Global Issues Initiative on Population and AIDS

Basic Policy Paper & Background Materials : Population Control & Health in Bangladesh

March 1995

JAPAN INTERNATIONAL COOPERATION AGENCY

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Introduction

The Government of Japan strengthened its commitment to the field of population in February 1994 with the announcement of its new Global Issues Initiative (GII) on Population an d AIDS. Under this initiative, Japan has pledged to spend US$ 3 billion through its Official Development Assistance (ODA) programme, over a seven year period from fiscal year 1994 on population issues and AIDS. Japan, together with the U.S.A., wishes to promote the worldwide effort concerning the population and AIDS issues which are part of the common agenda of all humankind.

Under GII, Front-line Initiative on Population and Family Health (FIPFH) was launched as a project because of Japan's intensified aid to population explosion, which is the most serious problem our world faces today. To implement this project and to met the objectives of GII, a policy paper on population control and health is required.

The future direction of population policy is centered on health, women's empowerment and human rights. The basic premise is that the funding agencies, international bodies and government of respective countries should assure the rights and well-being of people already born and those will invaluably born, rather than simply attempt to limit the ultimate size of world's population. This new orientation stated above has been reflected in the address delivered by the Deputy Prime Minister and Minister of Foreign Affairs of Japan, Yohei Kono at 1994 International Conference on Population and Development (ICPD) in Cairo on September 6, 1994. It is also reflected in the JICA documents on GII.

In Bangladesh, the present population policy is still centered on limiting the size of its population. But there are indications of change. As an example we can mention the decision of Ministry of Health and Family Welfare (MOHFW) to adopt basic minimum needs approach to increase the quality of life as a strategy to achieve the target of Health For All by the Year 2000 (HFA 2000) (see Section B : the lists of on-going projects). Recently greater emphasis has been given to intersectoral cooperation and holistic approach.

Many studies showed that the fertility rate, contraceptive prevalence rate etc. are directly related with sectors other than health and family planning. Increase in literacy rate and women's employment; status of women's right, economic development etc. are contributing factors towards population control. An authoritative document from World Health Organization (WHO) accepted intersectoral cooperation as one of the guiding principles of health stategy. This stategy recognizes that improvement of health will require contributions from many sectors, in particular agriculture, animal husbandry, food, industry, education, housing, public works, and communications. (see 'International Action for Health, WHO, 1986).

The Government of Bangladesh has also declared this strategy as its means to achieve HFA 2000. But it has been documented that inter-sectoral cooperation is lacking between health wing and family planning(FP) wing, medical and non-medical personnel issued the FP wing — not to mention intersectoral cooperation (see *Population Policies in Bangladesh: A Review of Ten Priority Areas*, URC and PC, 1994). The importance of the findings of this study cannot be over emphasized. The different exhibit contained in the report showed repeated attempts made by different MOHFW to develop better coordination between the health wing and family planning wing of the ministry. The Maternity and Child health (MCH) component is having

many problems as it is vaguely truncated between the two wings, though it is officially under control of the FP wing. It should be noted that Bangladesh has one of the highest maternal mortality rates in the world.

Attempts at restructuring, formation of district and thana coordination committees did not change the scenario. The recent field survey conducted by the researchers from JICA/JOCV also confirmed this observation.

The recent World Bank study on population dynamics of Bangladesh (see-- *The Determinants of Reproductive Change in Bangladesh : Success in a Challenging Environment*, John Cleland 1994) is an authoritive work on the subject and it contains very important and useful information . The book was collected in the last week of March, 1995 so the use of those information materials in this paper was not possible.

How to use this Paper

This policy paper comprises a brief outline of the present situation in the health sector with much emphasis on the population control activities. Considering the limitation of time and manpower the paper was designed. It is neither detailed nor analytical. It gives an overview of the present situation. Collection and compilation of most essential documents was done. The consultant recommends that a detailed policy paper can be made by summarizing and analyzing the following books and reports:

1. South Asia Study of Population Policy and Programmes: Bangladesh, UNFPA, 1990
2. Population Policy in Bangladesh: A review of Ten Priority Areas, URC (Bangladesh) and Population Council, 1994
3. The Determinants of Reproductive Change in Bangladesh : Success in a Challenging Environment, John Cleland et. al., The World Bank, 1994
4. Population Control Programme in Bangladesh: Past, Present and Future, MOHFW 1989
5. Matlab: Women, Children and Health, Vincent Fauveau (ed.), ICDDR,B 1994
6. Population Policies Reconsidered : Health, Empowerment, and Rights, Ed. Gita Sen et al. 1994
7. Bangladesh's Population Problem and Programme Dynamics, Mohammad A. Mabud (ed). 1992
8. Health and Family Planning in the Fourth Five Year Plan : Policy Outlines (Draft) MOHFW (undated)
9. Bangladesh Demographic and Health Survey (1993-94), NIPORT, 1994

All other books, manuals and reports so far collected (see *Section E:* Bibliography) can be used as supportive material to develop the detailed policy paper.

Four Foundation Stones of Health and Population Policy

The health and Population policy of Bangladesh is primarily based upon four foundation stones. These are ; the WHO definition of health, the Ottawa Charter, the Health for All 2000 Strategy and the World Population Plan of Action adopted in Bucharest in 1974. It should be noted that the health policy in particular is not available as a complete single document . A national Health Policy is being developed to reorganize/restructure the existing health care system. This policy paper is primarily based on the four Five Year Plans and other related policy documents.

The World Health Organization Definition of Health

In its founding constitutions of 1948, the WHO defines health as "a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity"

That health is a state of well-being indicates that health is not an activity (e.g. providing health care, or having employment or exercising), rather it is the outcome of all the activities which make up the lives of individuals, households, communities and cities. People are therefore more or less healthy according to the quality of their everyday lives -whether they have employment, adequate shelter, education, freedom from war and natural disaster, safe drinking water and sanitation, adequate social support in their community and access to primary health care within their community and so on.

This view of health differs markedly from the conventional view which has emerged in developed societies since the middle of the century. In this view, health care and medicine both have important roles to play in treating the sick, and in educating city populations around hygienic practices and lifestyle issues.

The Ottawa Charter

The second foundation stone of the health policy is the Ottawa Charter. the Charter is the product of an international conference on health promotion in Ottawa, Ontario, Canada November 17-21, 1986. It emphasizes that policy decisions in sectors other than the health care sector make key contributions to health. For example, policies which help to create supportive environments for health in the economic or social sectors, at the parameters for individual, family and community health behavioural decisions.

Local People have an important part to play both in the identification of priority actions and in their realization. by being closely involved in all stages of improvement, local redints gain in two ways : through taking action they develop personal skills which makes them more responsible citizens and secondly they gain directly from the improvements, which take place. Experience all over the Globe suggests that initiatives which fully support develop, harness and utilize the skills of local people have a much greater chance of lasting success than those which do not. In short if people are motivated to have greater chance of lasting success than those who do not, and also have greater control over their lives,so their health will improve.

Health for All

The third foundation stone of the health policy is the WHO Health for All by the year 2000 strategy, launched in 1977. This strategy sets out 38 targets to be achieved towards a vision of the city as a place where all people live longer in good health while disease and illness are greatly reduced. The targets fall into three main groups:

1. Targets 1-12 set out reductions in specific diseases to be achieved by the year 2000 as well as reductions in inequality between advantaged groups.

2. Targets 13-25 set out improvements to be achieved in living, working and environmental conditions and lifestyle.

3. Targets 26-38 set out required improvements in information systems, building awareness and infrastructure for health.

The Bucharest Conference

The main contribution of the Bucharest Conference was to make clear the relationship between population growth and socio-economic development. The inherent limitations of programmes that separated reproductive behaviour from its socio-economic encouragement were recognized. taking lessons from the Budapest Conference, population programmes within the broader objectives of social and economical growth.

Rapid population growth is not a problem of a particular country. Its ramifications cross geographical boundaries and it is difficult to be contained with the efforts and resources of a single country. Even increasing resources are being channeled into programmes by national governments designed to turn the tide of high population growth. But in a continent when poverty and human misery continue to be all too prevalent, it is vitally necessary to aim to alter those conditions which lie at the root of rapid population growth.

The overall resources of Bangladesh are limited. The International Community has, therefore, an important role to play in the years to come to enable the developing countries to confront squarely the challenges in all sectors of development including population.

Problems Bottlenecks encountered during 1985-88

The Fourth Five year Plan Period (1990-95) is nearing to its end and yet so far, no evaluation was done of the projects under Health Sector in general. Evaluation reports of some of the programmes are available but a general review of all the programme is yet to be done. Therefore, it is useful to mention the problems and bottlenecks encountered during the Third Five Year Plan Period (1985-88).

While implementing the projects under Health Sector, the following problems/bottlenecks were encountered :

(a) Inadequate allocation through ADPs compared to the PP requirement.
(b) Inclusion of new projects outside TFYP resulting thinning of resource allocation of projects scheduled to be implemented during the Plan.
(c) Delay in lining up the foreign assistance programmed to be made available.
(d) Delay in preparation/revision of projects.
(e) Lack of proper management and supervision in implementation of projects.
(f) Lack of proper training particularly for the field level health workers.
(g) Lack of deployment of field level workers particularly at grass-root level.
(h) Lack of inter sectional/ministerial coordination.
(i) Lack of proper monitoring and evaluation.
(j) Lack of utilities and logistics etc.

Policy Issues/Problems and Recommendations :

Major policy issues/problems and recommendations related to health sector programming and services delivery in the context of achievement of the objectives and targets of the TFYP were as follows :

(1) 'Health for All by the year 2000' is a national social goal and it can be fulfilled through the universal provision of Primary Health Care supplemented by adequate social measures. Universal access to PHC, provision of adequate resource (domestic & external), consolidation of existing facilities, improvement of the management of the health care system, active participation of the community/local self-government bodies in achieving self reliance in matters of health, and concentrated intersectoral actions etc. are the key factors for the attainment of Health for All by the year 2000.

(2) Though the Government has the major responsibility for the provision of health care, the people have the right and duty to participate individually and collectively in planning, management and cost sharing Sustaining the health care services through shared responsibilities needs a clearer definition.

(3) The non-government sector and communities should be encouraged and helped to develop and extend health care delivery services. Interventions and technologies that are appropriate for the country and lead towards national self-reliance are to be applied and promoted for health development.

(4) Planning and development deficiencies of the health services should be removed to improve their planning and management capabilities an functional deficiencies. For this purpose the planning outfit at the Ministry level should be rationalized both in terms of manpower and logistics, and at the agency level. i.e. DGHS level, an effective planning outfit should be developed.

(5) The health information and monitoring system should be properly developed to ensure availability and valid health related information for planning and management. Continuous monitoring and evaluation of projects should be done for guidance and correction.

(6) All the upazila health complexes should be completed in all respects. Diagnostic facilities including X-Ray and facilities for surgical operations at the UHCs should be established. Gradually some of the UHCs should be converted into 50-bed hospitals and provided with essential specialized services. Efforts should be made to establish Health posts at the ward level, but these should preferably be managed and partially financed by the local self-government community. A PHC supportive referral system at the secondary district level should be devised and put into effect in a systematic way.

(7) Major communicable diseases should be controlled as a most essential step towards the improvement of the overall health status. Particular emphasis should be given to the expanded programme of immunization, control of diarrhoeal diseases and national epidemiological targets.

(8) Adequate supplies and proper utilization of selected essential drugs, vaccines and other diagnostic/therapeutic substances must be ensured. the local production, quality control and efficiencies of such substances are also to be ensured.

(9) Appropriate type and number of health manpower is to be developed and deployed to meet the needs of the entire health programme, ensuring that such personnel are socially committed and responsible and possess the technical and managerial competence for the development and maintenance of comprehensive health care. Rationalization in production, improvement in managerial efficiency and optimum utilization of available manpower should be of the utmost concern .

(10) Intersectoral action between health and other related sectors, e.g. Agriculture, Food, Education, Public Health Engineering, Local Government and Rural Development, housing Social Welfare etc. should be fostered.

(11) Facilities for bio-medical and health system research including operational research (based on experimental/pilot models) should be improved; such research should be oriented to support the national strategies for Health.

(12) Domestic resources have remained a serious impediment to the development of health projects. Therefor, external assistance in favorable terms and conditions should be explored from donor agencies for health development projects/programmes.

The Fourth Five Year Plan : a brief discussion

The objectives of the Health Sector during the Fourth Five Year Plan have been formulated within the overall objectives of human resources development and based on the broad principles of promoting and supporting development and operation of national health care systems so as to attain the national strategy for 'Health for All by the year 2000'. The Fourth Five Year Plan will have special emphasis on consolidation of existing health facilities and programmes and strengthening of management capabilities to ensure efficient functioning and optimum utilisation of the same.

Objectives

Major objectives of the Fourth Five Year Plan will be follows :

i to improve the health status of population, particularly of mothers and children;

ii to consolidate and strengthen the coverage of Primary Health Care and its supporting services for improved quality and quantity of health services;

iii to deliver improved health and family planning services in a package to the family with a view to increasing its welfare;

iv to prevent, control and treat major communicable and non-communicable diseases;

v to improve nutritional status of the population particularly of mothers and children;

vi to foster appropriate health manpower development and its optimum utilization;

vii to promote adequate production, supply and distribution of essential drugs;vaccines and other diagnostic and therapeutic agents; and

viii to strengthen planning and management capabilities of the health system for utilisation of existing facilities to the fullest extent and optimisation to health services; and to promote and strengthen health systems and bio-medical research.

