papers);

(4) Determinants of Fertility Decline in Rural Bangladesh (4 papers); and

(5) Determinants of Infant and Child Malnutrition and Mortality and Consequences of Adult Mortality (3 papers).

Theme I on **Reproductive Health** includes analyses of the determinants of antenatal care-seeking behaviour; patterns and trends in induced and spontaneous abortion; levels of awareness and knowledge of STDs; and health-seeking behaviour and practices in the management of RTIs. Some of these papers also touch on the demographic and health consequences of these reproductive health behaviours. For example, induced abortion and RTIs/STDs may lead to infertility, maternal mortality and morbidity, or increased risk of HIV/AIDS transmission and other health problems.

Several papers in Theme II on **Contraceptive Use Dynamics** examine the socio-demographic and programmatic factors affecting the acceptance and continuation of contraceptive use, choice of provider, method-choice, reporting of side-effects, discontinuation and method switching. The effects of cultural factors such as gender preference, women's status and social mobility, and programmatic factors such as field-worker contact and quality of care on contraceptive behaviour are also examined.

Papers included under Theme III on **Demand, Cost, and Utilization of FP-MCH Services** examine several issues, including the determinants of demand for FP-MCH services and the effects of cash prices and access on demand. Also included is an analysis of the cost-effectiveness of alternative service delivery strategies and a multivariate analysis of the effects of fieldworkers contact on fertility preferences and desired family size. There is also a paper presenting a rapid assessment methodology for assessing awareness of, accessibility to, and utilization of health services at the subdistrict level.

Three papers included in Theme IV on **Determinant of Fertility Decline** examine the socioeconomic, demographic, and programmatic factors associated with fertility decline in Bangladesh from different theoretical perspectives and methodological approaches. One paper assesses the impact of the Project's OR on the national programme.

Under Theme V on **Determinants of child malnutrition and mortality and consequences of Adult Mortality**, the impact of length of birth intervals and number of siblings on infant and child malnutrition and mortality, and the impact of the death of either parent on the health and well-being of their children are examined.

Key Findings and Programmatic Implications

Some 90 distinct findings and over 50 programmatic implications were identified from the 24 papers.

THEME I: REPRODUCTIVE HEALTH KNOWLEDGE AND BEHAVIOUR

Key Findings on RTI/STDs:

- Awareness of RTI/STDs, including HIV/AIDS:
  - was low among rural women
  - knowledge of transmission and prevention was even lower
  - awareness was moderately high among clinic providers, although their knowledge of specific modes of transmission and means of prevention was weak
- In the clinic-based RTI study it was found that:
  - 6 percent of clients attending HFWCs and SCs sought services for RTI symptoms
  - half of the RTI clients did not know the causes, modes of transmission, or means of prevention of RTIs
  - one-third of the female RTI clients reported that their husband had some kind of genital problem
- RTI clients and their husbands generally:
  - go to village practitioners first
  - when not properly treated then go to SC/HFWC or pharmacy
- In the treatment of RTIs, paramedics commonly:
  - did not do a physical examination of clients
  - used substandard dosages of drugs
  - made no attempt to notify or treat male partners

Programmatic Implications for RTI/STDs:

- There is a need for increased awareness of RTIs, especially STDs/HIV/AIDS, in culturally acceptable and affordable ways

- Increased RTI/STDs services for men in the programme are needed (men are more likely to be symptomatic, are probably easier to treat, and male client partner notification and treatment may be less difficult)

- Training of health care providers in STD diagnostics, treatment and referrals is essential

Key Findings on Abortion:

- The probability of having an induced abortion increases with mothers:
  - age
  - number of living children
  - education
- Abortion rate has been increasing over time
- One third of abortions occur in the second trimester
- Illiterate women are twice as likely as educated women to have their induced abortions at home
- Many abortions are self-induced
- Women with children under age two are more likely to have induced abortion than those with older children
- Contraceptive use increased after an induced abortion, although less than one percent adopted sterilization
- Use of untrained providers for abortion was due to:
  - greater familiarity with village practitioners
  - inadequate information about safer alternatives
  - perceived low-quality of government services
  - concerns over high charges in the GoB system for services that are intended to be free
- There is a substantial unmet need for quality family planning services for women having induced abortions because:
  - These women are willing to take great risks to avoid unplanned births by induced abortion from untrained providers or through self-induction
  - majority of these women desired no more children

- many of them did not adopt contraception after the abortion
- almost none accepted sterilization after the abortion
- some of the induced abortions were the result of contraceptive failure or discontinuation due to side-effects
- 15 percent had multiple induced abortions

Programmatic Implications on Abortion:

- The high proportion of women having repeat abortions highlights the importance of, and missed opportunities for, post-abortion contraceptive counseling
- The programme needs to address the substantial unmet need for high quality family planning services among women having induced abortions

Key Findings on Maternal Health/ANC:

- Over 90% of all deliveries were at homes by untrained attendants, often under unsafe and unhygienic conditions
- One-third of women reported delivery-related complications
- Older, poor, and less educated women are less likely to seek antenatal care, and less likely to have births attended by a trained provider

Programmatic Implications on Maternal Health:

- More emphasis should be given to IEC activities to educate the community on the need for regular antenatal check-ups and delivery by qualified providers
- Training is needed for fieldworkers/providers in ANC, in identifying warning signs of pregnancy complications and the need for appropriate referrals to higher level care
- Access to and availability of trained providers and facilities for safe delivery needs to be improved

THEME II: CONTRACEPTIVE USE DYNAMICS

Key Findings:

- Contraceptive use and fieldworker contact is lowest among teenaged married women and newlyweds
- Method-mix is skewed toward temporary and non-clinical methods

- Use of fixed-site services is very low
- Women's status and gender preference have an impact on use of modern methods
- Quality of care is significantly and positively associated with use of modern contraception and the likelihood of future use among non-users
- About half of pill and injectable users discontinue during the first year of use, and the majority discontinue due to side-effects and health reasons
- Reporting of side effects is higher among:
  - women of lower socioeconomic status
  - those reporting lower quality contact with fieldworkers, and
  - women whose husbands were not involved in choosing the method
- Method switching is prevalent:
  - about half switch methods, one third of whom switch multiple times
- Switching was most common between pill and injectables
- Side-effects and the need for more appropriate methods were the main reasons for switching methods
- Husband's objection was an important reason for switching from male methods to other methods

Programmatic Implications:

- More emphasis should be placed on:
  - the special reproductive health needs of young and newlyweds
  - advising young newlyweds of some of the health and social advantages of delaying childbearing
  - providing quality clinical methods and services at fixed sites-promotion of male participation in family planning
- Further efforts are needed to improve the status of women and reduce parents gender preference for their children
- To increase contraceptive acceptance and reduce discontinuation and unnecessary switching, the programme needs to:
  - provide a broader method choice and constellation of services

- ➢ improve provider-client interactions
- ➢ improve side effects counseling

THEME III: DEMAND, COST, AND UTILIZATION OF SERVICES

Key Findings:

- Price of contraceptives did not adversely affect contraceptive use
- Prices, to some extent, affected the type of method chosen and the type of provider used
- Contraceptive prevalence has been maintained or increased in areas where the cluster service delivery approach has been introduced
- Increasing the number of Satellite Clinics from 8 to 20/24 and combining them with EPI Spots was more cost-effective than offering only Satellite Clinics

Programmatic Implications:

- Cost recovery for contraceptives is a feasible strategy, provided there is a safety net for the poor
- Improving accessibility to fixed sites services will increase the demand for and use of contraception
- Shifting from doorstep to fixed site services should lead to the increased use of long-term methods
- Increasing women's economic power (e.g., through membership in credit unions) will lead to increased use of fixed site services
- Increasing the frequency of satellite clinics combined with EPI services was more cost-effective. Policymakers should consider scaling-up the intervention.
- The cluster approach needs to be refined to make it more cost-effective. To increase the cost-effectiveness, efforts are needed to:
  - ➢ increase IEC
  - ➢ increase the catchment area for services, and
  - ➢ offer additional services

THEMES IV AND V:

There are a number of important findings and implications in theme IV concerning the positive impact of socioeconomic development, ideational change and the family planning programme on fertility decline. For example, the key findings are:

- Women's education, employment and access to the media have a significant and negative effect on fertility
- The national family planning programme has not only facilitated access to family planning but above all, legitimated the practice of family planning
- A satisfactory theory of fertility transition will have to incorporate both socio-economic and ideational change as well as the critical role of the family planning programme.

Programmatic Implications:

- The GoB should further strengthen its family planning efforts to accelerate the rate of fertility decline
- The GoB should also attach higher priority to development in the social sector

There are also some important findings and implications in Theme V.

Findings suggest:

- Children were more likely to be moderate-to-severely malnourished if:
  - previous or subsequent birth intervals were less than two years
  - there was a larger number of siblings
  - they were female
  - their mothers were less educated
  - they came from a poor family
- Infant and child mortality have been declining, slightly more rapidly in the Project sites than nationally
- Reduced infant and child mortality is associated with:
  - longer birth intervals
  - higher maternal education
  - childhood immunization
  - access to tube-well water

- Following the death of a parent:
  - child mortality was higher
  - children's education was disrupted
- Female children are more severely affected by an adult death in the household, and more so in the case of poor families and when parents are less educated
- Mother's death has a more negative effect than the death of a father on child's health and socioeconomic well-being

Programmatic Implications are:

- The programme should emphasize the potential importance of longer birth intervals and other factors for reducing child malnutrition and child mortality
- The health and socioeconomic consequences of adult mortality on the family deserves more indepth study, so that ways to help alleviate the detrimental effects may be found.

CROSS-CUTTING PROGRAMMATIC ISSUES IN REPRODUCTIVE HEALTH

- **Improving coverage/utilization of appropriate combined service sites and trained providers.** The research showed that women tend to first use untrained village practitioners for RTI/STD and abortion services, and also sometimes for maternal care.
- **Quality of care.** The issues of expanded choice of services, access to information, provider skills and competence, provider-client interactions, continuity of services, referrals and linkages between service delivery levels and between types of reproductive health services, and the need for service standards protocols, and quality facilities are cross-cutting quality issues affecting all areas of reproductive health.
- **Costs and sustainability issues.** These are also important for the different types of reproductive health services. The studies suggest there are some advantages of providing combined services over the vertical service delivery approach, providing at fixed sites versus doorstep delivery, and charging fees for commodities and for various reproductive health services.
- **Improving women's access to Reproductive Health Services.** This is another key cross-cutting issue. The studies indicate that improving women's status through education and membership in credit unions, for example, can increase their access to both reproductive health information and services.

- **Increasing male participation in Reproductive Health Services.** This is an issue that needs to be addressed more thoroughly by the programme. The research showed that men's participation in choosing methods led to reduced concerns about side effects among women. Males were generally not seeking STD services at health clinics, and little effort has been made to treat male partners of female RTI clients.

- **Informing adolescents and young adults about different Reproductive Health Risks and Services.** This is needed, particularly on the topics of family planning, maternal health and the risks of pregnancy, RTIs, and the health advantages of delayed childbearing and birth spacing.

CONCLUSIONS

Although the papers have been grouped in specific thematic areas it is important to note there are strong interrelationships between the various areas of reproductive health. It is clear that these various reproductive health problems can not be treated separately as isolated and unlinked issues in vertical programmatic strategies and service systems. The programmatic costs are likely to be prohibitive and the results of vertical and unlinked services would be less effective in meeting all of women and men's reproductive health needs.

It is therefore, most encouraging that the GoB and its health partners are adopting the client-oriented, combined service approach in the new National Integrated Health and Population Program (NIPHP), funded by USAID, and in the Fifth Health and Population Project (HAPP-V) to be funded by the World Bank and the donor consortium. Through these projects, the Bangladesh Health and Family Planning Programme will provide an essential package of services, covering a full range of reproductive health needs.

It is clear that both women and men must be further empowered with the information and services necessary for ensuring reproductive health. It is hoped that the most compelling findings and implications of the research presented here will contribute to effective national policies and programmes for improving reproductive health in Bangladesh.

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Bangladesh Family Planning Programme: Lessons Learned and Directions for the Future

Barkat-e-Khuda, John Stoeckel, Nancy Piet-Pelon

INTRODUCTION

The Bangladesh National Family Planning Program is one of the most well-documented in the world. There are strategy, planning, and research papers, as well as management and assessment reports from national and international experts.

Consequently, it is fair to ask what is unique about this monograph? What will make this a unique document is its timing and scope. This is one of the most critical times for the national health and family planning programme. The situation today is particularly challenging. The level of effort which has gone into the current success of the programme pales when compared to what the future will require. The Government of Bangladesh (GoB) is planning its family planning and health agenda to carry into the 21st century. Each principal development partner, USAID, World Bank, and UNFPA, is designing its next programme of assistance. The essential elements require consideration, review and thoughtful revision or readjustment as part of these processes.

This monograph draws heavily from various published and unpublished work, meetings with concerned programme officials, donor representatives, as well as insights from the field. We are extremely grateful to a large number of colleagues from the Directorates of Health and Family Planning, representatives of donor agencies and ICDDR,B colleagues for their very valuable inputs and suggestions. Particular mention should be made of Mr. Nawab Ali and Dr. Jahir Uddin Ahmed for their review of the monograph, before its finalization.

The presentation of the monograph is divided into five segments:

1) Background,
2) Future challenges,
3) Cross-cutting issues,
4) Programme components, and
5) Resolution of issues.

BACKGROUND

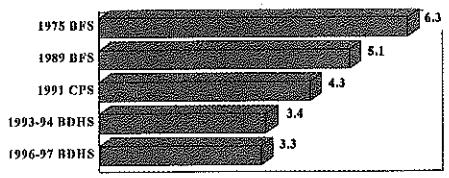
Despite pervasive poverty and underdevelopment, Bangladesh has been experiencing considerable fertility decline. During the past two decades, Bangladesh has experienced a rapid decline in fertility with the TFR dropping by about half. The Bangladesh model

is now being increasingly cited for adoption by many countries. This declining trend is illustrated in Graph 1.

Much of the fertility decline in Bangladesh has resulted from sharp increase in contraceptive prevalence. During the past two decades, contraception use has increased sixfold (Graph 2).

Graph-1

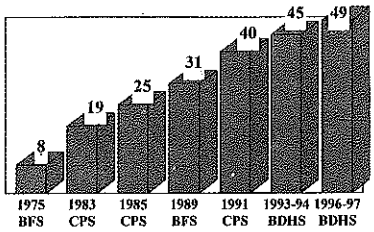
During the past two decades, Bangladesh has experienced a rapid decline in fertility with the TFR dropping by about half



Number of children per woman

Graph-2

During the past two decades, contraception use has increased sixfold



Family Planning

However, use of short-term methods (like pills, condoms, and injectables) has increased, while use of longer acting methods (like VS and IUD) has declined. For example, use of the pill has increased from 17 percent to 21 percent and now accounts for 42 percent of all contraceptive use, while female sterilization which accounted for 18 percent of contraceptive use in 1993-94 dropped to 15 percent in 1996-97. The change in method mix has implications, both from the point of view of demographic impact of the programme as well as the financial and sustainability consideration.

Also, discontinuation rate continues to be quite high. About half drop out within the first year of use. Dropout is highest for condoms (65 percent) and lowest for IUD (41 percent). Side-effects account for about half of all dropouts, and over 86 percent for IUD and 70 percent for injectables.

Maternal Health

- The 1996-97 BDHS found that for three-quarters of births the mother received at least one TT injection during pregnancy, rising from 66 percent in 1993-94.
- However, TT coverage is lower for births:
  - ➢ to older women (54 percent for 35+ women compared to 79 percent for those 20 years old or less)
  - ➢ to rural women (73 percent for rural women compared to 90 percent for urban women)

- in Sylhet Division (62 percent in Sylhet Division compared to 85 percent in Khulna Division)
- to less educated women (67 percent for women with no education compared to 92 percent for those with secondary school+)
- to high order births (58 percent for 6+ births compared to 83 percent for 1 birth).

- Regarding antenatal care, for 26 percent of births, ANC was received. However, only 19 percent of pregnant women had 2 or more ANC visits.
- ANC coverage is poorest:
  - among older women,
  - in rural areas,
  - in Sylhet Division,
  - among women with little or no education, and
  - among women with high parity.
- A final concern in maternal health is that only 8 percent of all births were assisted by a trained provider, down from 10 percent in 1993-94.

Child Health

Under-5 mortality declined from 170 per 1,000 births during 1982-86 to 116 in 1996-97. During the same period, child mortality declined from 62 to 37, and infant mortality from 115 to 82. However, infant and child mortality continue to be unacceptably high.

Only 54 percent of children 12-23 months are fully immunized. Vaccination coverage is lower:

- among girls (52 percent compared to 56 percent for boys);
- in rural areas (54 percent vis-a-vis 58 percent in urban areas);
- in Sylhet Division (42 percent compared to 68 percent in Khulna); and,
- among mothers with no education (50 percent compared to 70 percent among mothers with secondary school +).

FUTURE CHALLENGES

Bangladesh has achieved considerable success in contraceptive use. However, there is considerable room for improvements both with respect to contraceptive use as well as vaccination coverage. Also, the population in need of ESP services will continue to increase in the future, calling for additional resources, and more efficient use of resources. Costs incurred in the family planning sector alone will almost double from 120 million annually in 1995 to $220 million annually in 2005.