National Health Policy

The existing health system is beset with many problems and bottlenecks and has failed to fulfil the people's aspirations and health care needs. A National Health Policy is being developed to reorganise/restructure the existing health care system to ensure preventive, curative, promotive and rehabilitative health care to the general masses and to bring about qualitative and quantitative changes in health services. It aims at improvement of the overall standard of health services in the country through bringing about a reformative change over the existing health system. It will ensure the exercise of people's democratic right and community participation in planning, budgeting, implementation and management of local health programmes so as to ensure effective delivery of health care, better coordination and optimum utilization of health services. The main features/elements of the National Health Policy, among others, may be listed

as follows:

i Preparation and attestation of the list of destitute persons and distressed widows of the society to ensure preventive and curative health care and family planning services from the UHFWCs, UHCs and if required, from other hospitals at higher level at free of cost;

ii making public and private health services easily available with minimum cost to the people at all levels;

iii creation of special medical facilities for school students, mentally retarded persons, destitutes and disabled;

iv making treatment facilities of common diseases and injuries easily available to the people of all areas of the country at a minimum cost;

v taking special measures for control and treatment of epidemic and endemic diseases including diseases arising out of natural calamities;

vi increased access to safe drinking water and sanitation for the rural and urban population and mensures against environment pollution;

vii advocating breast feeding practices (at the national level) and creation of mass aware ness about the merits of breast feeding;

viii initiating special programmes towards creation of awareness on women's health and their health related problems, as within the existing social systems, they enjoy a lower health status and their health problems are neglected in the family as well as in society;

ix undertaking preventive, curative and reformative measures for safeguarding people from the curse of smoking, drug addiction, adulterated food and poor quality medicine;

x undertaking special measures towards preventing people particularly children from smok ing, drug addiction and drinks, formulation of acts towards awarding heavy punishment to the sellers and suppliers for selling these items of addiction to the boys and girls under 16 years of age;

xi reflection of national population policy in the programmes of family welfare activities and implimentation of population policy throuh providing different special facilities in education, social and cultural fields;

xii undertaking efforts for delaying marriage and preventing birth through raising the minimum age of marriage for male and female, if required;

xiii identification of under-previleged and vulnerable families locally and undertaking measures for providing food and nutrition to the children and women of these families;

xiv undertaking immunisation activities against "vaccine preventable" communicable diseases and making vaccination compulsory.

xv treatment of diseases caused by various professions and the creation of compulsory medi care facilities by the industrial entrepreneurs of mills and factories for their workers:

xvi undertaking measures for the provision of safe water and creation of a pollution free environment since health and environment are closely related;

Strategies for the Fourth Five Year Plan

In order to attain the above objectives, the following strategies were adopted :

i Primary Health Care Services will be provided through a three tier system for health promotion, disease prevention, treatment and referral. The level of services considered are (a) Community level-through community health workers, village defence party (VDP), mothers club etc. This would be linked to the overall village development programme with people's participation, as envisaged during the Fourth Five Year Plan. (b) Union level-through Union Health and Family Welfare Centre. The on-going programme for establishment of UHFWC and raising of voluntary community Health workers/health volunteers will be speeded up. All UHC's and UHFWCs will be equipped with necessary diagnostic and treatment facilities to provide PHC and act as referral centres.

ii Health and family planning services will be integrated through unification of the Directorate of Health Services and the Directorate of Family Welfare to provide comprehensive services of PHC and MCH including family planning, in a package form;

iii The immunisation and other related programmes such as health laboratory, epidemiological surveillance/health information system and health education will be further expanded and strengthened to control communicable diseases effectively;

iv Health manpower will be developed through development and implementation of appropriate curriculum and basic in-service training of all categories of health service providers i.e. doctors, para professionals etc. The thrust will be on production of specialised manpower (technical and managerial) and also on production of the mid and grass-root level health manpower. To meet the acute shortage of graded specialists, some of the existing medical colleges will be upgraded with necessary facilities for post-graduate level medical training and research;

v Health infrastrucure throughout the country will be built with special emphasis on development of graded services within thanas, district and national level, linked with a referal system. Thana Health Complexes will be strengthened in phases to provide first level specialised care; District hospitals will be expanded with increased numbers of beds for different specialities. Medical Colleges hospitals and specialised hospitals and institutes will be strengthened to provide services at the tertiary level;

vi Supply of essential drugs, vaccines, sera, chemical and reagents, rehydration fluids, etc. will be augmented by increasing their production in the country bottlenecks experienced in the past due to an over centralised system of supply of basic drugs and medicines will be removed by decentralisation of the system through establishment of supply depots and subdepots at district/ regional level and streamlining of the distribution system.

vii Intersectoral coordination and interaction between health and other sectors will be fostered, especially in relation to such fields as mother and child care, family planning,

nutrition, health education, safe water supply and sanitation, local production of essential drugs;

viii The entire health system will be restructured for efficient management and improved service delivery;

ix Development of indigenous and homeopathic systems of medicine will be encouraged under public and private sectors. To this end, manpower development through education, training and research will be pursued so that these systems play a complementary role to modern systems of medicine;

x Adequate health care facilities for the industrial worker will be developed through training of manpower in industrial health and setting up of appropriate infrastructure for the same;

xi To generate resources, various methods like cost sharing, health insurance and cooperative will be adopted keeping in view situations among various socio- economic classes; poor, destitutes and disabled persons will, however, be exempt from user changes;

xii Medical Research will be expanded to priority areas, particularly in development, operational and biomedical fields. The mechanism and processes for utilization of research findings will be strengthened;

xiii Private sector and NGOs will be encouraged in the setting up of hospitals, poly clinics, phamaceutical industries and development manpower, equipment etc. Appropriate processes and procedures will will be institutionalised to facilitate their activities.

xiv Simple managerial techniques and practices will be introduced across the health system at all levels for bringing efficiency in service delivery and optimisation of existing facilities. Medical audit system will be practised to prevent misuse, wastage and underutilization of manpower and scarce resources.

Population Policy

The cardinal principle of the national population policy is an integrated and comprehensive approach for population and development required to provide service that are relevant to actual needs and priority of the people. Towards this end, planning and implementation of population control and family planning objectives will receive high priority at the national as well as local level. It has emerged from a series of discussions that took place in the past that visible inter-sectoral population policies and programmes are of absolute necessity in order to diversify programme efforts with due focus on fertility reduction. Apart from a closely coordinated multi-sectoral programme, non-family planning interventions will be devised in order to create impact on fertility control. The responsibility for desired level of fertility reduction will be increasingly shared by the community and local level institutions, and thereby reduce the burden of the government.

The following may be listed amongst others as policy approaches to population issues :

a. To promote and pursue population planning as an integral part of the total development process and integrate population issues in all development programmes upto community level.

b. To accord top priority to population control and FP programme, build-up national commitment to generate "Social movement" and "mobilisation " to establish one-child family norm.

c. To ensure total identification with and "ownership" of FP programme by local communities so as to enable them to develop required vigilance and monitoring for programme execution. Appropriate resources, motivational and training input will be provided to activate the local committies for these purposes. Community level (Thana and Union) rewards and disincentives will be built to augment pertinent local efforts.

d. To decentralise authority and responsibility for programme planning, strategy formulation and resource utilization, and integrate population programme with the overall development programme at the local level.

e. To concentrate efforts towards visible multi-sectoral population programmes. The outreach manpower and facilities of all related development programmes to be harnessed for demand creation and service delivery where feasible.

f. To continue the "Cafetaria approach" in matters of contraceptive distribution with unhindered access to quality service at a nominal cost or free of cost

g. To mobilize educated women and those from influential families, satisfied clients and representative of local bodies to organise local women of MCH-FP support.

h. To include 'beyond family planning measures', such as steps to raise age at marriage, particularly female age at marriage. This would be helped by introducing female stipend and other special measures for enhancing post-primary level female education, and supportive change in legal age at marriage.

i. To issue appropriate health and family planning legislations for the success of national policies and programmes; they are also needed to provide legal security and legal order, so that certainty prevails in respect of rights, authority, duty, obligation and responsibility of various parties involved in delivering and receiving MCH and Family Care services.

Strategies

Keeping in view the demographic goals of the FFYP(1990-95) the following strategies are proposed :

a. attaining time-bound demographic and MCH goals by achieveing programme targets through providing quality services at all levels of the family welfare and MCH programme.

b. Strengthening MCH component through a comprehensive MCH programme with special emphasis at the PHC level.

c. Expanding FP-MCH efforts through integrated service delivery approaches by utilising both family welfare and health workers. For intensive follow-up care for motivation, supplies and referral services, female village defence workers will be utilised.

d. Improvement of the quality of service through counselling and follow up care for increasing acceptablility as well as continuation rate of contraceptive pratice.

e. Strengthening information, education and motivational programme particularly contraceptive educational and counselling to increase the level of effective knowledge. Special programmes will be developed through target setting specific groups of clients and potential client couples in different age parity categories, teachers, students and youth groups (future parents and leadership); and opinion leaders including religious leaders.

f. Mobilising the communities to provide social legitimacy for late marriage, birth spacing and planning, acceptance of small family norm and contraceptive practice. In this regard collection and distribution of Quranic verses and Hadiths, relating to family planning will be taken up.

g. Undertaking special programmes for women with a view to rasing their status by education and income generative activities enabling them to decide about pregnancy and number of children.

h. Encouraging the voluntary and non-government agencies to promote their supplementary and complementary role in the implementation of the national programme and to innovate cost effective and nationally replicable models.

i. Establishing local population data-base for local level programme planning and formulation of strategy.

j. Developing capability for manufacturing of contraceptives and steroids.

k. Raising professional expertise in planning for achieving demographic and contraceptive goals, and for ensuring effective accountability of all other concerned agencies and functionaries including co-ordination and monitoring of multisectoral projects and NGO ac-

tivities.

l. Progressively incorporating appropriate population variables into the sectoral plan and policies of various development sectors and particularly of education, including medical education, rural development, social welfare, women's affairs, labour welfare and agriculture.

m. Developing the efficiency and expertise of field functionaries by preparation of appropriate and realistic training modules, imparting job-related and problem solving training through utilization of available facilities.

n. Improving resources under utilisation of the infrastructure at thana level and below, and rationalizing worker-population ratio as much as possible.

o. Streamlining funding mechanism keeping in view programme priorities, changing needs overtime, and mechanisms for timely utilisation of the allocations by developing framework of programme oriented funding rather than somewhat inflexible requirements for specific project related funds.

p. Assessing the impact of the programme in terms of the demographic effect rather than programme efforts and input during a particular period. Accurate birth and death statistics at individual, local and national levels will be used. Efforts will be undertaken to develop the required data base through a nationwide vital registration system. Besides, potential for collection, compilation and utilisation of data through MIS will be expanded.

q. Professors of Medical Colleges and other doctors will be given areawise responsibilities in the family planning programme to ensure proper implementation.

Traditional Systems of Health care

The Indigeneous (Unani and Ayurbedi) and Homeopathic systems of medicine are deeply rooted in the country. Indigeneous or traditional systems of medicine has been practiced from time immemorial and Homeopathic system was introduced a century earlier. Both Indigeneous and Homeopathic systems of medicinepopular among the poor people, both urban and rural, because they can afford the expenses of treatment. The cost of modern treatment is much higher in the government institutions and in the private clinics and hospital it is so high that most of the people cannot afford.

Homeopathic medicine are imported from the USA, Germany and other countries and are also produced locally using imported raw materials. . Whereas the traditional medicine(Unani and Ayurbedi) is only produced locally. These are made of natural products can easily be assimilated by human body and for inbuilt correctives those are free from side-effects or rare toxic. Drugs prepared in combination of active ingredients of similar thrapeutic value produce synergistic effect. Traditional medicine needs easily available local raw materials, unsophisticated methods and expertise so are less expensive compared to modern medicine. Traditional medicine has a holistic approach of considering human being in his totality within a wide ecological spectrum. For above reasons, traditional medicine is considered one of the surest means to achieve total health care coverage of the world population by the year 2000.

Traditional medicine is already rendering valuable services to our people. Bangladesh has a rich medico-cultural heritage of traditional medicine. Both Unani and Ayurvedic systems are firmly enrooted and traditional practitioners look after the health of our people even in the most peripheral areas.

Bangladesh being in the sub-tropical region have been blessed with vast resources of medicinal plants. Traditional medicine is an import-substitute, made of easily available local natural sources, do not require high-tech sophisticated costly mechanism so cheap and affordable. But it is true, technological revolution can also develop and upgrade traditional medicine. Still herbal drugs will be less expensive.

The awareness of the importance of traditional(indigenous) systems has been reflected in all the five-year plans. The Fourth Five Year Plan indicated that "homeopathy and indigenious system of medicine will be integrated and brought to the mainstream of modern health system. Programme to upgrade formal education in homeopthy and indigenious systems of medicine and to improve the skill of these group of practioners will be taken up". A new medical college and hospital was established in Mirpur, Dhaka which practice traditional medicine and treatment. But funds allocated to this system of medicine are poor.

Within a span of ten years, the number of homeopathic colleges increased from 18(1982) to 22(1992). The number of homeophathic medicine producing firms increased from 27(1982) to 65(1992). The number of Unani and Ayurvedic medicine producing firms fluctuated. It was 371 in 1986 and gradually increased upto 405 in 1991 but suddenly decrease to 390 in 1992. The latest data could not be made available.

The expenditure of the GOB has been much increased in the health side but still only about 18% of the total population is brought under the national health care delivery system. On the other hand about 13% of the total population solely depend on tradition(according to Public Health Dialogue /VHSS). Govt. contribution to this subsector is very negligible being only 0.0075% of the total annual health budget.

In a study conducted by Syed M. Hashemi from Development Research Centre, it was recorded that 7-15% of the study population was treated by traditional herbal care and 8-14% were treated by Homeopathic medicine. (Report on Population Health and Child Survival in Bangladesh, Population Council).