Here, are some statistics about increasing population size in need of ESP services:

- MWRA will increase from 29 million in 1996 to 39 million in 2006.
- The number of contraceptive users will have to more than double to 21 million by 2005, if replacement level fertility is to be reached by 2005.
- Urban population will increase from 27 million in 1996 to 47 million in 2006.

Contraceptive prevalence will have to be increased to around 70 percent in order to achieve replacement level fertility. Also, as the programme matures mere increase in contraceptive prevalence will not be enough.

- The relative share of longer-acting methods will have to be increased in order to be able to achieve a better method-mix.
- Discontinuation rate will have to be reduced considerably in order to enhance the demographic effect of contraceptive use.
- In addition and quite importantly, interventions related to maternal and child health need considerable strengthening through substantial increase in vaccination coverage, ANC and PNC coverage, and medically-assisted deliveries.

CROSS-CUTTING ISSUES

Although the programme has achieved considerable success, we still have a long way to go. It is appropriate that the cross-cutting issues impeding effective implementation of the programme are identified and appropriate actions taken to address those issues, so that the programme is able to achieve even greater success in the future. There are eight identified cross cutting issues.

- The needs and intentions of the family planning (FP) programme have changed from providing FP-MCH to providing an Essential Services Package (ESP). This will pose a major challenge to the programme in terms of both the human and material resources required for the introduction of the package.

- The management of the FP programme is oriented more toward the interests of providers than the needs of clients. The programme is still effected by a history of "target-orientation". While there are no official targets in today's programme, there is still a target mentality.

- There is inadequate cooperation and coordination between the FP and Health Directorates. This is apparent in the delivery of health and family planning services at most levels. However, there is a marked improvement in coordination at the community level where services are now provided through combined SC and EPI sessions.

- There are internal conflicts between medical and non-medical staff within the FP Directorate. This occurs primarily between the TFPOs and MO MCHs with regard to: pay scale and status, financial drawing and disbursing authority, and career advancement opportunities. Such conflicts are believed to be severely hindering the clinical contraception programme.

- Staff hired under the development budget have lower morale than those hired under the revenue budget.

- There is a lack of accountability in the public sector, including the health and family planning programme. There is no formal performance appraisal for staff, and no system of rewards for good performance or punishment for poor performance. There is a lack of clarity in job descriptions, and a confusion in the direct-line supervision for the personnel at the field level. Also, drugs and other supplies are lost in the system.

- There is inadequate cooperation and coordination between government and NGOs. This has resulted in areas being poorly démarcated, duplication of services and overlap in work between field staff.

- The health and family planning programme is donor dependent. In fact, almost 60 percent of the MCH-FP programme funds are from donors. The donors will not be able to maintain this level of funding for an extended period so the programme will need to achieve greater self-sufficiency.

PROGRAMME COMPONENTS

Service Delivery

Household level

At the household level, it is difficult to provide quality services, particularly medical back-up for contraceptive complications. Household services are inadequate to manage: contraceptive complications, maternal care, child health, and the broader reproductive health issues.

Clinical Level

Access to clinical methods is not assured as providers and sites are not prepared. The quality of services, the condition of facilities, the logistics and supply system and the training for clinical methods - all need improvements.

More than one brand of IUDs and injectables negatively affect clinical services, as it increases training and logistics requirements.

Administration

There is no human resource development plan.

Manpower shortages exist at all levels with one-third of TFPO posts are vacant and 2000 FWVs are needed but only 1000 recruited. There are also vacant posts in the health sector.

Even when personnel are recruited, manpower utilization problems continue. For example 250 Medical Officers have been recruited for H&FWC, but none stay there.

Training

Training has been inadequate. Particularly, NIPORT-organized refresher courses are less than frequent and not often need-based. NIPORT and the FP and Health Directorates do not coordinate training effectively. There is inadequate provision of, and capacity for, training, particularly for ESP.

IEC

There is inadequate audience segmentation, resulting in lack of appropriate messages. There are also gaps in topics covered. A continued lack of coordination between GoB and NGOs involved in IEC leads to duplication and overlapping of effort and a waste of resources.

Monitoring

The MIS is overloaded with information on less critical variables. Data feedback is neither timely nor particularly useful for local managers or frontline workers.

Supervision

Supervision at all levels is a major weak link in the health and FP programme, thereby affecting performance at different levels.

Logistics and Supplies

It is positive to note that at the Thana level, rate of contraceptive stockouts has markedly declined. Yet, there are delays in procurement of supplies, because donors have their own schedules for delivery. There is also high staff turnover and vacancies at both the thana and central levels. Finally, there will be additional demands related to ESP.

Urban Programme

Unlike in rural areas where the programme is more organized, this is not the case in urban areas. Rather, there is a multiplicity of providers and agencies, resulting in duplication and overlap. There is also a lack of effective coordination among the service providers and agencies.

RESOLUTION OF ISSUES

In order for the programme to address the cross-cutting issues, and thereby, move forward to achieving greater success, changes will be required in the management, structure and organisation of the MOHFW and its Directorates. A High Level Committee (HLC) has been established by the GoB to address these issues. The HLC will provide recommendations on management and organizational reforms, along with a plan and timetable for implementing these reforms in the next health and population programme. The setting up of the HLC is a major step toward improving programme performance, and the government should be lauded for this positive step. However, the critical task at hand is for the HLC to provide their recommendations for the needed reforms. Therefore, the work of the HLC needs to be accelerated so that implementation of the reforms can take place under HAPP-V. This is particularly important, because there are likely to be problems related to implementation which will require additional time for resolution.

Programme Components

Service delivery: There is need for careful consideration to be given to gradually phasing out the existing labour-intensive, expensive, home-based service delivery by alternative modes of service delivery that can better ensure quality of care and is cost-effective.

Administration: Human resource development for the entire programme needs immediate and sustained attention. Particular emphasis needs to be given to retraining service providers, who will be needed to implement the ESP.

Training: Consideration should be given to: use of new approaches or training styles such as locally - organized, team approach training; development of curricula and training plans which respond to service needs in the field, including ESP; joint planning for training by the FP and Health Directorates to ensure that programme needs

are met; recruitment of highly qualified trainers for NIPORT to enhance its training capacity; and, exploration of the potential of using private sector organisations to augment the MOHFW training capacity.

IEC: In addition to various general improvements such as appropriate messages, adequacy of topics covered, the existing IEC strategy will have to incorporate the ESP needs. In this connection, I am pleased to inform you that last week a high-level committee has been formed, with the Additional Secretary, MOHFW as its chairperson, to come up with a comprehensive IEC strategy, building upon the existing FP-MCH Strategy. I am also happy to inform you that a combined IEC flipchart for ESP has been developed by the Extension Project in collaboration with MOHFW and its two directorates.

Monitoring: The MIS should be made more user-friendly. Also, particular attention should be given to ESP data requirements.

Supervision: Weak supervision and lack of adequate accountability should be addressed by the development and implementation of a standard plan that facilitates supportive supervision (e.g., supervisory tools for frontline supervisors and managers, and performance review meetings developed by the Extension Project).

Logistics and Supplies: Consideration needs to be given to the expected increased volume in contraceptives along with the additional commodities required for the ESP. Also, there is a need for a decentralized system for storage and supplies.

Urban Programme

There is a need for better coordination of providers and services in urban areas so that services are accessible to all, but not duplicated. The role of NGOs and the private sector, particularly the SMC, can be further expanded to provide the quality and level of services required for the ever-increasing urban population, especially the disadvantaged groups, i.e., the slum and floating population.

From family planning to family health: the Essential Services Package (ESP)

The vision of the GoB is "....to be responsive to clients' - especially women's needs, to provide better quality services, to become financially sustainable, and to develop adequate delivery capacity [the] government will focus on the essential package of services. Within the essential package, the government's highest priorities will include ... maternal and child health ... reduction of maternal and child mortality".

To accomplish this vision, discussion is underway for managerial and structural reforms that will produce a "unified management structure" under which the programme components will operate.

Three options for implementing managerial reforms have emerged from this review.

- First, the process should be initiated in a phased-in manner, both in respect to the programme components as well as the service delivery tiers.
- Second, instead of adopting a phased-in approach, there will be a unified merger and complete integration at all levels of service delivery and all components of the programme.
- Third, complete integration should occur at only a selected high-performing district instead, before its introduction nationwide.

I have come to the end of this presentation, bringing before you three options for implementing the needed reforms. I would urge you to deliberate on the merits/demerits of the options and decide which option to adopt and when to begin its implementation.

Summary of Discussion for Scientific Session III

The discussion following the third scientific session focussed on several key topics. First, the discussants dealt with the critical issues of organizational reform. While each complimented the programme's success in family planning, they emphasized the future challenges. They also sounded a warning that if the challenge of organizational reform was not managed, the programme would not be able to sustain its current success.