Section B

Demographic Characteristics

Basic Health Indicators in Bangladesh and Related Data/Information

List of Ongoing projects on Health and Population (1994-1996)

Demographic Characteristic of Bangladesh

There are numerous statistics on Bangladesh demographic characteristics. However, the major source of data is the decennial census. The other sources are : (1) National sample survey and vital registration of Bureau of Statistics; (2) Small sample surveys conducted by Population Development and Evaluation Unit (PDEU) of Planning Commission; (3) Bangladesh Institute of Development Studies (BIDS); (4) Demographic surveillance area of ICDDR,B. The population of Bangladesh according to 1871 census was 22.79 million. This increased to 35.6 million in 1931, 59.85 in 1951 and 107.99 in 1991. The rapid increase of population is shown in Table B.1

Growth rate . The population in Bangladesh grew by less than 1% till 1951 except for the period 1931-1941. the rate of increase of growth of population was 2.8% in 1981. The rate of growth of population earlier was related to high mortality.

Table B.1
Decennial census report on population size and annual growth rate in the area now comprisingBangladesh

Census Year	Population in (000)	Annual Growth Rate (%)
1872	22,779	
1881	24,926	1.0
1891	27,010	0.8
1901	28,928	0.7
1911	31,555	0.9
1921	33,254	0.3
1931	35,604	0.7
1941	41,994	1.6
1951	42,083	0.15
1961	50,854	1.93
1974	71,479 (76,338)	2.67
1981	87,052 (89,940)	2.8
1991	107,992	2.17

Source : Armindo, 1982, p. 50 as modified by Waren Robinson, 198; p. 32 (Modified)

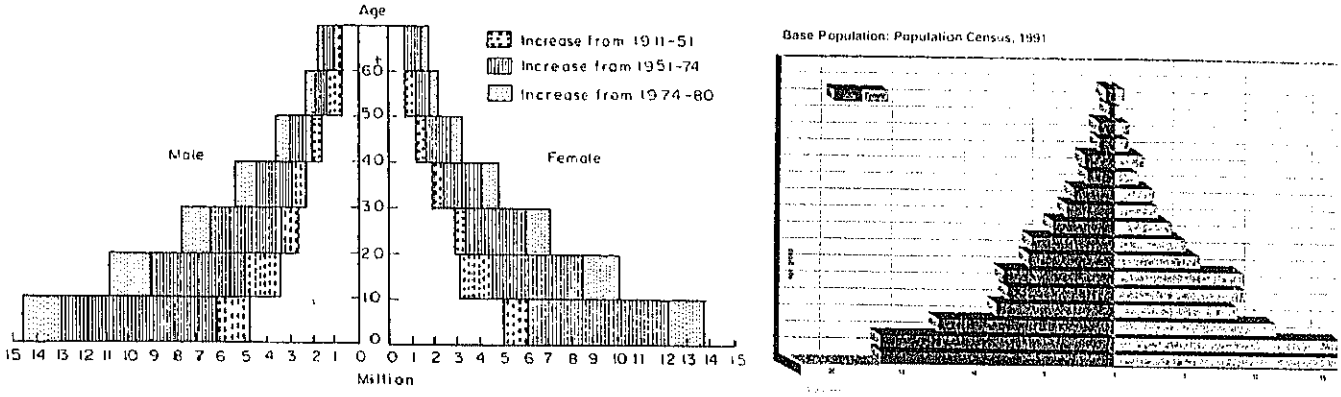
Doubling time : The implication of growth rate of population is to consider how long it would take a population to double itself. It took more than 60 years for Bangladesh to double its population from 28.9 million in 1901 to 57.5 million in 1965. But later, in only 20 years (between 1961-81) the population nearly doubled itself, from 50.8 to 89.9 million. If the growth rate of population is 2.0 the population doubles itself in 35 years.

Declining space per person: The increase in population reduces the space available per person. Land-man ratio may be seen from Table B.2. By 1960 Bangladesh was the 5th most densely populated country in the world; it became 4th in 1980 and could soon be the 3rd most densely populated country after Hongkong and Singapore.

TableB.2
Land-man ratio by cropped area, Bangladesh

Years	Net cropped area (1000 acres)	Total population (in 1000s)	land-man ratio
1961	19,138	54,531	0.35
1974	20,550	76,398	0.27
1980	21,000	89,715	0.23

Figure B.1
Population distribution by age and sex

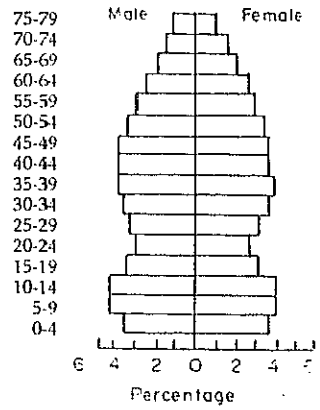


Source : Rahim and Rabbani, Office of the Census Commissioner, 1962

Age and sex pyramid. The graphic age and sex pyramid (Fig.B.1) gives avisual presentation of population growth in Bangladesh. the pyramid which shows an wide base and narrow apex, indicates a higher ratio of population in younger age group indicating a rapid population growth in future. The pyramids of developed countries are usually with a narrow base, wide in the body (middle)and narrow in the apex (Fig. B.2).

Figure B.2
Population Pyramid of Sweden,1956

Fig. 5. Population pyramid of Sweden, 1956



Source : Park, J. E. and Park, K. Textbook of Preventive and Social Medicine 1989.

Dependency ratio. The population of Bangladesh is very young. The population of 0-14 years age group constitutes more than 45%, while the population over 60 years constitutes about 4.0%. thus the dependency ratio of Bangladesh is 96.7 (1974). Dependency ratio for developed countries is around 50 while for other developing countries it is around 80.

Sex ratio. Overall sex ratio has shown more male than female since 1911. While the case is reversed for some younger age groups, those over 30 years of age invariably reveal more males than females. Lower sex ratio for male over female for 0-4 years age group indicates inherent weakness of male child, while higher male to female ratio during fertile period indicates a high maternal mortality rate.

Birth rate. During 1911-1976, CBR for Bangladesh varied from 54 to 42 per 1000 population. Mabud (1986) has shown that birth rate in Bangladesh has declined by 12%. Since 1976 , reduction is almost 1.1% per year Based on small scale survey, the Planning Commission's estimate of CBR for 1981 was 43 per 1000 population, for 1985 it was 39 per 1000 population; and based on 1985 CPS results and assumed increase in contraceptive prevalence rate upto 28% in 1987, CBR for 1987 was indirectly estimated to be 38 per 1000 population. CBR is affected not only by the actual fertility level, but also by age and marital structure (Table B.3).

Table B.3
Estimated birth rate, death rate and rate of natural increase in population, Bangladesh, 1911-1986.

Years	Birth Rate (per 1000)	Death rate (per 1000)	Natural increase of Pop. growth (% per year)
1911	53.8	45.6	0.82
1921	52.9	47.3	0.56
1931	50.4	41.7	0.87
1941	52.7	37.8	1.47
1951	49.4	40.3	0.91
1961	51.9	29.7	2.17
1962-65 (PGE[1])	53.0	18.5	3.15
1967-68 NIS[2])	42.0	-	-
1974 (BRSFM[3])	48.3	18.0	3.03
1981 (Pl. Com. estimate).	43.0	16.0	2.7
1985 (ibid)	39.0	15.5	2.35
1986 (USAID)	38.9	14.6	2.43
1986 (NFPFS)	38.0	15.0	2.30

Sources :
1. Pop. Growth Estimate, Publication for 1962-64
2. National Impact Survey, 1968.
3. Bangladesh Retrospective Survey of Fertility and Mortality 1974.
4. Bangladesh Fertility Survey, 1975
5. USAID estimates derived from 1986 CPS figures.

Death rate. Death rate in Bangladesh from 1911 varied from 47.3 to 37.8 per 1000. Death rate started declining from 1961 and according to national planning and fertility survey report, death rate in 1986 ws 15.0. Population growth from 1911-1951 was less than 1% while from 1961 it started increasing; from 1981 it has shown a very slow decline (TableB.3)

Fertility

The average Bangladeshi woman can give birth to 6-7 children in an uninterrupted married life, before she reaches the end of her reproductive period (which is roughly from 15 to 45 years of her age). There has been almost no change in fertility of Bangladeshi women since 1960s.

Fertility is the actual level of performance (capacity for bearing children) in a population based on the number of live births that occur, whereas fecundity is the potential level of performance.

Total Fertility Rate (TFR). Total fertility rate is considered as a refined measure of fertility. It is defined as the total number of live births which a woman of reproductive age (15-49 years) experiences under current age specific schedule. It is estimated from live births occured in the last twelve months preceeding the enumeration (survey of census) which documents the event.

Table B.4.
Total Fertility Estimates of Bangladesh.

Year	Total Fertility Rate
PGE 1962-65	7.07
NIS 1966-68	6.02
BRSM 1974	7.07
BFS 1975	6.35
CPS 1979	6.25
USAID 1986	5.60
NFPFS 1986	5.55

Source : Population Growth Estimate (PGE) 1962-65; National Impact Survey (NIS) 1966-68; Bangladesh Retrospective Survey of Fertility & Mortality (BRSFM) of BDS, 1974; Contraceptive PrevalenceSurvey (CPS) 1979; National Family Planning Fertility Survey (NFPFS) 1986.

When TFR of a country is 2.1 the population of that country is said to have come to replacement level. However, the population continues to grow for 50-60 years to become stationary. This happens because a large number of the younger population are in the reproductive age group.

Growth of population of a country is largely dependent on the birth rate and death rate of the country. The comparison birth rate and death rate in some selected countries is given in Table B.5. Migration has also a role in population growth. Birth rate minus death rate is called, natural increase in population. The effect of natural increase is important for estimation of

population growth. When birth rate minus death rate is zero, the population growth has reached a stationary level. The rate of natural growth of population is an important indicator of fertility behaviour.

Table B.5
Birth rate and death rate in selected countries, 1985

Countries	Birth Rate	Death Rate
Sweden	11	11
France	14	10
Germany F.R.	10	11
U. K.	13	12
Canada	15	7
USA	16	9
Srilanka	25	6
India	32.7	6
Bangladesh	40	15
Pakistan	44	15
China	18	7
Japan	13	6
Singapore	17	5
Libya	45	10
Kuwait	42	8
Egypt	36	10
Saudi Arabia	42	8

Source : World Bank (19870. World Development Report 1987, New Delhi.)

Remarks: In comparison to other developing countries in the case of health profile, Srilanka is an exception. Its birth and death rate is much lower. The higher number of nurses and success in mobilisation of the community are contributory factors.

Factors that affect fertility. Important factors that affect fertility are: (a) women's education above primary level, (b) gainful employment of women outside home, i.e. per capita income, (d) general education above 60%, (e) urbanization, (f) industrialization (g) age at marriage, (h) consumption of electricity and (i) modernization of values, (j) breast feeding , (k) some social norms, prohibition of coitus during specific period etc.

Factors favouring high fertility in Bangladesh. The factors are: age at marriage of girls, which is 16-17 years, slow process of urbanization and industrialization, high illiteracy (women literacy in Bangladesh is 13%), preference of son over daughter, non-acceptance of delayed child birth after marriage (the girl is considered infertile if birth is delayed).

Age at marriage . Age at marriage has a great impact on fertility behaviour. Studies in India have shown that girls who marry before the age of 18 years, have more children than those who marry later. It is estimated that if marriage takes palce at age 20-21 instead of age 16 years, the number of births will be reduced by 20-30%. the current age at marriage for girls in Bangladesh is 17 years.

Breast feeding. Breast feeding plays an important role in fertility behaviour. It is estimated that about 20-28% of births in Bangladesh are averted by breast feeding alone. Average breast feeding period in Bangladesh is 30-38 months and lactation amenorrhoea is 15-19 months. Robinson (1984) indicated that the ovulation of retarding effect of about 2 months lactation is equal to that of one month post partum amenorrhoea.

Sterility . This is defined as the incapability of a female to conceive due to various defects. According to a survey (Robinson 1984) about 15-20% of femalesin the age group 25-49 are sterile in Bangladesh.

Contraception. Use of contraceptives is the most important factor in affecting fertility. Effecient use of contraceptive in age group 20-30 has the greatest effect in declining population growth. In Bangladesh unfortunately, though CPR is about 35% most of those who use contraceptives are women aged 30 years and above. Those women already have about 3 or more children. Further, these women in a fair number of cases already suffer from secondary sterility. Thus the effect of contraceptive use in Bangladesh has less influence on the reduction of population growth.

Abortion. Abortion plays an important role in reduction in fertility. It was found very efficient in East European countries and Japan. Bangladesh though predominantly a Muslim country and despite legal barriers, abortion is quite high, 10% of conception (Mesham et al. 1981.) A survey of village practitioners shows that on average they perform or help to perform about 1.6 abortions per month (Rahman 1982).

Education. Female education above primary level and the participation in the labour force effect a reduction in fertility. Mabud, has shown that those who received training and worked outside the home , irrespective of educational exposure, experienced fewer births than those who received training but worked at home. Mysore (India) population study shows that illiterate women aged 15 years and above on the average had 5.3 children compared to women who were educated upto high school and more,

Economic status. Studies have shown that people of high economic status have fewer children than people in lower socio-economic status.

Religion. Because of a value system it was found that religion has an effect in fertility behaviour. Muslims in general have more children than Christian or Hindus.

Selected Basic Facts about Bangladesh

1. Geographical Location : Between 20° 34' and 26°38' north latitude and between 88°01 and 92°41 east longitude

2. Boundary :
North : India
West : India
South : Bay of Bengal
East : India and Burma

3. Area : 56977 sq. miles or 147570 sq. km.
Territorial water : 12 nautical miles.

4. Administrative and other Units :

	Number	Average Population, 1991, in '000' up to Mouza (Adjusted for undercount)
Division	5	22291.0
Zila	64	1741.5
Thana	489	227.8
Union	4,451	25.0
Mouza	59,990	1.9
Household	19,979,932 (1991 Pop. Census)	5.6

Number of Municipalities(excluding city corporation): 106
Number of City Corporation : 4
Municipal population* 1991 (Adjusted) : 12.8 million.