The programme is being pushed by its new HPSS strategy, particularly the stated goals of ESP. At the same time, the sheer numbers of people that must be reached for ESP services, particularly women for family planning services is a formidable challenge. The urgency of making the needed changes cannot be ignored.

The GoB will need to determine its priorities because the higher costs of delivering ESP mean that funds may be inadequate. The programme will have to seek more cost effective ways of managing services and personnel. Particular mention was made of the High Level Committee and their on-going deliberations.

Second, the discussants recognized the unique contribution of the Centre. The experimentation which began in Matlab and has been greatly expanded by the Extension Project has been a critical factor for the national programme. The Centre was lauded for its international reputation, as well as its singular contributions in Bangladesh.

Third, the discussants sounded several warnings -- particularly about the deeply disturbing issues of maternal and child health. While family planning acceptance has continued to increase, other aspects of maternal and child health have not made similar gains. Improvement of the health status of women and children is a primary concern for the immediate future and the Extension Project was called upon to continue to work with the GoB to solve the formidable challenge of reaching families with ESP services.

Fourth, there was an expressed recognition that the national programme does have to make fundamental changes and that the Centre is in a position to continue to help the GoB find ways to make those changes. The importance of continual research of the highest quality was emphasized.

Fifth, IEC which is fitting for ESP has to be developed. This IEC package will need to include all the priority health messages and be delivered in culturally sensitive ways.

Finally, each discussant reminded the audience that the challenges which lie before the programme are greater than those which have been overcome. The programme will need the help of all other sectors of GoB, the NGO and private sector, and of the development partners to meet the challenges which lie ahead.

Remarks
Professor John C. Caldwell

I have been observing family planning programmes around the world, with my wife Pat, for the past 40 years. I have been an observer of the Bangladesh programme for the past 30 years. Though I have never lived here, I have stayed here and done research for many months at a time on my different visits. During my years of doing research in Bangladesh I have seen immense change, particularly immense change in the family planning programme.

It is very easy to think from the perspective of Bangladesh that ICDDR,B is a common-type of institution with others like it found throughout the world. It isn't. It is a unique institution, the only one of its kind in the world. It is very fortunate for Bangladesh that it is here and it is very fortunate for ICDDR,B that Bangladesh is such a distinct place for it to be. It, of course, was originally concerned with diarrhoeal diseases; and its amazing contributions to the development of ORS; its use of tetanus toxoid for pregnant women; and testing what really happens over the long-term with measles immunizations.

A very important part of ICCDR,B is the Extension Project. The Project has changed over time. It has probably done that because apart from the health side of ICDDR,B, it developed in Matlab the world's greatest population laboratory, there is nothing like it anywhere. If you look at the quantitative social science literature on family planning about half the references to the Third World are references to Matlab because that was what was measured. It has changed now to the extended Extension Project (Rural) because it was important to see if the lessons learned in Matlab could be transferred to the rest of the country.

The Extension Project has evolved since its beginnings in Matlab. It has become a broad project, much more associated with Government. It has grown in size and provided leadership to the Government. It has also become much more indigenized and I think that is probably inevitable too. I think, on the whole, the evolution has been positive.

Many important programme interventions have come out of Extension project research. They first demonstrated the value of field workers for household distribution of contraceptives. They have now shown that the FWA can be used even more effectively, if she manages clusters. As their research develops, they will probably be suggesting further modifications.

One of the future challenges is population momentum. What population momentum really means is that the mothers of today were born not when the total fertility was 3.3 but when it was 7. Their sheer numbers are horrendous and no matter what the Project does, no matter what the GoB does, there is going to be enormous population growth in the future. In terms of the family planning success, we're not yet halfway.

There is another problem that faces us. Total fertility is now down to 3.3. In some parts of the country it is considerably below that. It is at dangerously low levels in terms of the

individual family when infant and child mortality rates continue to stand where these are today. Evermore, the family planning programme will have to become a reproductive health programme. The family planning programme will have to put as much emphasis on getting down infant and child mortality as it does on lowering fertility. It is going to prove easier to get down fertility than mortality.

There have been enormous changes, as I said, in Bangladesh. The future challenges cannot be done by the family planning programme alone. Rather the family planning success will be based on the changes and successes of all aspects of development in Bangladesh. The family planning programme should be grateful for other programmes the government runs, the contribution of the NGOs and the health programmes of the Ministry of Health and Family Welfare.

Finally, let me say that this has been an extremely interesting seminar. I found it useful and I am sure that others did as well.

Chief Rapporteur's Report
Nancy Piet-Pelon

We are here, deliberating on difficult and challenging issues, because the national family planning programme has been a success. [In fact, Mr. Secretary, I could add parenthetically that the word success has been mentioned at least 2000 times since you left the room yesterday.]

Of course, there are things in the national programme that each of us would like to change. It is not a perfect programme. Nevertheless, success allows us to be challenged to move forward. If the recently announced contraceptive prevalence rate (CPR) were 20 percent, instead of 49 percent, there is little doubt that we would be thinking through different issues:

- HPSS would be a distant dream
- The MCH/FP Extension Project (Rural) of ICDDR,B would possibly still be experimenting with fieldworker registers or other programme basics
- Perhaps some of Bangladesh's proud development partners would have had to go elsewhere with their technical assistance and their funds
- Certainly it would be difficult to imagine the objectives and goals of NIPHP.

Yet, thanks to the current status of the family planning programme, each of us is challenged to bring our best to the next years in order to move forward. The programme is being pushed by the sheer numbers of women, and their families, which need to be served. Many numbers have been aired in this room since yesterday. But perhaps one of the most compelling is that 21 million women will need contraceptive services by 2005. At the same time, the programme has challenged itself to expand to deliver the Essential Services Package (ESP) to the families of this growing nation.

So, how do we get there? How do we move from the success of today to meet the challenges of the future?

Dr. Barkat-e-Khuda highlighted in his presentation this morning eight cross-cutting issues which effect the programme and erode confidence in the future. Because of time constraint, I'd like to highlight three of those as examples:

- The management of the family planning programme is oriented more toward the interests of providers than the needs of clients.
- There is inadequate cooperation and coordination between the Family Planning and Health Directorates.
- There are internal conflicts between medical and non-medical staff within the Family Planning Directorate.

These seem like intractable problems, particularly when viewed from the national or central MOHFW perspective.

At the same time Dr. Thomas Kane talked about new areas of concern in reproductive health, which impact directly on the delivery of ESP. Some of the issues he mentioned were:

- RTIs/STDs -- what we know of women's perceptions is limited and our knowledge needs to be improved before we can design and deliver appropriate services.
- Abortion -- it is particularly worrisome that an apparently large group of women chose to use traditional abortions in a country where a successful family planning programme and national menstrual regulation (MR) services exist.
- Antenatal care -- continues to elude the majority of women who need it.

Then there are the issues which effect special groups -- adolescents, newlyweds and -- that unique half of the reproductive health population -- men.

These new issues, when combined with the seemingly intractable problems mentioned by Dr. Khuda, add up to formidable challenges. Yet, the goals of HPSS are set and each of the issues must be addressed if these are to be met.

Thus, the operations research results presented here are timely. These are part of the bridge to the future. A number of findings have been presented here which can be grouped into five principal themes.

1) **Change is possible** -- even changing a successful approach can be done. The most compelling example is the role of FWAs. These workers are credited for much of the success of the current programme. They reach women with information and services at the doorstep -- and do it effectively. But, the results of the operations research on the **cluster approach** show that it is possible to change their role and good things happen. Knowledge and coverage increase, and the CPR does not drop.

FWAs also have time to do other important tasks when they work through clusters. Their time is freed to visit the hard-to-reach clients.

Certainly changing the role of FWAs is not easy. However, it can be seen as part of an evolution. Those in this room who have been involved with the programme for a long time certainly remember the days when the idea of hiring women workers was first considered. There had to have been many "nay-sayers" who worried that women workers would not be effective. The next step of having those same workers deliver contraceptives at the doorstep also would have been evolutionary. The steps that are being suggested by the results of operations research on clusters is part of this evolution.

2) **Sustainability** -- In the Health Secretary's opening remarks, he mentioned that a combination of three factors is forcing the programme into greater cost containment: more people to serve; more services to be provided -- particularly with ESP; and fewer resources.

Many have returned to that theme throughout the workshop. What we have learned from the results of the operations research on payment for contraceptives is that clients are willing to pay a nominal fee. There was no drop in the CPR when payment was introduced. Even more interesting was the savings that could be accrued by decreasing wastage when clients pay for contraceptives. Heady figures, in the millions of dollars in savings to the programme, were mentioned.