5. Population :
111.4 million on 11 March, 1991 (Population Census; adjusted)
57.3 million male
54.1 million female
Annual growth rate (1981-1991) : 2.17%
Sex ratio : 106 males per 100 females
Density : 755 per sq. km.
as on March 1991 (Census)

Literacy rate (7 years and above 1991) : 32.4

Life expectancy at birth 91992) :

Both sex	57.1
male	57.4
Female	56.8

* Population of 107 municipalities including City Corporation as of March 1991.

6. Capital city : Dhaka

7. Areas and Population of Statistical Metropolitan Area (SMA) 1991 :
(Population Census ; adjusted)

	Area (sq. km.)	Population
Dhaka	1353	6,950,920
Chittagong	986	2,387,749
Khulna	267	1,016,140
Rajshahi	377	549,350

8. Main Seasons : Winter (November-February), Summer (March-June), Monsoon (July-October)

9. Climatic Variations :

Winter temperature average maximum	29°C
Winter temperature average minimum	11°C
Summer temperature average maximum	34°C
Summer temperature average minimum	21°C
Monsoon, average rainfall 1194 mm to	3454 mm.

10. Standard time : GMT + 6 hours

11. Principal rivers : Padma, Meghna, Jamuna, Brahmaputra, Teesta, Surma and Karnaphuli (Total 230 rivers including tributaries)

12. Principal seasonal crops and fruits : Rice, wheat, jute, tea, tobacco, sugarcane, pulses, oilseeds, spices, potato, vegetables,banana, mango, coconut and jackfruit.

13. Principal industries : Jute & cotton textiles, garment making, tea processing, paper, newsprint, cement, chemical fertilizer, light engineering, sugar.

14. Principal minerals : Natural gas, lignite coal, limestone, ceramic clay and glass sand.

15. Principal exports : Ready made garments, raw jute, jute manufactures, tea, fish, hides and skins, and news print.

16. Ports : Sea : Chittagong and Mongla
Inland : Dhaka, Chandpur, Barishal, Khulna, Baghabari, Sirajganj, Sharishabari, Narayanganj, Bhairab Bazar, Ashuganj

17. Airports : Dhaka, Chittagong, Jessore, Ishwardi, Sylhet, Comilla, Cox's Bazar, Thakurgaon, Syedpur and Rajshahi.
Of which International :Dhaka, Chittagong and Sylhet

18. Radio Stations : Dhaka, Chittagong, Khulna, Rajshahi, Rangpur, Sylhet, Rangamati, Comilla and Thakurgaon, Broadcasting Programmes (In addition to Bengali) : in English, Urdu, Hindi, Arabic and Nepali.

19.	Television Station :	Dhaka	
	Relay Station :	Chittagong, Sylhet, Khulna, Natore, Mymensingh, Rangpur, Noakhali, Satkhira,, Cox's Bazar and Rangamati	
20.	Education : Institutes and enrollments, 1992	Govt. universities:	11
		Non-Govt. Universities :	6
		Govt. Medical colleges :	13
		Non-Govt. Medical colleges :	4
		Engineering colleges :	4
		Colleges :	1046
		Polytechnique institutes :	18
		Secondary schools	9,892
		Primary schools:	49, 964
		University enrollment :	52, 722
		College enrollment :	8, 53, 343
		Secondary school enrollment :	4.0 million
		Primary school enrollment :	13.7 million
21.	Health Facilities and Manpower :	Hospitals :	890
		(of which Thana Health Complex and Rural Health Complex, 400)	
		Hospital beds :	34, 353
		Persons per Hospital bed :	3, 243
		Registered Physician :	21, 004
		Persons per Physician :	5, 304
		Households per Physician :	951
22.	National income and GDP		
	GDP in 1991-92 at 1984-85 constant market price :		536.2 Billion Taka
	and at current market price :		906.5 Billion Taka
	Per capita GDP in 1991-92 at 1984-85 market price :		Taka 4813
	and at current market price :		Taka 8137
23.	Agricultural crop production index : (1972-73=100)		172 (1991-92)
24.	Energy production index (1981-82=100)		
	Electricity :		307 (1991-92)
	Natural gas :		296 (1991-92)
25.	Industrial production index (manufacturing) : (1981-82=100)		189 (1991-92)
26.	Price indices : (1969-70=1000		
	Wholesale prices of agri. and industrial products :	1323	(1991-92)

27. Money and Credit, June, 1992 : (Billion Taka)

Money supply (Narrow) :	82.6
Money supply (Broad) :	285.6
Scheduled banks time deposits :	202.7
Scheduled banks credit :	222.8

28. Govt. finance, 1991-92

	(Billion Taka)
Revenue receipt :	95.2
Revenue expenditure:	80.0
Public Sector development exp.	60.2
Foreign exchange reserve as on 30-6-1992 :	62.7
US $ (million)	1646.0

29. Foreign aid, 1991-92

	(Billion Taka)
Gross Disbursement :	61.4
Debt. repayment : of which	12.8
Principal :	8.0
Interest :	4.8

30. Foreign trade, 1991-92 (p)

	(Billion Taka)
Export (fob) :	74.2
Import (cif) :	132.2
	(Million US $)
Export (fob) :	1948
Import (cif) :	3471
Consumer prices (Dhaka)	1671(1991-92)

Table B6
Number of indoor and outdoor patients in different hospitals and clinics, 1992

Types of Hospital/ Clinics	Number	No. of bed	Indoor patient	Outdoor patient
Post Graduate Hospital	5	1750	34628	406424
Govt. Medical College*	8	5400	209417	1216795
District Hospital	59	3850	335359	3698741
Other General Hospital	4	525	2142	331842
T.H.C./R.H.C.	400	11275	561421	21987434
T.B. Hospitals	12	566	3358	n.a
T.B. Clinics	44	-	-	150687
Leprosy Hospital	3	120	3508	17244
I.D Hospital	5	180	12926	14698
Mental Hospital	1	400	1161	16725
Dental Hospital	1	n.a.	n.a.	n.a.
School Health Clinics	25	-	-	140925
Urban Dispensaries	35	-	-	n.a
U.S.C.	1318	-	-	14719995
M.C.W.C	96	748	n.a.	n.a.
Railway Hospital	9	476	n.a.	n.a.
Jail Hospital	19	1003	n.a.	n.a.
Madakashakta	1	50	n.a.	n.a.
Voluntary Agency/ Clinics	280	7242	n.a.	n.a.
Total :	2345	34353	1163920	42701510

Note : * Out of 13, 5 newly established Govt. Medical colleges do not need to have hospital facilities for teaching purposes at present.
THC/RHC= Thana Health Complex/Rural Health Complex.
ID=Infectious Disease.
USC=Union Sub-Centre
MCWC= Maternity and Child Welfare Centre.

Source : Health Information Unit, D.G. Health Services, Ministry of Health and Family Welfare.

Indicators of Health and Family Planning Sector

	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	Ratio (1992/1982)	Ratio (1992/1986)
Total No. of Hospitals	709	724	760	759	764	875	875	875	875	890	890	1.26	
No. of Govt. Hospital	545	560	596	605	600	608	608	608	608	610	610	1.12	
No. of Non-Govt Hospital	164	164	164	154	164	267	267	267	267	280	280	1.71	
No. of Govt Dispensaries	1468	1493	1559	1275	1275	1310	1310	1310	1310	1318	1362	0.93	
Total No. of Hospital beds	23907	25057	29000	29585	28077	33038	33334	33376	33376	34353	34353	1.44	
No. of beds in Govt. hospitals & dispensaries	19136	20286	21370	22243	23306	26575	26871	26913	26913	27111	27111	1.42	
No. of beds in Non-Govt Hospitals	4771	4771	4771	4460	4771	6463	6463	6463	6463	7242	7242	1.52	
Persons per hospital bed	3765	3736	3334	33354	3354	3664	3187	3198	3220	3189	3243	0.86	
No. of Registered Physicians	10513	14635	13300	14944	16090	16429	17475	18323	19387	20371	21004	2.00	
Persons per Physicians	8810	6529	7368	6640	6393	6219	6100	5954	5543	5380	5304	0.60	
No. of registered Nurses	4500	5164	5800	6418	6912	7000	7390	7035	9274	9655	10607	2.36	
No. of registered midwives	2934	3424	3850	4399	5199	5837	6556	7035	7485	7713	9363	3.19	
No. of T.B. Clinics	44	44	44	44	44	44	44	44	44	44	44	1.00	
No. of maternity & child welfare centres	93	96	96	96	96	96	96	96	96	96	96	1.03	
No. of family planning personnel	16240	16229	17000	15619	7263	16546	19250	21856	81188	81744	81744	5.03	
No. of medical colleges	10	10	10	10	10	10	10	10	8	8	13	1.30	
No. of homoeopathic Colleges	18	18	19	18	19	19	19	22	22	22	22	1.22	
No. of pharmaceutical industry (allopathic)	163	-	172	160	189	190	196	198	198	198	207	1.27	
No. of Homoeopathic Medicine Producing Firms	27	27	23	20	49	52	55	55	58	58	65		1.33
Unani and Ayurvedic medicine producing firms	10	–	–	–	371	384	392	401	405	405	390		1.05
Both sexes	3	–	–	–	55	56	56	56	56	57	57		1.04
Male		–	–	–	55	56	57	56	56	57	57		1.04
Female		–	–	–	55	56	56	56	56	56	57		1.04
Crude birth rate		–	–	–	34.4	33.3	33.2	33.8	32.8	31.6	30.8		0.90
Crude death rate		–	–	–	11.9	11.5	11.3	11.4	11.4	11.2	11		0.92
Rate of infant mortality (both sexes)		–	–	–	116.7	113	110	98	94	92	88		0.75
Total Govt. expenditure on health including family planning (crore taka)		–	–	–	283	354	409	636	591	698	957		3.38
Per capita government expenditure on health and family planning (taka)					28	34	38	60	54	62	86		3.07

Source : * Statistical Pocket Book , 1986, 87, 90, 91 &1993

Remarks : From the table above, it is observed that during the past deacde, the government expenditure has been increased more than three-fold. A huge number of family planning personnel has been recruited (5 times greater than 1982). The number of doctors was 2.3 times greater than that of nurses in 1982, after a decade it is still only about two-fold. Whereas it should be ideally opposite.

Major Health Indicators : Targets and Achievements during SFYP and TFYP

Sl. No.	Name of the items	Unit	Achievemnet during SFYP (1980-85)	Target for TFYP (1985-90)	Achievement during TFYP 1985/86 (Actual)	1986/87 (Actual)	1987/88 (Estimated)
1	2	3	4	5	6	7	8
HEALTH STATUS							
1.	Infant mortality	.. Per 1000	125	100	..	*116.6	114
2.	Child Mortality	.. Per 1000 (1 to 5 years)	22	12	..	*13.1	12.5
3.	Maternal Mortality	.. Per 1000 Live births	6	4	..	6	6
4.	Crude birth rate	.. Per 1000 Population	39.00	31.00	..	34.4	33
5.	Crude death rate	.. Per 1000		39.00	..	31.00 ..	34.4
		Population	15.00	13.00	..	11.9	11
6.	Population growth	.. % per year	2.40	1.80	..	2.3	2.20
7.	Life expectancy at birth	.. Birth in year	50	54	..	* 53.2	54
8.	Hospital beds :	.. Cumulative number	27,637	40.734	31681	32,113	32,988
	(a) Health Services	.. Ditto	19,661	29.534	22,874	23,906	23,801
	(b) Other Ministries & Private Sector	Ditto	7,976	11,200	8,807	8807	9,187
9.	Population per Hospital bed	Ditto	3,589	2,712	3,156	3,188	3,092
10.	Upazila Health Complexes	One in each rural Upazila	341	397	344	347	351
11.	(a) Union Health & Family Welfare Centres Union (UHFWC)	One in each	2,329	4,500	..	2,615	2,865
	(b) Health post for Community basic services (self financing)	One for about 5000 People	..	397	..	..	..
12.	Immunization against :						
	(a) Tuberculosis	.. % under 15 yrs. covered	60	90	63.38	*70.94	75
	(b) Diptheria, Whooping Cough and Tetanus	% under 2 yrs. immunized	2	80	2.66	*7.3	55
	(c) Measles ..	.. % Coverage	0.8	80	2.29	*7.00	34

Sl. No.	Name of the items	Unit	Achievement durig SFYP (1980–85)	Target for TFYP (1985–90)	Achievement during TFYP 1985/86 (Actual)	1985/87 (Actual)	1987/88 (Estimated)
1	2	3	4	5	6	7	8
14	Control of Tuberculosis	% case finding and treatment of estimated total diseased.	13	35	20	23	25
15	Delivery by trained Mid-wife/Birth Attendant		5	50	..	..	..
16	Antenantal Care ..	% pregnant women given care at least once.	20	50	..	..	..
17	Blindness Provenition ..	% children under 6 receiving Vit. A Capsule.	76	90	82·26	83·62	85
18.	Goitre Control ..	% covered for protection.	30	100	61	70	80
19.	Nutrition Services ..	% of 2nd/3rd degree malnutrition.	5	30	..	..	..
20	Coverage of population by primary heath care services.	% of population	30	65	..	..	..
21	Essential drugs and vaccines.	Availability for public heal h services (% of total required.)	25	60	..	..	..
22	Production of essential drugs vaccines, ORS & I.V. fluids.	Value in million Taka.	80	300	220·25	245·76	290·00
23	Health Laboratory Services ;						
	(a) Simple clinical diagnostic laboratory facilities at UHC's.	% of coverage	25	100	86	87	92
	(b) District laboratory facilities.	Ditto	25	60	59	59	59
	(c) Simple tests in UHFWC.	Ditto	5	25	..	..	..
24	X-Ray facilities in the UHCs.	Ditto	20	60	105	105	126
25	Blood transfusion services in District hospital	Cumulative Number.	20	64	33	33	33
	HEALTH MANPOWER						
26	Graduate Doctor ..	Cumulative Number.	16,000	22,500	17,341	18,102	19,340
27	Post-Graduate Doctor ..	Ditto	1,050	2,100	1,162	1,316	1,450
28	Dentist	Ditto	510	750	566	651	685
29	Basic Nurse/Midwife ..	Ditto	6,500	10,200	6,773	7,789	8,200

Sl. No.	Name of the items	Unit	Achievement during SFYP (1980–85)	Target for TFYP (1985–90)	Achievement during TFYP 1985/86 (Actual)	1986/87 (Actual)	1987/88 (Estimated)
1	2	3	4	5	6	7	8
30	Medical Assistant ..	Cumulative Number	3,600	4,600	3,776	4,022	4,348
31	Laboratory Technician ..	Ditto	1,350	2,000	1,376	1,611	1,642
32	Radiographer ..	Ditto	350	700	361	459	472
33	Pharmacist (Diploma) ..	Ditto	5,800	3.500	5.820	6,067	6,163
34	Health Sanitary Inspector	Ditto	1,265	1,500	..	..	..
35	Asstt. Health Inspector ..	Ditto	1,870	4,500	4,200	4,200	4,200
36	Health Assistant ..	Ditto	15,000	23,000	21,000	21,000	21,000

Source of information : (i) *BBS, Dhaka.

(ii) **Project Director, EPI.

(iii) Rest of the information from DGHS (HIU), Dhaka.

Table- Major Health Indicators and Targets of the Fourth Five Year Plan (1990-95)

Sl. No.	Health Indicator	Unit	1989-90 Bench Mark	1994-95 Target
1	2	3	4	5
1.	Infant Mortality Rate	/1000 live Birth	110	80
2.	Child Mortality Rate	/1000 upto 5 Years	11	9
3.	Maternal Mortality Rate	/1000 live Birth	7	4.5
4.	Crude Birth Rate	/1000 Population	35.2	30
5.	Crude Death Rate	/1000 Population	13.9	12
6.	Population Growth	%/Year	2.16	1.8
7.	Life Expectancy at birth	years at birth	53	55
8.	Hospital Beds	Comulative	34488	36488
	a) Health Services	Ditto	24501	26001
	b) Other Ministries & Private	Ditto	9987	10487
9.	Upazila Health Complex	One in each Upazila	351	397
10.	UHFWC/RD	One in each Union	3375	4325
11.	Immunization (0-1 Years)			
	a) BCG	% coverage	75	85
	b) DPT	Ditto	68	85
	c) Measles	Ditto	50	85
	d) Polio	Ditto	68	85
	e) TT (Pregnancy)	Ditto	45	85
12.	Control of Diarrhoea	% of coverage of ORS Distribution	90	90
13.	Control of T.B.	% of cases found (sputum positive)	20	50
14.	Delivery by trained personnel	% of pregnant women	20	50
15.	Antenatal care	% of pregnant women	45	60
16.	Nutritional Status	Av. adult energy intake in kcal	1850	2100
17.	Prevention of Night Blindness	% of children under 6 receiving Vit-A capsule	66	90
18.	Control of Goitre	% covered for protection through i) Lipiodol	70	100
		ii) Iodized salt	10	100
19.	Nutrition services	% of 2nd/3rd degree malnutrition treated	50	60
20.	Coverage of population by PHC	% of population	50	80
21.	Essential drugs and vaccines	Availability for public health services (% of total required)	60	70
22.	Health Lab Services			
	a) Simple lab facilities at UHCs	% of coverage	100	100
	b) Simple lab facilities at district level	% of coverage	100	100
23.	X-Ray facilities in UHCs	Number	143	397
24.	Blood transfussion uplo District level (including medical Colleges)	Number	46	71
25.	Production of essential drugs, ORS, vaccines & I.V. fluids	Value in million taka		
	Public		4317	4826
	Private		389	408
26.	Health Manpower :		3928	4418
	a) MBBS Doctors	Cumulative	20590	25600
	b) Dentist	Ditto	805	1150
	c) Basic Nurse	Ditto	9100	11350
	d) Medical Assistant	Ditto	4348	4700
	e) Lab Technician	Ditto	1702	2050
	f) Radiographer	Ditto	522	850
	g) Pharmacist	Ditto	6283	7000

* Source : PDEU, Planning Commission.

Number of registered medical personnel

Year	Post-graduate		M.B.B.S. & L.M.F.		Dentist		National Pass		Grand Total
	No.	Total	Number	Total	Number	Total	Number	Total	
1979	33	324	874	7909	35	164	19	1256	9653
1980	48	372	1279	9188	42	206	171	1427	11193
1981	60	432	877	10065	42	248	566	1993	12738
1982	126	558	268	10333	54	302	108	2101	13294
1983	142	700	1163	11496	25	327	20	2121	14644
1984	98	798	1358	12854	58	385	11	2132	16169
1985	114	912	1300	14154	54	439	8	2140	17645
1986	139	1051	1436	15590	61	500	5	2145	19286
1987	32	1083	839	16429	35	535	3	2148	20195
1988	279	1362	1046	17475	20	555	2155	4303	23695
1989	n.a-	n.a.	848	18323	39	594	n.a.	n.a.	—
1990	n.a.	n.a.	1064	19387	25	619	n.a.	n.a.	—
1991	n.a.	n.a.	1617	21004	n.a.	n.a.	n.a.	n.a.	—
1992	n.a.	n.a.	745	21749	83	702	n.a.	n.a.	—

Note : Totals show the progressive figures.

Sources : Director General of Health Services (Health Information Unit), Ministry of Health and Population Control

Number of hospital and hospital beds

Category	1987		1988		1990		1991		1992	
	No.of hospital	No. of bed	No.of hospital	No. of bed	No.of hospital	No. of bed	No.of hospital	No. of bed	No.of hospital	No. of bed
A. Health Division :										
i) District Hospital	59	3850	59	3850	59	3850	59	3850	59	3850
ii) Sub-Divisional Hospital	—	—	—	—	—	—	—	—	—	—
iii) Teaching Hospital	13	7329	13	7100	13	7232	13	7232	13	7232
iv) Other big Hospital	3	525	2	275	4	525	5	725	5	725
Specialized Hospital										
i) T.B. Hospital	4	406	4	406	4	406	4	406	4	406
ii) T.B. Segregation	8	160	8	240	8	160	8	160	8	160
iii) Leprosy	3	130	3	130	3	130	3	130	3	130
iv) Infectious Diseases	5	180	5	180	5	180	5	180	5	180
v) Mental Hospital	1	400	1	400	1	400	1	400	1	400
vi) Dental College	—	—	—	—	1	20	1	20	1	20
vii) U.H.C./RHC	364	11032	364	12225	367	1162	412	11125	412	11125
Total Health Division :	**460**	**24012**	**459**	**24806**	**465**	**14066**	**511**	**24228**	**511**	**24228**
B. Population Control Division : Maternity	96	612	96	612	96	748	96	748	96	748
C. Other Ministry : Railway Hospital	9	476	9	476	9	476	9	476	9	476
Jail Division :	39	1771	39	1771	39	1771	39	1771	39	1771
i) Jail Hospital	19	1003	19	1003	19	1003	19	1003	19	1003
ii) Police Hospital	20	768	20	768	20	768	20	768	20	768
iii) Madakashakta Hospital	—	—	—	—	1	50	1	50	1	50
iv) Voluntary Agencies	267	6463	267	6463	280	7242	312	7242	312	7242
Grand Total	**910**	**35105**	**909**	**35899**	**890**	**24353**	**1007**	**36286**	**1007**	**36286**

Note : Including beds and dispensaries managed by district and Union Councils. Figures for 1989 are not available.

Sources : (i) Health Information Unit, Health Division,
(ii) Ministry of Health and Population Control

Source : Statistical Yearbook of Bangladesh 1993, BBS

District-wise non-govt. hospitals/clinics with beds in Bangladesh, 1991-92

Sl. No.	Name of Districts	No. of Hospitals	No. of Beds
1.	Rangamati	2	179
2.	Chittagong	22	299
3.	Cox's Bazar	4	207
4.	Comilla	2	18
5.	Brahmanbaria	2	45
6.	Noakhali	2	10
7.	Laxmipur	2	30
8.	Sylhet	10	114
9.	Habiganj	10	77
10.	Moulvibazar	27	382
11.	Dhaka	97	2889
12.	Gazipur	3	55
13.	Manikganj	2	13
14.	Narayanganj	3	22
15.	Narsingdi	3	45
16.	Faridpur	3	33
17.	Madaripur	1	25
18.	Gopalganj	2	32
19.	Sherpur	3	63
20.	Mymensingh	9	113
21.	Netrokona	3	25
22.	Tangail	1	951
23.	Barisal	4	87
24.	Perojpur	1	10
25.	Jessore	3	50
26.	Khulna	23	
27.	Bagerhat	4	130
28.	Kushtia	3	56
29.	Meherpur	4	106
30.	Chuadanga	1	10
31.	Barguna	1	10
32.	Bogra	7	156
33.	Dinajpur	7	287
34.	Panchagarh	1	35
35.	Pabna	3	46
36.	Serajganj	2	3
37.	Rajshahi	9	296
38.	Natore	9	130
39.	Rangpur	7	43
40.	Kurigram	2	100
41.	Lalmonirhat	2	20
42.	Nilphamari	1	40
43.	Kishoreganj	1	—
44.	Jhenaidah	1	—
45.	Narail	1	—
46.	Nawabganj	2	—
	Total	**312**	**7242**

Sources : Health Information Unit, Ministry of Health and Population Control.

Source : Statistical Yearbook of Bangladesh 1993, BBS

Region-wise distribution of health facilities, 1991-92

Sl. No.	District	District Hospital (*)	Other Hospital		Thana Health Complex (*)	Union Sub-Centre/ Rural Disp. (*)	Other outdoor facilities (*)
			Health Division (*)	Private (*)			
01	Panchagarh	1	—	1	4	16	—
02	Thakurgaon	1	—	—	4	13	1
03	Dinajpur	1	—	10	12	20	2
04	Rangpur	—	2	6	7	40	2
05	Nilphamari	1	1	1	5	22	1
06	Lalmonirhat	1	—	1	4	12	—
07	Kurigram	1	—	2	8+1	19	1
08	Gaibandha	1	—	—	6+1	36	1
09	Joypurhat	1	—	—	4	12	—
10	Bogra	1	1	5	10	50	2
11	Sirajganj	1	—	2	8+1	27	1
12	Pabna	1	2	1	8	13	2
13	Natore	1	—	—	5	15	1
14	Naogaon	1	—	—	10	44	—
15	Nawabganj	1	—	—	4	20	1
16	Rajshahi	—	3	9	8	32	2
	Divn. Total	**14**	**9**	**38**	**107+3****	**391**	**17**
17	Kushtia	1	—	2	5	25	2
18	Meherpur	1	—	2	1	12	1
19	Chuandanga	1	—	1	3	13	1
20	Jhenaidah	1	—	—	5	13	—
21	Magura	1	—	—	3	9	1
22	Narail	1	—	—	2	7	—
23	Jessore	1	1	1	7	21	2
24	Satkhira	1	—	—	6	11	—
25	Khulna	1	3	9	9	13	2
26	Bagerhat	1	—	3	8	10	1
27	Perojpur	1	—	—	5	6	1
28	Jhalakati	1	—	—	3+1	5	—
29	Barguna	1	—	1	4	8	—
30	Patuakhali	1	—	—	5	12	1
31	Bhola	1	—	—	6+1	7	—
32	Barisal	1	2	1	9+1	31	2
	Divn. Total	**16**	**6**	**20**	**81+3****	**203**	**15**

(Contd.)

Source : Statistical Yearbook of Bangladesh 1993, BBS

Region-wise distribution of health facilities, 1991-92

Sl. No.	District	District Hospital (*)	Other Hospital		Thana Health Complex (*)	Union Sub-Centre/ Rural Disp. (*)	Other outdoor facilities (*)
			Health Division (*)	Private (*)			
33	Shariatpur	1	—	—	5	18	—
34	Madaripur	1	—	1	3	33	1
35	Gopalganj	1	—	1	4+1	23	1
36	Faridpur	1	1	3	7	21	2
37	Rajbari	1	—	—	3	24	—
38	Manikganj	1	0	1	6	30	—
39	Dhaka	—	13	97	6	18	22
40	Munshiganj	1	—	—	5	26	1
41	Narayanganj	1	1	2	4	12	1
42	Narsingdi	1	—	3	5	18	—
43	Gazipur	1	1	3	4	17	—
44	Tangail	1	—	4	10	59	2
45	Jamalpur	1	—	—	6	28	1
46	Sherpur	1	—	2	4	9	—
47	Mymensingh	—	1	7	11	43	2
48	Kishoreganj	1	—	—	12	18	1
49	Netrokona	1	—	3	9	27	—
	Division Total	**15**	**17**	**127**	**104+1**	**424**	**34**
50	Sunamganj	1	—	—	9	24	1
51	Sylhet	—	4	10+2	10	24	2
52	Moulvi bazar	1	1	27	5	16	1
53	Habiganj	1	—	10	7	22	—
54	Brahmanbaria	1	1	3	6	26	1
55	Comilla	1	0	1	11	48	2
56	Chandpur	1	—	—	6	20	1
57	Lakshmipur	1	—	2	3	15	—
58	Noakhali	1	—	1	5+1	25	3
59	Feni	1	1	—	4	19	1
60	Khagrachhari	1	—	—	7	14	—
61	Rangamati	1	—	3	9+1	11	2
62	Chittagong	1	3	21	14+2	74	9
63	Bandarban	1	—	—	6	1	—
64	Cox's Bazar	1	—	4	6	15	1
	Division Total	**14**	**10**	**82**	**108+5****	**354**	**24**
	Grand Total	**59**	**42**	**280**	**400+12****	**1372**	**90**

Note :

* Other Hospital : Medical College Hospital
Health Division Specialised Hospital
Infection Disease Hospital
Leprosy Hospital
T B Hospital.