There is another element of cost containment which will make the programme more sustainable. In any service programme, like family planning or health, its most costly component is manpower. It follows then, that saving costs on manpower will increase the programme's sustainability. The results of the operations research on ESP showed that supervisors did their supervision tasks and did those more effectively. At the same time, when health and family planning service providers at the community level worked together, there was less duplication. The cluster approach showed that FWAs were able to cover more clients and potential clients with services and information. Their efficiency was increased without increasing their work time. Finally, the results of the operations research on networking showed that when all sectors at the community level were organized to work together on common goals, positive results were achieved.

Much more work needs to be done to maximize the use of manpower as a cost containment measure but one lesson is clear: when workers do the jobs they are trained to do to maximum effectiveness, it saves the programme money.

3) **Coordination and cooperation are possible** -- One of the on-going problems of the programme is the lack of cooperation between health and family planning workers. The results of the operations research in ESP Satellite Clinic combined with EPI, and networking have shown that these workers can work together effectively at the community level. The coordination of their efforts has had several positive results: increasing coverage; avoiding duplication; and improving worker morale.

4) **Information is needed at two levels** -- For both new programmes, like essential obstetric care (EOC) and long-standing ones, like family planning, a constant flow of information is required for both service providers and the community. If we take the example of EOC, the service providers and the site required massive preparation to be able to deliver all elements of EOC -- including Caesarean section. Yet, the preparation of the site and the training of the staff for this new service was only one aspect. The community requires information not only about the new service existence but targeted information on why it should be used. Current child birth practice is sustained by culture and age-old traditions which will not change without compelling and continual information which supports change.

It is important to be cautious (when new programmes are begun) about how results are evaluated. Using EOC as an example, there was some disappointment expressed that only 6 Caesarean sections were conducted in Mirsarai THC in the year since the EOC services were set up. However, it is important to evaluate all the other aspects of the EOC programme which have the potential to benefit reproductive outcomes: pregnant women have been registered; ante and post natal care visits have increased; women have been given and maintained a pictorial card on child birth; and assisted deliveries have increased.

5) **An enormous level of effort and goodwill has to be maintained for programme success** -- The MOHFW at all levels has had a significant effect on the positive success of the Extension Project's operations research programmes. It is difficult to measure this level of effort but it is integral to the outcomes. Certainly, it starts at the central level with the support of the MOHFW officials at the highest levels. This support is reflected throughout the programmes to the community level.

Less attention has been given directly to the role of the staff of the Extension Project. There have been questions from the floor, and a challenge, to quantify their role both in terms of technical assistance and cost. The audience has variously labeled them as catalysts or simply "nice people". Certainly, they have often been involved in conflict resolution as they have stood between different factions, helping them overcome obstacles which have prevented them from working together.

Before the successes reported upon here are replicated in the national programme, the roles of the MOHFW and the Extension Project staff must be dissected and more clearly understood. These will also have to be replicated if similar results are to be achieved on a national scale.

Project research is only truly useful if the results are adapted by the national programme and contribute to its success. In Dr. Barkat-e-Khuda's first presentation this morning, he shared an impressive list of contributions of the Extension Project into the national programme. These are in the areas of management improvement, quality of care and sustainability. The results that have been presented at this workshop can also contribute to the programme if adapted.

We have also been reminded by Dr. Khuda, in his second presentation, that two future challenges remain: unified command and the delivery of the ESP. In order to meet these challenges, managerial reform is necessary. Three possible ways of approaching this reform were suggested during the course of the development of the monograph presented this morning:

- Managerial reform should be initiated in a phased-in manner, both in respect to the programme components as well as the service delivery tiers.

- Managerial reform should not be phased but there should be unified merger and complete integration at all levels of service delivery and all components of the programme.

- The third option is a variant of the second, managerial reform should be one of complete integration but done in only a selected high-performing district first.

In order for the programme to move forward, one of these must be selected. The results of the operations research presented here show that change is possible and point toward ways these next formidable challenges can be overcome.

Dr. Jack Caldwell mentioned in his opening remarks this morning, that we cannot predict all the ways the work disseminated at this workshop will influence the national programme. However, we can predict that there will be a positive influence and we will gather together in five or ten years time in this room to examine those results together.

Closing Remarks
Mr. Muhammed Ali, Secretary
Ministry of Health and Family Welfare
Government of Bangladesh

Professor Habte, Professor Caldwell, distinguished participants, ladies and gentlemen.

We have come to the end of this two-day seminar of considerable programmatic relevance and significance. Let me begin by congratulating all the presenters and the discussants for excellent quality of deliberations, and ICDDR,B for organising this important dissemination seminar.

I would particularly thank Ms. Nancy Piet-Pelon for her very clear and incisive report as chief rapporteur. I must admit she has again admirably proved her ability to present a long discussion spread over two days on complex issues in a clear and compact manner while at the same time making sure nothing important is left out.

I also would like to thank Professor Jack Caldwell for his very useful and thought-provoking remarks.

The ICDDR,B's Rural Extension Project's track record in operations research assures us of a level of dedication unsurpassed. As we have heard this morning and from the deliberations of yesterday, the Project has developed and tested many innovative approaches in its field sites. Several of these have already been adopted in the national programme. Furthermore, many of the Project findings have greatly influenced the development of the Health and Population Sector Strategy (HPSS), the Fifth Health and Population Programme (HAPP-V), and the National Integrated Population and Health Program (NIPHP).

Many of the findings which have been shared with us during this workshop, as well as those referred to in the two volumes that we have been presented, support the idea that **reform** in the health and population sector will be required to provide adequate health care for the people of Bangladesh. The Government of Bangladesh strongly believes that various cross-cutting issues impeding effective implementation of the programme must be urgently overcome, particularly in improving management and accountability and in reducing duplication and wastage. I, further, believe that the inefficiencies due to bifurcation need to be urgently resolved, and that the present organisational structure needs further improvements to ensure a more transparent, sustainable, and cost-effective delivery of essential services.

Based on these and other findings, I believe that the following issues will need to be considered carefully:

1) What is the most cost-effective service delivery strategy? This is an issue of major concern, given the rising costs of the programme.

2) Has the programme given due consideration to the needs of the clients?

3) Have staff at different levels of the programme been efficient and effective in organising and managing their activities such as family planning, maternal health, child health, and disease control?

4) What will be needed in terms of additional resources such as training, IEC, etc. to support the additional elements of the Essential Services Packages?

5) How can reform in the health and family planning sector be achieved in a way that maximises the desired output with minimum disturbances in the system? Professor Khuda mentioned three possible options of implementing the Essential Services Packages. Each has its advantages and disadvantages. Let us all think through the three options and come up with one that makes the most sense. We are at a critical stage of the programme, and time is running out. The Ministry is committed to achieving the desired reforms in the shortest possible time.

Resolution of cross-cutting issues will require an unfaltering level of dedication and teamwork among all development participants. Yet, expediently implemented, they will pave the way for greater trust, and less reliance on centralized decision-making mechanisms.

Thus, it will be imperative that the ICDDR,B's MCH-FP Extension Project continues to work closely with the Bangladesh Government, NGOs and the private sector, to ensure a health and family planning programme which is able to ensure better health for all.

Before I conclude, I would like to congratulate Professor Barkat-e-Khuda and his colleagues for their continued excellent work, and would like to assure them of my Ministry's fullest support and cooperation.

Vote of Thanks
Professor Demissie Habte

Mr. Muhammed Ali, Dr. Richard Brown, Mr. Shamim Ahsan, colleagues from the Government, donor agencies, NGOs, and my colleagues from the Centre.

I think you will agree with me that the last two days have been exciting and useful. I am inclined to think this seminar has been a defining moment in the history of ICDDR,B's involvement in population and family planning. Perhaps it is a little bit of an exaggeration but it will be a defining moment for the national family planning programme because we are at a critical crossroads and we need to be very careful in selecting which way to go.

I take two messages with me, both good and bad news. After impressive gains in family planning in this country, we have the bad news that we have greater challenges facing us than we have overcome. The good news is that we know what to do and how to do it. The past collective effort and inputs from GoB, research of the Centre, health infrastructure, NGOs and private sector, all indicate that we will succeed.

It is now my very pleasant duty to give a vote of thanks to many individuals. I want to start by thanking the participants from GoB and NGO, as well as the Centre, who have been patiently sitting and listening but also contributing. Without you, we could not have a successful meeting. My special thanks to all the speakers from the Centre, the distinguished discussants, and those who worked as Chairs to steer the meeting. To our donors and other development partners, we are grateful that we continue to be partners and continue to work together.

The GoB -- if ICDDR,B is a success it is because it has been blessed by a people and government which understands and appreciates what we do. We are exceedingly grateful to the people of Bangladesh and the GoB.

And then I come to the Secretary of the Ministry. Mr. Ali and I generally agree on a lot of things but we occasionally clash when it comes to sartorial codes. But today we did match. Mr. Ali has been a genuine friend of the Centre, somebody who has a mastery of facts of his job, he is a person we can call on at any time of need and I'd like to say we cherish this relationship and are exceedingly grateful for this.