Outdoor Facilities : TB Clinic
School Health Clinic
Urban Dispensaries.

** 10 Bedded Rural Health Centre.

Source : Health Information Unit, Director-General Health Services.

Source : **Statistical Yearbook of Bangladesh 1993, BBS**

Number of family planning personnel by region

Region (Greater District)	Family Planning Assistant (Male)				Family Welfare Assistant (Female)				No. of married women (age 15-49) (census, 1981)
	1988-89	1989-90	1990-91	1991-92	1988-89	1989-90	1990-91	1991-92	(Thousand)
Bandarban	28	28	28	24	41	84	84	83	30
Chittagong	262	262	262	234	804	1009	1094	1137	876
Chittagong H.Ts.	56	57	57	76	217	266	267	295	97
Comilla	336	337	337	342	1439	1656	1700	1945	1251
Noakhali	169	170	170	165	653	815	886	957	694
Sylhet	284	287	291	300	881	1170	1274	1525	1003
Dhaka	406	407	409	389	1568	2018	2050	2181	1705
Faridpur	305	303	303	310	1169	1173	1428	1431	841
Jamalpur	110	66	110	108	588	397	641	666	452
Mymensingh	339	383	448	333	1210	1868	2261	1793	1197
Tangail	122	112	109	89	527	611	621	625	441
Barisal	213	214	214	218	1016	1163	1201	1235	828
Jessore	245	235	236	307	976	1146	1154	1149	693
Khulna	235	235	235	230	824	1062	1092	1153	764
Kushtia	107	107	107	108	520	590	602	621	400
Patuakhali	90	91	91	97	444	443	461	541	339
Bogra	133	141	141	136	691	780	771	769	514
Dinajpur	189	195	195	192	853	972	967	884	594
Pabna	158	154	154	148	691	860	862	860	592
Rajshahi	270	270	273	245	1040	1359	1395	1368	913
Rangpur	331	331	331	339	1314	1713	1795	1822	1181
Total	**4388**	**4385**	**4364**	**4390**	**17466**	**21155**	**21901**	**23000**	**15405**

Sources : i) Directorate of Family Planning,
ii) Directorate of Population Control,
iii) Population Census, 1981

Source : **Statistical Yearbook of Bangladesh 1993, BBS**

Projection and achievment of family planning activities by method during fourth five year plan

Method	1991-1992			1992-1993		
	Projection	Performance	Achievement %	Projection	Performance	Achievement %
Sterilization (cases)	340000	161278	47.4	350000	113658	32.5
I U D (cases)	330000	269565	81.7	350000	261914	74.8
Oral pill (CYC)	47850000	46628916	97.4	50700000	63922897	126.1
(In CYP)	3190000	3108594	—	3380000	4261527	
Condom (pieces)	156000000	159514283	102.3	175500000	224137459	127.7
(In CYP)	1040000	3063429	—	1170000	1494230	
Injectable (Doses)	4160000	2254778	54.2	4680000	2561263	54.7
(In CYP)	1040000	563695	—	1170000	640316	
EMKO (vial)	150000	2166	1.4	98000	777	0.8
(In CYP)	39500	542	—	24500	194	
Foam T. (pieces)	5925000	9258	0.2	3675000	1788	0.0
(In CYP)	39500	62	—	24500	12	
Other M. R.	No Target	83832	—	—	98989	—

Note : CYP (Couple Year of Protection)

Source : Directorate of Family Planning. (MIS unit).

13.20 Yearwise projection for new contraceptive acceptors requirement under fourth five year plan

(In Lakh)

Method	1990		1991		1992		1993		1994		1995	
	N	T	N	T	N	T	N	T	N	T	N	T
Sterilization	0.55	23.6	2.4	25.7	3.4	28.7	3.5	31.8	0.7	35.0	3.9	38.2
I U D	2.0	5.1	3.6	7.6	3.3	9.4	3.5	10.9	3.7	12.4	3.9	13.8
Oral Pill	28.0	28.0	29.2	29.2	31.9	31.9	33.8	33.8	36.1	36.1	38.6	38.6
Condom	5.5	5.5	8.2	8.2	10.4	10.4	11.7	11.7	13.2	13.2	14.9	14.9
Injection	5.0	5.0	8.2	8.2	10.4	10.4	11.7	11.7	13.3	13 3	14.9	14.9
Other	14.5	14.5	9.2	9.2	5.9	5.9	4.9	4.9	3.7	3.7	2.4	2.4
Total	55.5	81.7	60.8	88.1	65.3	96.7	69.1	104.8	73.7	113.7	78.6	122.8

Notes : N—New user, T—Total.

Sources : Directorate of Family Planning (MIS unit).

Yearwise mix of different contraceptives under fourth five year plan

Method	1990	1991	1992	1993	1994	1995
Sterilization	28.9	29.1	29.1	30.3	30.8	31.1
Oral Pill	34.4	33.2	33.0	32.3	31.7	31.4
Condom	6.8	9.3	10.7	11.2	11.7	12.2
I U D	6.1	8.7	9.7	10.4	10.9	11.3
Injectable	6.1	9.3	10.8	11.2	11.7	12.1
Other	17.7	10.4	6.1	4.6	3.2	1.9
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source : Directorate of Family Planning (MIS Unit).

Source : **Statistical Yearbook of Bangladesh 1993, BBS**

Region-wise family

Region (Greater District)	Iud (No. in '000')			Vasectomy (No. in '000')			Tubectomy (No. in '000')			Condom (Thousand dozen)		
	1989-90	1990-91	1991-92	1989-90	1990-91	1991-92	1989-90	1990-91	1991-92	1989-90	1990-91	1991-92
Bandarban	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	—	—
Chittagong	24	22	20	—	—	—	—	—	—	344	214	250
Chittagong H.Ts.	3	2	2	—	—	—	—	—	—	74	64	65
Comilla	17	14	13	—	—	—	—	—	—	456	349	393
Noakhali	9	7	6	—	—	—	—	—	—	316	209	233
Sylhet	17	16	14	—	—	—	—	—	—	325	247	323
Chittagong Division	70	61	55	—	—	—	—	—	—	**1515**	**1083**	**1264**
Dhaka	56	49	45	—	—	—	—	—	—	1091	772	754
Faridpur	22	18	16	—	—	—	—	—	—	400	368	361
Jamalpur	11	6	6	—	—	—	—	—	—	253	149	183
Mymensingh	21	18	16	—	—	—	—	—	—	416	373	379
Tangail	6	7	5	—	—	—	—	—	—	251	170	169
Dhaka Division	116	98	88	—	—	—	—	—	—	**2411**	**1832**	**1846**
Barisal	21	17	15	—	—	—	—	—	—	339	238	229
Jessore	21	18	15	—	—	—	—	—	—	522	293	319
Khulna	12	20	19	—	—	—	—	—	—	742	404	439
Kushtia	8	8	7	—	—	—	—	—	—	312	186	193
Patuakhali	10	8	8	—	—	—	—	—	—	146	92	85
Khulna Division	72	71	64	—	—	—	—	—	—	**2061**	**1213**	**1265**
Bogra	10	7	6	—	—	—	—	—	—	272	140	122
Dinajpur	13	11	10	—	—	—	—	—	—	257	129	141
Pabna	13	11	10	—	—	—	—	—	—	419	238	212
Rajshahi	19	15	14	—	—	—	—	—	—	489	319	285
Rangpur	42	26	22	—	—	—	—	—	—	402	266	242
Rajshahi Division	97	70	62	—	—	—	—	—	—	**1839**	**1092**	**1002**
Other programme	—	—	—	—	—	—	—	—	—	8674	6993	7915
Bangladesh	355	300	269	—	—	—	—	—	—	16500	12213	13292

Note : n.a.—Not available.

Sources : Directorate of Population Control and Family Planning.

→ contd.

Source : **Statistical Yearbook of Bangladesh 1993, BBS**

planning activities

Oralpill (Thousand cycle)			Emko (vials in '000')			Injection (No. in '000')			M.R. (No. in '000')			Foam tablets (No. in '000')			Sterilization (No. in '000')		
1989-90	1990-91	1991-92	1989-90	1990-91	1991-92	1989-90	19-90 91	1991-92	1989-90	1990-91	1991-92	1989-90	1990-91	1991-92	1989-90	1990-91	1991-92
n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
951	1189	1230	2	1	2	42	56	70	7	6	5	2	1	—	7	6	7
305	299	331	—	—	—	9	10	11	1	1	—	4	1	1	1	1	1
1340	1895	2123	—	—	—	91	111	12	3	2	2	1	2	1	8	9	7
865	1039	1113	—	—	—	33	51	64	2	1	1	5	5	2	6	6	4
687	970	1234	—	—	—	28	52	61	3	2	3	—	—	—	7	3	4
4148	**5392**	**6031**	**2**	**1**	**2**	**203**	**280**	**333**	**16**	**12**	**11**	**12**	**9**	**4**	**29**	**25**	**23**
4445	5636	5595	—	2	—	196	266	326	25	27	27	19	1	—	68	67	62
1309	1938	2037	—	—	—	42	81	94	2	2	1	3	—	—	5	3	3
1076	1584	1988	—	—	1	38	62	72	1	—	—	3	4	1	3	1	3
1844	2890	3113	—	—	—	77	131	182	5	5	5	—	—	—	11	8	9
912	1155	1422	—	—	—	21	24	32	3	3	2	5	—	—	8	7	5
5986	**13203**	**14155**	—	**2**	**1**	**374**	**564**	**706**	**36**	**37**	**35**	**30**	**5**	**1**	**95**	**86**	**82**
3171	1914	1953	—	—	—	60	118	144	8	7	5	1	—	—	10	5	4
1664	2300	2497	—	—	—	101	151	206	3	2	3	3	1	1	5	4	3
1751	2553	2649	—	—	—	70	94	118	6	5	6	—	—	—	7	5	4
1134	1598	1692	—	—	—	67	102	117	1	1	1	2	—	—	3	3	3
468	682	771	—	—	1	28	39	45	2	1	2	4	—	—	5	4	3
6388	**9047**	**9562**	—	—	**1**	**326**	**504**	**630**	**20**	**16**	**17**	**10**	**1**	**1**	**30**	**21**	**17**
1472	2077	1967	—	—	—	54	69	78	1	1	1	5	2	1	6	3	4
1009	1193	1372	—	—	—	49	79	79	2	2	2	10	5	1	16	7	7
1242	1983	2136	—	1	1	82	108	116	5	7	6	3	—	—	8	7	5
1904	2992	2695	1	—	—	66	93	110	5	3	3	6	—	—	13	12	9
1613	2621	2728	—	—	—	101	156	193	7	7	8	1	1	—	27	19	14
7245	**10866**	**10898**	**1**	**1**	**1**	**352**	**505**	**576**	**20**	**20**	**20**	**25**	**8**	**3**	**70**	**48**	**39**
6978	8276	4986	—	—	—	23	—	10	—	—	—	1470	4	—	—	—	—
34345	46784	45632	2	4	5	1258	1854	2255	92	85	83	1547	27	9	224	180	161

Source : Statistical Yearbook of Bangladesh 1993, BBS

Percentage and current use of contraceptives among currently married women under 50 years of age by method

Contraceptive status	No. of currently married women (weighted)		Percentage			
	1983	1985	1983	1985	1989	1990-91
Modern methods (Total)	1055	1439	13.8	18.4	24.4	31.2
Oral pill	255	399	3.3	5.1	9.1	13.9
Condom	117	139	1.5	1.8	1.9	2.5
IUD	78	113	1.0	1.4	1.7	1.8
Tubectomy	472	615	6.2	7.9	9.0	9.1
Vasectomy	95	121	1.2	1.5	1.5	1.2
Injection	19	37	0.3	0.2	1.1	2.6
Vaginal method	20	15	—	—	0.2	0.0
Traditional methods (Total)	413	540	5.4	6.9	7.0	8.7
Abstinence	27	41	0.4	0.5	0.5	0.5
Safe period	184	298	2.4	3.8	3.8	4.7
Withdrawal	98	71	1.3	0.9	1.2	2.0
Others	104	130	1.4	1.7	1.5	1.5
Any method	1467	1979	19.1	25.3	31.4	39.9
No. method	6195	5843	80.9	74.7	68.6	60.1
Total	7662	7822	**100.0**	**100.0**	**100.0**	100.0

Source : Contraceptive Prevalence Survey, 1989, 1991.

Percentage of currently married women under 50 years of age using contraceptives by method, Bangladesh 1975, 1983, 1985, 1989 and 1991

Method	BFS 1975	CPS Year			
		1983	1985	1989	1991
Oral pill	2.7	3.3	5.1	9.1	13.9
Condom	0.7	1.5	1.8	1.9	2.5
IUD	0.5	1.0	1.4	1.7	1.8
Tubectomy	0.3	6.2	7.9	9.0	9.1
Vasectomy	0.5	1.2	1.5	1.5	1 2
Injection	—	0.2	0.5	1.1	2.6
Vaginal method	—	0.3	0.2	0.2	0.0
Abstinence	1.1	0.4	0.5	0.5	0.5
Safe period	1.0	2.4	3.8	3.8	4.7
Withdrawal	0.6	1.3	0.9	1.2	2.0
Others	0.3	1.4	1.7	1.5	1.5
Total use rate	7.7	19.2	25.3	31.5	39.9

Sources : (1) Bangladesh Fertility Survey, 1975, 1983, 1985 and 1989 and 1991.
(2) CPS—Contraceptive Prevalence Survey, 1983, 1985, 1989 and 1991.

Source : Statistical Yearbook of Bangladesh 1993, BBS

Percentage distribution of current users of a non-clinical family planning method by reported source of supply, 1985 and 1989.

Source of Supply	Oral pill		Condom		Vaginal method	
	1985	1989	1985	1989	1985	1989
Pharmacy	43.4	36.2	33.8	52.4	46.7	63.3
General store	5.5	—	17.3	—	—	—
Pan/Cigarette shop	0.5	—	5.8	—	—	—
Quack	4.0	3.0	5.8	0.6	—	—
Qualified doctor	4.0	2.1	0.7	—	—	—
Depot-holder	—	—	—	—	6.7	—
Clinic/hospital	6.8	9.0	2.9	6.8	6.7	11.1
Field worker	32.3	45.1	25.9	32.1	26.7	7.2
Others	1.0	3.0	—	1.8	—	—
Don't know	2.5	1.6	7.2	5.0	13.2	18.3
Unspecified	—	—	0.6	—	—	—
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Source : Bangladesh Contraceptive Prevalence Survey, 1985.

Cost implications for population control and family planning sector activities for fourth five year plan

(In crore Taka)

Programme areas/Activities	Amount (in 1989-90 price)
1. Service Delivery Support	800.00
2. Physical Infrastracture Development including equipment transport and maintenance of building	225.00
3. Information Education and Communication (IEC)	55.00
4. Manpower Development (Training)	50.00
5. MCH Programme (including MSR and Nutrition)	205.00
6. Clinical Services (Sterilization, IUD Norplant, MR etc.)	50.00
7. Multi-sectoral programme including Womens programme	80.00
8. Innovative programmes	20.00
9. Contraceptive (IUD, Condom, Oral pill injectables etc.) procurement cost with transportation to Upazila level	150.00
10. Contraceptive Manufacturing plant (Condom, Oral pill, Injectables manufacturing plant)	50.00
11. Research, Evaluation and Monitoring	25.00
Total	**1710.00**

Source : Fourth Five Year Plan, 1990-95.

Source : **Statistical Yearbook of Bangladesh 1993, BBS**

Percentage of currently married women under 50 years of age using contraceptives by age group in 1985, 1981 and 1989

Age group	CPS 1985		CPS 1981	Difference in Percentage	CPS 1989	CPS 1990	CPS 1991
	No. of currently married women (weighted)	Percentage	Percentage		Percentage	Percentage	Percentage
0–14	118	5.1	2.9	+ 2.2	14.6	18.7	13.0
15-19	1282	10.7	9.5	+ 1.2	—	—	19.5
20-24	1619	21.7	17.6	+ 4.1	25.1	32.6	32.7
25-29	1577	33.5	23.8	+ 9.7	36.4	40.6	45.7
30-34	1200	35.6	25.3	+10.3	44.2	52.5	52.3
35-39	897	34.4	23.2	+11.2	44.8	57.0	57.1
40-44	617	26.4	23.4	+ 3.0	34.9	46.4	39.7
45-49	512	15.0	12.5	+ 2.5	21.7	29.9	39.9
All	7822	25.3	18.6	+ 6.7	31.4	—	—

Source : CPS—Contraceptive Prevalence Survey, 1985, 1989–1991.

Percentage distribution of current users of a non-clinical family planning method by reported source of supply 1985 and 1989

Source of Supply	National		Rural		Urban	
	1985	1989	1985	1989	1985	1989
Pharmacy	41.0	39.6	33.1	36.2	59.2	47.6
General store	8.3	—	9.9	—	4.7	—
Pan/Cigarette shop	1.8	—	2.1	—	1.2	—
Quack	4.3	2.5	6.0	3.4	0.4	0.3
Qualified doctor	3.1	1.7	3.4	1.5	2.5	2.1
Depot-holder	0.2	—	0.3	—	—	—
Clinic/hospital	5.8	8.7	6.3	9.2	4.7	7.5
Field worker	30.6	42.4	33.6	44.6	23.5	37.3
Others	0.7	2.8	1.0	2.6	0.2	3.1
Don't know	4.0	2.4	4.0	2.3	3.4	2.6
Unspecified	0.2	—	0.3	—	0.2	—
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Source of Supply	CPS 1991		
	National	Rural	Urban
Field workers	64.3	69.3	47.1
Shop (Including Pharmacy)	24.4	19.7	40.7
Clinics/Hospitals	4.9	4.7	5.8
Others	4.5	4.4	4.5
Dont, know	1.9	1.9	1.9
Total	**100.0**	**100.0**	**100.0**

Source : Bangladesh Contraceptive prevalence Survey, 1985, 1989, and 1991.

Source : Statistical Yearbook of Bangladesh 1993, BBS

Progress of sinking deep tubewells in coastal saline areas

Region (Greater District)	No. of tubewells completed upto the year							
	1984-85	1985-86	1986-87	1987-88	1988-89	1989-90	1990-91	1991-92
Chittagong	3015	3053	3153	3207	3421	3879	6006	7225
Noakhali	910	920	1066	1136	1405	2095	3247	3964
Sylhet	6429	6470	6668	6715	6715	6715	6369	6665
Khulna	583	583	621	650	720	1049	1450	1663
Barisal	3463	3573	3891	4028	4863	8333	12067	13654
Patuakhali	3894	3951	4364	4514	5004	6852	8382	10524
Faridpur	38	38	53	57	86	291	512	622
Total	**18332**	**18588**	19816	**20307**	**22214**	**29214**	**38033**	**44317**

Source: Directorate of Public Health Engineering.

Number of hand/shallow tubewells for drinking water in rural areas by region

Region (Greater District)	1986	1987	1988	1989	1990	1991	1992
Bandarban	1662	1662	1662	1662	1662	2483	2728
Chittagong	33097	33191	36580	36961	37579	32836	35328
Chittagong-Hill Tracts	5379	5371	5379	5379	5379	7752	8472
Comilla	53253	57137	59068	60485	62485	63926	65837
Noakhali	29973	31349	32131	32449	33040	34055	36544
Sylhet	41872	44866	40746	42194	44073	46727	48272
Dhaka	57327	61194	63155	64591	66702	72505	75472
Faridpur	38570	41768	42722	43737	45447	48667	50602
Jamalpur	18779	20235	21607	22172	23019	24340	25469
Mymensingh	52471	55403	58429	59414	60642	67838	71063
Tangail	19896	21065	21865	22240	22652	23028	23856
Barisal	28409	30036	30762	31210	31927	28471	30923
Kushtia	18556	19170	19886	20401	21121	22807	23731
Jessore	36236	37789	38964	39777	40925	43021	44523
Khulna	30636	32952	34135	34530	35083	35349	36506
Patuakhali	6825	7332	7334	7334	7334	—	80
Bogra	22672	23845	24320	24718	25328	28874	31068
Dinajpur	29271	30930	32010	32465	33115	33075	35238
Pabna	27117	28870	30103	30477	31027	35598	37868
Rajshahi	44311	46645	48626	49226	49925	58180	62640
Rangpur	49172	54130	56069	58131	61088	63388	67210
Bangladesh	**645484**	**684940**	**705553**	**719553**	**739553**	**772920**	**813430**

Notes : Figures include deep tubewells in the coastal areas. Average discharge capacity of hand tubewell is about 4–5 gallons per minute. Figures are as on 30th June.

Source : Directorate of Public Health Engineering.

Source : Statistical Yearbook of Bangladesh 1993, BBS

Number of Imams trained and expenditure incurred thereon in Bangladesh

Year	Number of Imams trained	Expenditure (in thousand taka)
1979-80	541	—
1980-81	741	1749
1981-82	862	2402
1982-83	1617	3428
1983-84	3523	7160
1984-85	6274	11793
1985-86	1525	5397 (Upto May/86)
1986-87	2261	14016
1987-88	3895	159870
1988-89	2213	90642
1989-90	2491	11267
1990-91	880	15115
1991-92	1838	89787
Total	**28661**	**412626**

Source : Imam Training project, Islamic Foundation, Bangladesh.

Number of Imam trained by region from 1979 to June, 1992

Region (Greater District/Division)	No. of Imams trained up to June'1992
Bandarban	54
Chittagong	1655
Chittagong H. Ts.	101
Comilla	1842
Noakhali	1165
Sylhet	1126
Chittagong Division	**5943**
Dhaka	2114
Faridpur	1412
Jamalpur	447
Mymensingh	1240
Tangail	1338
Dhaka Division	**6551**
Barisal	2447
Jessore	1391
Khulna	2245
Kushtia	604
Patuakhali	2823
Khulna Division	**9510**
Bogra	1202
Dinajpur	1334
Pabna	1307
Rajshahi	2366
Rangpur	1448
Rajshahi Division	**7657**
Bangladesh	**29661**

Source : Imam Training Academy' Islamic Foundation, Bangladesh.

On - going project on Health and Population

Three Year Rolling Investment Programme (FY 94-96)

I. Sector: Health

Project Titles (Source)

A. Agency: Ministry of Health & Family Welfare (Health Wing)

On-going: Investment

01. Establishment of 18 NTC and Running Crush Programme (UNICEF)
02. Establishment of Cancer Institute and Research Hospital Dhaka.
03. Expansion of IV Fluid Production Unit & Production of Vaccine & Antiserum & DPT.
04. Establishment of Thana Health Complexes (Phase-II) (NORAD, WHO)
05. Institute of Child and Mother Health, Dhaka (IDA)
06. Establishment of 200 Bed Modernized Hospital at Faridpur
07. Further Development of RIHD, Dhaka
08. Establishment of Dhaka Dental College (at a new site) (OPEC)
09. Establishment of 10 Bed Hospital at Dahgramm Angorpota Chitmahal
10. Reconstruction and Modernisation of Hospital at Dinajpur
11. Construction of 100 Bed Hospital at Madaripur
12. Establishment of 300 Bed Shaheed Sharwardy Hospital, Shere Bangla Nagar, Dhaka (Phase-I) (OPEC)
13. Post Flood Rehabilitation of 74 Thana Health Complex and 21 District Hospital under EEC Assistance (EEC)
14. Construction of 5 Ladies Hostel at Mymensingh, Sylhet, Chittagong, Barisal, SSMC & Auditorium at Rajshahi Medical College
15. Improvement of Essential Drug Management System at PHC Level (UNICEF)
16. ADB Assisted Second Health & Family Planning Services Project (ADB)
17. Comprehensive Public Health Nutrition Programme (Australia, IDA)
18. Integrated Control of Vector Borne Diseases (ICOVED)
19. Control of Diarrhoea Diseases Programme (IDA)
20. Production & Distribution of ORS for the Control of Diarrhoea Diseases (UNICEF)
21. Family Health Education Programme (Netherlands, IDA)
22. Strengthening of IV Fluid Plant for Production of Blood Collection & Nutritional Fluids & Setting up of a Unit for Production of Diagnostic Reagents and Biological (IDA)
23. Functional Improvement of 50 Thana Health Complex (Phase-I) (EEC)
24. Management Information System for Health (CIDA)
25. Prevention & Control of Sexually Transmitted Diseases (ODA, IDA)
26. Training of Different Categories of Health Personnel in Operational Management and in Selected Clinical Specialities. (NORAD, IDA)
27. Further Development of TB and Leprosy Control Services (Netherlands, IDA)

28. Co-ordinated Nutrition Programme of Bangladesh National Nutrition Council (IDA)
29. Establishment of 5 Medical Colleges at Dinajpur, Bogra, Faridpur, Khulna & Comilla
30. Development of 18 District Hospitals (IDA)
31. Further Development of 4 Medical College Hospitals at Mymensingh, Rajshahi, Sylhet & Sir Salimullah Medical (IDA)
32. Further Improvement of the Medical Colleges (IDA, ODA)
33. Construction of Dr. Shamsul Alam Khan Milon Auditorium at the Premises of Dhaka Medical College
34. Procurement of Medical Equipment & Ambulance under Japanese Commodity Assistance for Cyclone Rehabilitation Programme (Japan)
35. Expansion & Development of NIPSOM (Australia)
36. Strengthening of IEDCR (ODA, IDA)
37. Acute Respiratory Infection Control Programme (IDA)
38. Strengthening of Bangladesh Medical Research Council (BMEC) (Australia, IDA)
39. Modernisation and Reorganisation of the Existing Drug Testing Laboratory (DTL) Dhaka (NORAD, IDA)
40. Pilot Project for the Development of Maternal and Neonatal Health Care (NORAD, SIDA)
41. Strengthening of Nursing Education and Services (ODA, IDA)

* *New: Investment*

42. Intestinal Parasite Control (Pilot Project) Programme (IDA)
43. Disaster Preparedness Programme at Bashkhali Thana under CTG District (IDA)
44. Strengthening and Expansion of the Institute of Chest Diseases Hospital Mohakhali, Dhaka
45. Expansion of Diabetic Hospital & Rehabilitation Centre at Comilla-II
46. Establishment of National Centre for Control of Rheumatic Fever & Heart Diseases (Japan)
47. Establishment of 100 Bed Hospital at Mirpur Dhaka
48. Expanded Programme of Immunisation EPI (Phases-III) (UNICEF, IDA, USAID, WHO)
49. Further Development of the National Institute of Mental Health & Research at Dhaka
50. Expansion to Thakurgoan 50 Bed District Hospital to 100 Bed Hospital
51. Expansion of Gazipur 50 Bed District Hospital to 100 Bed Hospital
52 Expansion of Noakhali 150 Bed District Hospital to 200 Bed Hospital
53. Expansion of Magura 50 Bed District Hospital to 100 Bed Hospital
54. Expansion of Jessore 100 Bed Hospital to 250 Bed Hospital
55. Establishment of National Institute of Cardiovascular Diseases at Dhaka(Phase-III)
56. Establishment of On-Shore Hospital at Hiron Point in Sundarban Area
57. Further Development of Dhaka Institute of Post Graduate Medicines and Research, Dhaka
58. Establishment of a National Institute of Kidney Diseases and Urology