Last but not least, I would like to thank the Extension project leadership Mr. Shamim Ahsan and Dr. Barkat-e-Khuda and the staff for putting up a great show.

Appendix: Press Clippings

THE BANGLADESH OBSERVER
DHAKA FRIDAY JULY 4, 1997

ICDDR,B's new steps to ensure better health

The Maternal, Child Health and Family Planning (MCH-FP) extension project of International Centre for Diarrhoeal Diseases and Research, Bangladesh (ICDDR,B) is now designing several new interventions to meet the changing needs and priorities of families and the desire to ensure better health for all in Bangladesh.

The interventions include broader essential service package of Health and Family Planning Services, strengthening maternal and neonatal health, promoting involvement of males in reproductive health, prevention and treatment of HIV-related diseases, improving nutrition for children under two years and reaching out to undeserved groups, mainly men and adolescents.

An ICDDR,B official told BSS in Dhaka on Wednesday that the present vision of the project, as also of the government, is to ensure better health for the whole family as about 25,000 women die of complications related to childbirth and pregnancy every year in Bangladesh.

He said maternal deaths associated with pregnancy and childbirth could only be prevented through the provision of emergency obstetric care which is yet to be made available to most of the women in Bangladesh and other developing countries of the world.

"The centre is working on developing services that are feasible, sustainable and replicable", the official said, adding that a pilot project opened in Mirsarai Thana Health Complex last year started giving obstetric care to the needy women.

He said this is for the first time that such service is being provided to the deserving women at thana level in Bangladesh. The lessons learnt from it has been analysed and compiled but the challenge now is how to extend such services to all other thanas so that every pregnant woman is benefited.

"The ICDDR,B will continue to work in this important area", he said, adding that the accumulated findings of the MCH-FP project were used to a great extent in the preparation of the health and family planning programme in the country.

The project has been continuing its stride through other interventions for over two decades to ensure sustainability of national health and family planning programme which resulted in a positive development with women becoming more aware about he need for family planning.

The interventions are: alternative delivery approach, known as "cluster visitation", cost recovery through pricing of commodities and supplies and networking among service providers to develop effective coordination between the government and the NGOs working at the community level.

The project has also had a significant influence in shaping the mandate of the USAID-funded national integrated population and health programme and the health and population sector strategy for Bangladesh Government, the ICDDR,B official said.

"The support and contribution of the project to the national programme have earned national and international recognition and acclaim, he said adding that the government recruited 10,000 additional field workers based on the recommendations of the project officials to improve the field-worker and the client ratio considerably.

The MCH-FP work of the centre started at Matlab under Chandpur district in 1977 and its success created the rural MCH-FP project in 1982, the largest collaborative operation research efforts between the ICDDR,B and the Bangladesh Government's Ministry of Health and Family Welfare.

The project, being funded by the USAID and technically assisted by the Population Council, has a national steering committee which is being headed by the Health Secretary providing overall policy guidance and reviewing its activities.

"The challenge facing the country now is to develop a second generation of affordable family planning service where the delivery shifts to fixed facilities outside the home while maintaining and increasing both coverage and quality of services", the official observed.

The ICDDR,B is actively involved in developing such services at its various field sites, he said.

The Daily Star
Founder-Editor : Late S. M. Ali
Dhaka, Thursday, July 3, 1997

MCH-FP Extension Project

New interventions to ensure better health for all planned: ICDDR,B

Maternal, child health and family planning (MCH-FP) extension Project of the International Centre for Diarrhoeal Diseases and Research, Bangladesh (ICDDR,B) is now designing several new interventions to meet the changing needs and priorities of families and the desired to ensure better health for all in Bangladesh.

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An ICDDR,B official told BSS in the city yesterday that the present vision of the project is to ensure better health for the whole family.

He said maternal deaths associated with pregnancy and childbirth could only be prevented through the provision of emergency obstetric care which is yet to be made available to most women in Bangladesh.

Nearly 25,000 women die of complications related to childbirth and pregnancy every year in this country, he added.

"The centre is working on developing services that are feasible, sustainable and replaceable," the official said, adding that a pilot project opened in Mirsarai Thana Health Complex last year started giving obstetric care to the needy women.

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The Independent

DHAKA THURSDAY 3 JULY 1997

New package of health & family planning services planned

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The Daily Star
Founder-Editor : Late S. M. Ali
Dhaka, Wednesday, July 2, 1997

Structural reform in health sector stressed

By Staff Correspondent

Speakers at a seminar in the city stressed structural reform in the health sector to attain self-sufficiency and cater the needs of the clients.

The topic of yesterday's dissemination seminar held at ICDDR,B Sasakawa auditorium in the city was 'Lessons Learned and Programmatic Implications'.

The two-day seminar concluded yesterday, was held under the auspices of ICDDR,B MCH-FP Extension Project (Rural) and Ministry of Health and Population Welfare with support from USAID and the Population Council.

The Secretary of Ministry of Health and Family Welfare, Mohammad Ali chaired the concluding session of the day's programme in which three papers were presented.

Dr Barkat-e-Khuda presented two papers entitled 'Bangladesh Family Planning Programme: Lessons Learned and Direction for the Future' and 'Improving the Bangladesh Health and Family Planning Programme: Lessons Learned through Operations Research'.

These papers were prepared with two other co-authors Dr John Stoeckel and Nancy Piet-Pelon, Dr Barkat told the seminar.

Dr Thomas Kane presented another paper titled 'Reproductive Health in Rural Bangladesh: Policy and Programmatic Perspectives'.

The discussants included high officials of the government and officials of World Bank and USAID, based in Dhaka.

"The needs and intentions of the family planning programme have changed from providing FP-MCH to providing an essential services package," said Dr Barkat. He said manpower shortages at all levels and a lack of coordination will pose a major challenge to the programme.

"There are internal conflicts between medical and non-medical staff with the FP directorate," he said. "And staff hired under the development budget have lower morale than those hired under the revenue budget."

Dr Barkat suggested a unified management structure for the health sector and proposed three alternative options for its implementation.

According to him the reforms could be implemented in phases, both in respect to the programme components as well as the service delivery tiers, or through a unified merger and complete integration at all levels of service delivery and all components programme.

The Secretary, Ministry of Health and Family Welfare, said that the government was developing its family planning and health programme keeping in view of the needs of the 21st century.

He also said the government was aware that the sector needed structural reform to ensure services to meet the needs of the clients.

Measures like recruitment of more health service personnel has already been initiated, he said.

He also said that the suggestions and recommendations of the seminar will be given due importance for future implementation.

THE BANGLADESH OBSERVER
DHAKA WEDNESDAY JULY 2, 1997

Dissemination seminar

Contraceptive users should be doubled

The number of contraceptive users should be more than doubled to 21 million to reach replacement level fertility by the year 2005, reports UNB.

The suggestion came at the end of a two-day dissemination seminar on "lessons learned and programmatic implications" at ICDDR,B in Dhaka on Tuesday

It said contraceptive prevalence rate (CPR), now at 49 per cent, should be increased to around 70 per cent to achieve the replacement level fertility.

The CPR was increased to 49 per cent this year from 8 per cent in 1975. Bangladesh has achieved a dramatic decline in its total fertility rate, from 7 in 1975 to about 3.3 in 1997.

The seminar pointed out lack of accountability in the public sector, including the health and FP programme. There is no formal performance appraisal for staff, and no system of rewards for good performance or punishment for poor performance.

"There is lack of clarity in job descriptions and a confusion in the direct-line supervision for the personnel at the field level. Also, drugs and other supplies are lost in the system."

Participants at the seminar observed that the health and FP programme is donor— fed and almost 60 per cent of the MCH-FP programme is donor dependent.

The donors will not be able to maintain this level of funding for an extended period, they said Suggesting that the programme will need to achieve greater self-sufficiency.

They suggested that careful consideration be given to gradually phase out the existing labour-intensive, expensive, home-based service delivery by alternative modes of service delivery that can better ensure quality of care and is cost effective.

The seminar viewed that there is inadequate cooperation and coordination between government and NGOs, which has resulted in areas being poorly demarcated, duplication of services and overlap in work between field staff.

Chaired by Health and Family Welfare Secretary Muhammad Ali, the closing session was also addressed by DG of NIPORT AKM Rafique Zaman, DG of Directorate of Family Planning Shirazul Islam, USAID director in Dhaka David L Piet and ICDDR,B director Demissie Habte.

Some 200 representatives from government agencies, national and international NGOs, ICDDR,B and donor agencies took part in the seminar, jointly organised by MCH-FP Extension Project (Rural) of Health and Population Extension Division, ICDDR,B, Ministry of Health and Family Welfare, USAID and Population Council participate in the seminar.

THE FINANCIAL EXPRESS
28/1 TOYNBEE CIRCULAR ROAD, DHAKA-1000
Wednesday, July 2, 1997
Asharh 18, 1404 BS : Safar 26, 1418 Hijri

Contraceptive users 'more than doubled' to 21m

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The Independent

18 Ashar 1404, 25 Safar 1418

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Seminar on health, population held

by Staff Reporter

Speakers on the concluding day of a two-day long seminar on health and population at the ICDDR,B in the city expressed satisfaction over the decline of fertility rate by 50 per cent in the last two decades in the country.

Three essays on the concerned issue which were prepared by Professor Barkat-e-Khuda, Thomas T Kane and James F Phillip were presented at the seminar.

Chaired by Muhammad Ali, Secretary, Ministry of Health and Family Welfare the seminar was addressed by Md Nurul Abedin, Additional Secretary, MOHFW, Luqueman Ahmed, Joint Chief, MOHFW, Professor John C Caldwell, Prof AKM Nurul Anwar, Shirajul Islam, Dr MA Mabub, AKM Rafiquz-Zaman Davit L Piet, Nancy Piet-Pelon and SK Shudhakar.

Barket-e-Khuda observed in his essay that sexually transmitted diseases in rural Bangladesh is currently a topic of great concern.

Thomas T Kane said that rural women are reluctant to seek antenatal services from health centres, even they are provided free of charge. But antenatal care practice affects maternal morbidity and mortality, he added.

DHAKA, WEDNESDAY, JULY 2, 1997

The New Nation

ICDDR-B MCH-FP Extension project seminar held

The five major areas in the health and population sector, to which the Government of Bangladesh is currently focusing in order to materialise its long term vision, are: designing and implementing the Essential Service Package (ESP), re-organising public sector provision, improving the financial substainability of the programme, paving greater role of the private sector and NGOs, and reviewing and updating the national drug policy.

The fifth Health and Population Plan attaches high priority to the health and population sector, as achievements in this sector greatly determines the well being of the people and the quality of life. Mr. Muhammed Ali, Secretary, Ministry of Health and Family Welfare said this while speaking to a august gathering at the inaugural ceremony of the two-day dissemination seminar, organised by the ICCDR, B MCH-FP Extension Project (Rural). The Secretary also reiterated the strong better health for the whole family through an effective health and population sector. He commended ICDDR. B's role in the sector, and for working as the research arm for the government.

Dr Richard Brown, Mission Director, USAID, Dhaka,in his speech highlighted the NIPHP priorities, and said as a NIPHP partner ICDDR, B MCH-FP Extension Project has a great role to play.

Several research presentations were made in the first day in the seminar in two scientific session under the themes: I) Broader Reproductive Health Agenda, and II) Sustainable Service Delivery Approaches, followed by lively discussions by a pool of distinguished discussants includig DGs of Health and Famil Planning and other government officials, representatives of International Organisations, NGOs and donor communities.

The presentations made were well received. The senior officials, in their didcussions, siad that the reearch work presented in the seminar were in line with the government priotities, and were acknowledged for their policy impacts inthe national health and population programme.

The second day of the semihar will be chaired by the Secretary,Minisry of Health and Family Welfare. The theme of today's scientific session will be Lessons Learned and Programmatic Implications.

The Independent

DHAKA TUESDAY 1 JULY 1997

Health and Family Welfare Secretary Muhammad Ali addressing a dissemination seminar at the ICDDR,B auditorium in the city yesterday. –Independent photo

'Tremendous success in FP programme achieved'

Decision to introduce EOC at thana level

Bangladesh has achieved tremendous success in Family Planning Programme by dramatically increasing contraceptive prevalence and decreasing total fertility rate, reports UNB.

The evaluation was made yesterday by experts from home and abroad who noted that contraceptive prevalence increased from 8 per cent in 1975 to 49 per cent in 1997 while total fertility rate decreased from 7 in 1975 to 3.3 this year.

They were speaking in a two-day dissemination on "Lessons Learned and Pragmatic Implementation" at ICDDR,B auditorium in city in the morning.

Chaired by ICDDR,B Director Prof Demissie Habte, the seminar was addressed, among others, by Health Secretary Muhammad Ali, Mission Director of USAID, Dhaka, Dr Richard M Brown, Syed Shamim Ahsan, Division Director of HPED, and Prof Barkat-e Khuda, Project Director, MCH-FP.

It was jointly organised by Maternal Child Health and Family Planning (MCH-FP) Extension Project, Health and Population Extension Division (HPED) of ICDDR,B, Health Ministry, USAID and Population Council.

Muhammad Ali said client-oriented reproductive health approach is the most effective way to reduce unwanted fertility rate.

"Our politics need to encourage delays in the age at first marriage thereby delaying first and subsequent births," said the Health Secretary.

He told the function that the government had allocated about Tk 5,360 crore to the health and population sector, especially for mothers and children, in the fourth five-year plan to integrate population issues within overall development programme, to initiate a multi-sectoral population programme, strengthen and consolidate primary health care and prevention of communicable diseases.

The draft of the fifth five-year plan has attached top priority to the health and population sector, he said.

The secretary said the government was currently focusing the areas including designing and Essential Service Package (ESP), reorganising public sector, improving financial sustainability of the health programme, paving the way for a greater role of the private sector and NGOs, and reviewing and updating national drug policy.

Giving emphasis on ESP the government has already decided to introduce Emergency Obstetric Care (EOC) services at thana level across the country.

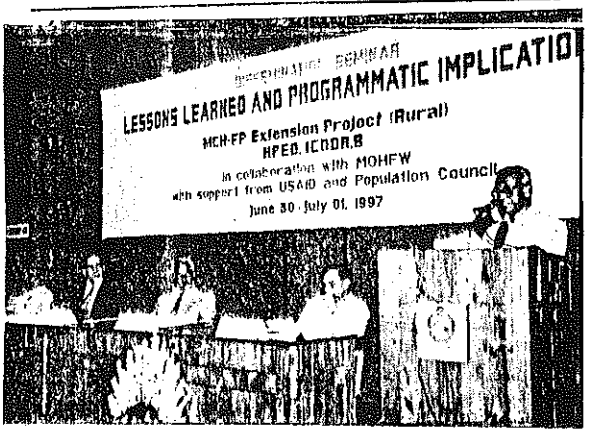
Health Ministry will implement it as an initial step in five thanas from each division with technical assistance from ICDDR, B.

Richard Brown said a seven-year National Integrated Population and Health Programme (NIPHP) had been designed on the basis of evaluation of MCH-FP with seven major components including rural and urban service delivery, social marketing, quality improvement, Operation Research (OR), urban immunisation and contraceptive logistics.

The USAID will fund 210 million US dollar for the implementation of the NIPHP, he said.

A Memorandum of Understanding (MOU) between USAID and Bangladesh government has already been signed in this regard, Brown informed the function

THE BANGLADESH OBSERVER
DHAKA TUESDAY JULY 1, 1997



Secretary of the Ministry of Health and Family Welfare Muhammed Ali addressing the inaugural session of a two-day dissemination seminar on lessons learned and programatic implication at Sasakava auditorium on Monday morning.

Bangladesh achieves success in FP plan

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The Daily Star
Founder-Editor : Late S. M. Ali
Dhaka, Tuesday, July 1, 1997

Country achieves great success in family planning: Fertility rate down to 3.3

Bangladesh has achieved tremendous success in family planning programme by dramatically increasing contraceptive prevalence and decreasing total fertility rate, reports UNB.

The evaluation was made yesterday by experts from home and abroad who noted that contraceptive prevalence increased from a per cent in 1975 to 49 per cent in 1997 while total fertility rate decreased from 7 in 1975 to 3.3 this year.

They were speaking at a two-day dissemination seminar on 'ICDDR,B MCH-FP Extension Project (Rural)' at ICDDR,B auditorium in the city yesterday.

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The USAID will fund worth US dollar 210 million for the implementation of the NIPHP, he said.

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THE FINANCIAL EXPRESS
28/1 TOYNBEE CIRCULAR ROAD, DHAKA-1000
Tuesday, July 1, 1997
Ashath 17, 1404 BS : Safar 25, 1418 Hijri

Fertility rate declines from 7pc to 3.3pc

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Chaired by ICDDR,B Director Demissie Habte, the seminar was addressed, among others, by Health Secretary Muhammad Ali, Mission Director of USAID, Dhaka, Dr Richard M Brown, Syed Shamim Ahsan, Division Director of HPED, and Prof Barkat-e Khuda, Project Director, MCH-FP.

It was jointly organised by Maternal Child Health and Family Planning (MCH-FP) Extension Project, Health and Population Extension Division (HPED) of ICDDR,B, Health Ministry, USAID and Population Council.

Muhammad Ali said client-oriented reproductive health approach is the most effective way to reduce unwanted fertility rate.

"Our politics need to encourage delays in the age at first marriage thereby delaying first and subsequent births," said the Health Secretary.

He told the function that the government had allocated about Tk 53.6 billion (5,360 cr) to the health and population sector, especially for mothers and children, in the fourth five-year plan to integrate population issues within overall development programme, to initiate a multi-sectoral population programme, strengthen and consolidate primary health care and prevention of communicable diseases.

The draft of the fifth five-year plan has attached top priority to the health and population sector, he said.

The secretary said the government was currently focusing the areas including designing and essential service package (ESP), reorganising the public sector, improving financial sustainability of the health programme, paving the way for a greater role of the private sector and NGOs, and reviewing and updating national drug policy.

Giving emphasis on ESP the government has already decided to introduce Emergency Obstetric Care (EOC) services at thana level across the country.

Health Ministry will implement it as an initial step in five thanas from each division with technical assistance from International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B).

Richard Brown said a seven-year national integrated population and health programme (NIPHP) had been designed on the basis of evaluation of MCH-FP with seven major components including rural and urban service delivery, social marketing, quality improvement, operation research (OR), urban immunisation and contraceptive logistics.

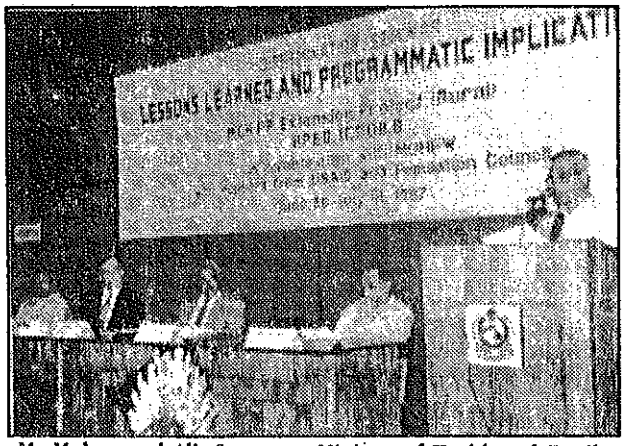
The USAID will fund 210 million US dollar for the implementation of the NIPHP, he said.

A memorandum of understanding (MOU) between USAID and Bangladesh government has already been signed in this regard, Brown informed the function.

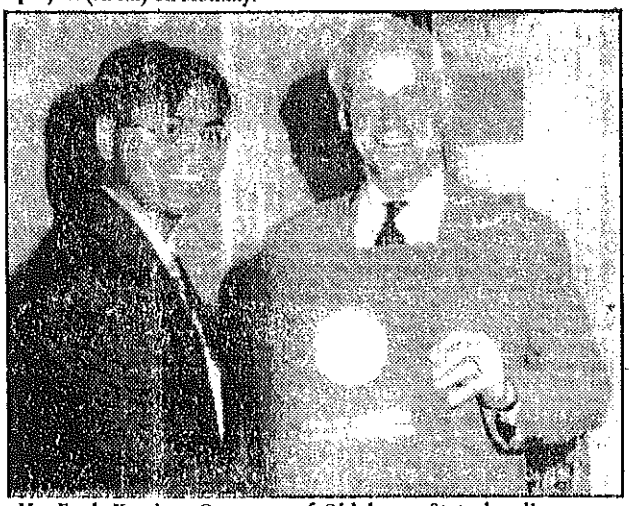
The New Nation

DHAKA, TUESDAY, JULY 1, 1997

The New Nation City



Mr Muhammad Ali, Secretary, Ministry of Health and Family Welfare addressing a seminar on "Lesson learned and programmatic implication" organised by ICDDR,B, MCH-FP extension project (Rural) on Monday.



Mr. Fank Keating, Governor of Oklahoma State handing over Honorary Citizenship certificate to Sayeed Anwar Risbad-a Bangladesh student.

To mark the International Day Against Drug Abuse and Illicit Trafficking Bangladesh Inter-Religious Brotherhood Association (BIRBA) brought out a procession on June 26, 1997.

The New Nation

DHAKA, MONDAY, JUNE 30, 1997

Seminar to share experiences and lessons learned

The ICDDR,B MCH-FP Extension Project (Rural), in collaboration with Ministry of Health and Family Welfare and with support from USAID and Population Council, is going to hold a two-day Dissemination seminar today at Sasakawa Auditorium in the ICDDR,B premises.

The inaugural session of the seminar will be chaired by Professor Demissie Habte, Director, ICDDR,B. Mr Muhammed Ali, Secretary, Ministry of Health and Family Welfare will be present as the chief guest at the inaugural, and will also chair the final scientific session. Mr Richard M Brown, Mission Director, USAID, Dhaka will be present as special guest.

Mr Syed Shamim Ahsan, Division Director, Health and Population Extension Division, ICDDR,B, and Professor Barkat-e-Khuda, Director, MCH-FP Extension Project (Rural) will also speak at the inaugural session. The seminar will be participated and attended by senior level policy makers and programme managers from the government and other agencies engaged in health and population sector strategies, and from the donor agencies.

Monday June 30, 1997

THE FINANCIAL EXPRESS
28/1 TOYNBEE CIRCULAR ROAD, DHAKA-1000
Monday, June 30, 1997
Asharh 16, 1404 BS : Safar 24, 1418 Hijri

ICDDR,B seminar on child health

A two-day dissemination seminar begins at the ICDDR,B auditorium Monday to share operations research findings of Maternal, Child Health and Family Planning (MCH-FP) Extension Project (Rural). International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) has organised the seminar with the objective to share the project's one and half decade's experiences and lessons learned through operations research from the national health and family planning programme. Health and Family Welfare Secretary Muhammed Ali will inaugurate the seminar at 9.30 am while USAID Mission Director in Dhaka Richard M Brown will be present as special guest, reports UNB.

বাংলাবাজার পত্রিকা

সত্যের মুখোমুখি প্রতিদিন

বাংলাবাজার পত্রিকা

ঢাকা ঃ সোমবার ১৬ আষাঢ় ১৪০৪

আজ থেকে ঢাকায় প্রজনন স্বাস্থ্য বিষয়ক সেমিনার

প্রজনন স্বাস্থ্য বিষয়ক প্রেক্ষিত, স্বাস্থ্য ও পরিবার পরিকল্পনা সেবাদানে টেকসই পদ্ধতির বাস্তবায়ন এবং কার্যক্রম বাস্তবায়নে অর্জিত অভিজ্ঞতা ও পরিকল্পনা প্রণয়নে এর প্রভাব— এই তিনটি প্রতিপাদ্য বিষয় নিয়ে আজ সোমবার থেকে ঢাকায় দু'দিনব্যাপী এক সেমিনার অনুষ্ঠিত হতে যাচ্ছে। ইউএসএআইডি এবং পপুলেশন কাউন্সিলের সহায়তায় আইসিডিডিআরবি'র মা, শিশু স্বাস্থ্য ও পরিবার পরিকল্পনা সম্প্রসারণ প্রকল্প (গ্রামীণ) এবং স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয় যৌথভাবে এই সেমিনারের আয়োজন করেছে। আইসিডিডিআরবি সাসাকাওয়া মিলনায়তনে অনুষ্ঠিত দু'দিনব্যাপী এই সেমিনারের উদ্বোধনী অনুষ্ঠানে প্রধান অতিথি হিসেবে উপস্থিত থাকবেন স্বাস্থ্য সচিব মোহাম্মদ আলী।

উল্লেখ্য, কার্যক্রমের ব্যবস্থাপনা উন্নয়ন, সেবার মান নিশ্চিতকরণ ও সেবা প্রদানের ক্ষেত্রে টেকসই পদ্ধতি উদ্ভাবনের লক্ষ্যকে সামনে রেখে আইসিডিডিআরবি গত দেড় দশক ধরে মা, শিশু স্বাস্থ্য ও পরিবার পরিকল্পনা কার্যক্রম সম্প্রসারণে কাজ করে আসছে। বিজ্ঞপ্তি।

The Daily Star

Founder-Editor : Late S. M. Ali

Dhaka, Monday, June 30, 1997

What's on today

Dissemination seminar: The ICDDR, B MCH-FP Extension Project will hold a two-day dissemination seminar to share operations research findings of the project. Venue: ICDDR, B Sasakawa Auditorium. Time: 9:30 am.

দৈনিক জনকণ্ঠ

স্বাধীনতা ও নিরপেক্ষতায় অঙ্গীকার The Daily Janakantha

ঢাকা ঃ সোমবার ১৬ আষাঢ় ১৪০৪ বাংলা

আজকের ঢাকা

সেন্টার ফর হেলথ এ্যান্ড পপুলেশন রিসার্চ দু'দিনব্যাপী সেমিনার উদ্বোধন, আইসিডিডিআরবি-এর সাসাকাওয়া অডিটরিয়াম সকাল সাড়ে নয়টা।

CENTRE
FOR HEALTH AND
POPULATION RESEARCH