59. Further Development of Dhaka Medical College & Hospital
60. Establishment of a 250 Bed Bangladesh China Friendship General Hospital, Dhaka (China)
61. School Health Programme (IDA)
62. Further Development of Existing National Institute of Ophthalmology and Hospital with 250 Beds
63. Establishment of Three 100 Bed Casualty Hospital at Kashinathpur, Feni & Dhaka

On-going: Technical Assistance

64. Intensification of PHC and Health for All Leadership Development at Village Level (UNDP, WHO)
65. Survey of Health Institutions for Preparation of Master Plan (IDA)
66. Feasibility Study for Production of Essential Medical and Surgical Instruments (IDA)
67. Latherus & Latherium Research in Bangladesh (Belgium)
68. Development of Epidemiological Surveillance System for Prevention and Control of Cancer (IDA)
69. Community Based Alternative Vector Control Field Research Trial (Canada)
70. Survey of Maternal Neonatal Health Care (IDA)
71. Development of Health Care Quality Assurance Hospital Programme (NORAD, SIDA)
72. Bangladesh AIDS Prevention and Control Programme (UNDP)

New: Technical Assistance

73. Basic Training of the Newly Recruited Health Assistants (IDA)
74. Procurement of Equipment for the National Institute of Cardiovascular Diseases and Hospital 8 CCH in 8 Medical College Hospitals one unit at IPGMAR, Dhaka (France)
75. Formulation of a Master Plan for Development of Human Resources for Health & Family Planning (CIDA, ODA)
76. Nursing Midwifery Curriculum Revision and Refreshers Training (ADB)
77. Small Scale Technical Assistance for the Proposed Bangladesh Nutrition (ADB)
78. Large Scale Operational Trial of Alternative Methods for Malaria Control (ODA)

II. **Sector:** **Family Welfare**

Project Titles (Source)

A. Agency: Family Welfare Wing

* *On-going: Investment*

01. Family Planning Service Delivery Project (Phase-V) (IDA, CIDA EEC, NORAD/ KfW/ Netherlands)
02. Strengthening of MCH Programme (Phase-IV) (IDA, UNFPA)
03. Family Planning Clinical Services Project (Phase-IV) (SIDA, USAID, IDA, NORAD/UNFPA)
04. National Institute of Population Research and Training (NIPORT) (Phase-IV) (GTZ, USAID, IDA, AVSC)
05. Training of TBA (Phase-IV) (IDA, UNICEF, Netherlands)
06. Warehousing and Distribution System of the MCH & FP Programme (Phase-IV) (USAID, IDA, ADB)
07. Establishment of Union PWC and Reconstruction of Rural Dispensaries (Phase-IV) (IDA)
08. Strengthening of IEM Activities (Phase-IV) (UNFPA)
09. Strengthening of MIS Activities (Phase-IV) (CIDA)
10. Mohammadpur Fertility Service and Training Centre (Phase-IV) (SIDA)
11. Community Participation in National FP MCH Activities (IDA)
12. Construction of FP Stores at Thana Level (USAID)
13. Project Finance Cell (Phase-IV) (IDA)
14. Management Development Unit(Phase-II) (ODA, NORAD, Netherlands)
15. Establishment of Condom manufacturing Plant in Bangladesh
16. Construction of Health and Population Bhaban (IDA)
17. Health, FP & MCH Related Innovative Programme(Phase-II) (IDA, NORAD)
18. Construction & Maintenance Management Unit (Phase-IV) (IDA)
19. Strengthening of MCH Training Institute at Azimpur & Lalkuthi Sub Centre (Japan)
20. MCH Coordination Cell (NORAD)
21. Reorganization of Health & FP Programme (Study) (IDA)

New: Investment

22. Project Monitoring and Supervision Unit (IDA)
23. IUD Manufacturing Project (UNFPA)
24. Metropolitan Dhaka F.P. Satellite Project
25. Construction of 64 Districts Family Planning Office cum Resident (Phase-I)

On-going: Technical Assistance

26. Comprehensive Community Family Health Project Rajshahi (Bogra) (FRG)

27. Strengthening BIRPERHT Institutional Capacity Development (Ford Foundation)
28. Computer Based MIS in the District FP Offices (UNFPA)
29. MCH Bases MR Programme (SIDA)
30. Norplant Continuation of Clinical Trial in Two Centres Ford Foundation)
31. Support for Research and Other Activities of BIRPERHT (CIDA, Ford Foundation)
32. Health Economics Unit (ODA)
33. Development of Antishigella Drug from Plants of Bangladesh(IDA)

New: Technical Assistance

34. Local Initiative Programme (LIP) (USAID)
35. Introduction of Laperrosopic Technique in Bangladesh (IDA)
36. Community Education on Maternal and Neonatal Health (UNICEF)
37. Introduction of Low Dose Oral Pill in Bangladesh(CIDA)
38. Gender Training for F. P. Personnel (UNFPA)\
39. Technical Assistance for Inter-Sectoral Project (UNFPA)
40. Survey of Physical Condition of the Existing Union FP MCH Infrastructure (CIDA)

B. Agency: Rural Development & Cooperative Division

On-going: Investment

41. Strengthening Population Planning through Women Co-operative (Phase IV) (IDA)
42. Use of Rural Co-operatives in Family Welfare and Population Control (Phase-IV) (UNFPA)

C. Agency: Ministry of Social Welfare

On-going: Investment

43. Use of Mother Centres for Population Activities (Phase-IV) (IDA)

D. Agency: Ministry of Women's Affairs

On-going: Investment

44. Women's Vocational Training Programme for Population Activities (Phase-IV) (IDA)

E. Agency: Statistics Division

On-going: Investment

45. Population and Housing Census 1991 (UNFPA, Netherlands)
46. Health Demographic Survey and Vital Registration (UNFPA, IDA)

On-going: Technical Assistance

47. Follow up Census Project (UNFPA, Netherlands)

F. Agency: Ministry of Information

On-going: Investment

48. Population Planning Cell in Bangladesh Radio(Phase-IV) (IDA)
49. Population Planning Cell in Bangladesh Television (Phase-IV) (IDA)

G. Agency: Implementation Monitoring Evaluation Division (IMED)

On-going: Technical Assistance

50. Population Development and Evaluation Unit (IDA, USAID)

III. Sector: Social Welfare, Women's Affairs & Youth Development

Project Titles (Source)

A. Agency: Directorate of Social Services

On-going: investment

01. Institute for Correctional Services
02. Expansion of Medical Programme
03. Bangladesh Institute of Research and Rehabilitation in Diabetics
04. Community Based Family Development Project (NORAD, Netherlands)
05. Establishment of Braile Press and Artificial Limbs Production for Centre for Physically Handicapped Children
06. Expansion of Programme Activities of Bangladesh Shishu Academy
07. Expanded Rural Social Services (Phase-IV) (UNICEF, EDM)
08. Community Based Family Development Programme for Education & Maintenance of Orphan Children (NORAD)
09. Community Based Rehabilitation Programme for Disable Old, Physically Handicapped and Distressed (NORAD)
10. Institute for Mentally Retarded Children, Chittagong
11. UCD Programme for Welfare and Rehabilitation of Children in Especially Difficult Circumstances (CEDC) (UNICEF)

New: Investment

12. Conversion of Existing Sarkari Shishu Sadans into Shishu Paribars (Phase-II)
13. Development and Expansion of Training and Rehabilitation Centre for the Distressed and Vagrants Home
14. National Heart Foundation Hospital (Japan)
15. Development of Bangladesh Association for the Aged and Institute of Geriatric Medicine
16. Assistance for Local NGOs for programme Development

17. Training and Rehabilitation of Socially Handicapped Women & Released Prisoners
18. Expanded Rural Social Services (Phase-V) (EDM)
19. Establishment of a Planetarium in Shishu Academy, Dhaka (Japan)
20. Expansion of Integrated Educational Programme for Blind Children
21. Training & Rehabilitation Centre for Socially Handicapped Women in 4 Divisional Head Quarters

On-going: Technical Assistance

22. Consultancy Services for Special Education Programme for the Dis abled in Bangladesh

New: Technical Assistance

23. 11th ASIA-PACIFIC LEADERSHIP. Training Seminar in Capacity Building Toward Equality and Full Participation of the Disabled in Society

B. Agency: Directorate of Women's Affairs

On-going: Investment

24. Women Support Centre (NORAD)
25. Day Care Services for Children of Working Women (DANIDA)
26. Integrated Programme for Participation of Women in Income GeneratingActivities and Legal Aid Assistance
27. Rural Women Employment Generation Project (ADB)
28. Self Reliance Project for Rural Women

New: Investment

29. Community Based Programme for Poor Women & Children through NGOs (Phase-IV) (WFP)
30. Advocacy Awareness & Strengthening Information Base for WID (Phase-II) (UNICEF)
31. Urban Based Women Development Project
32. Home Based Enterpreneurship Development for Rural Women
33. Livestock Training Centre for Rural Women
34. Rural Women Project
35. Career Women's Hostel

On-going: Technical Assistance

36. Technologies for Rural Employment with Special Reference to Women (Phase-I) (ILO)
37. Technical Support from OISKA Fourth Agriculture Training for Women in Bangladesh (OISCA, IDB, Japan)
38. Strengthening Planning Capabilities of Ministry of Women's Affairs (DANIDA)

New: Technical Assistance

39. Technologies for Rural Employment with Special Reference to Women

C. Agency: Directorate of Youth Development

On-going Investment

40. Unemployment Youth Training & Self Employment Project
41. Establishment of Youth Training Centres
42. Thana Resource Development & Employment Project (Thardep) Phase-III) (Revised) (ADB)
43. Technical Training Project for Unemployed Youths
    New: Investment
44. National Youth Centre (Phase-I)
45. Involvement of Youth Clubs in population Planning & Income Generating Activities (IDA)

On-going: Technical Assistance

46. Staff Development Training Materials Research & Development (ADB)

New: Technical Assistance

47. Promotion of Human Resources Development Self Employment & Poverty Alleviation Programme for the Youth (UNDP)

Section C

Population Programme and Policies

Family Planning Programme

Field Level Problem Identified

Population Programme and Policies

Bangladesh is characterized by high birth rate, high mortality and morbidity rates and high rate of population growth. The population of Bangladesh today is, according to 1991 census, 108 million with an annual growth rate of about 2.2 per cent. Estimated crude birth rate of about 36 and crude death rate of about 14 per 1000 for 1989 reflect the scenario. Other demographic indices include high infant mortality of 110 or so per 1000 and life expectancy at birth as low as 52 years. At the present rate of growth the population would be 130, million around the turn of the century. GNP per capita of the country of $ 160.00 is among the lowest in the developing world. More than four-fifths of the population live in rural areas, based largely on subsistence agriculture, and absorbing more than 70 per cent of the labour force. Land holding is 0.29 acre per capita and more than 70 percent Population are living on agriculture. More than half of the population is landless. A third of the labour force remains unemployed and under employed. Nearly 85% of the population is below the poverty line in terms of availability of basic needs and pervasive malnutrition. About three-quarters of the women population live in rural areas and are the most disadvantaged group-educationally, socially, economically. These circumstances put policy makers and development planners of the country in a great challenge in making definitive investments for improvement in the quality of life of the population.

Evolution of Family Planning Activities

Family Planning (FP) efforts in Bangladesh began in early fifties under voluntary auspices of a group of social and medical workers. Categorical FP programme emerged during Third Five Year Plan of the erstwhile Pakistan Government. A national population policy was initiated in Bangladesh in the immediate post liberation, this policy was oriented, among others towards decelerating population growth with fertility regulations.

Organizationally the Family Planning Programme in Bangladesh Has passed through a number of transformations. Five distinct and broad phases may be identified as : (a) Private and voluntary clinic-based programme with little government support (1953-60); (b) Family planning services through government health care facilities (1960-65); (c) Large scale field based government family planning programme administered by an autonomous board (1965-75); (d) MCH-based multi-sectoral programme (1975-80); (e) Functionally integrated health and family planning programme emphasizing MCH, PHC and FP as a package.

Progress in Family Planning Activities

Despite the formidable predicament of resource constraints of various kinds, high infant mortality, economic insecurity, traditionalism in cultural and social orientation, low level of literacy and urbanization, lower status of women, in short, a 'below threshold' level of development of both fertility and mortality decline, progress has been made in several crucial areas like

: (a) Adoption of a national population policy; (b) Adoption of a multisectoral approach within the broad-based population and development framework; (c) Creation of a definite administrative infrastructure from the national headquarters down to the local level; (d) increased resource allocation for population and related activities; (e) Strong policy commitment at the highest level of the government; (f) Development of a large number of service infrastructure with about 3500 Union Health and Family Welfare Centres in the countryside; (g) recruitment, training and development of a large fleet of outreach workers; (h) A significant headway with respect to nationwide awareness about FP programme method and message of small family norm; (i) A modest but by no means non trivial gain in contraceptive dissemination and use.

Subsequently targets were set with respect to population size and to attain replacement level facility. As of mid-1976 the goal was to bring down the existing number of children born per woman from 6.4 to replacement level by 1986, and a population of 121 million by 2000. However, the overall achievement remained very low.

Service Delivery Organizational Structure

The MCH-FP objectives of the Fourth Five Year Plan (1990-1995) were :

To reduce	From (1990)	To (1995)
Maternal mortality	5.7 per 1000 live births	4.5 per 1000 live borths
Infant morality	110 per 1000 live births	80 per 1000 live births
Neonatal mortality	80 per 1000 live births	60 per 1000 live births

These objectives were to be achieved through the MCH-FP package of services including such interventions as ante natal care, safe delivery, post-natal services, immunization, distribution of Vitamin A, supply of oral rehydration solution (ORS), health and nutrition education, family planning motivation, supply of contraceptives and follow-up. The MCH-FP services are presently delivered largely through the Directorate of Family Planning, while some, like distribution of Vitamin A capsules and ORS packets, are delivered through the Directorate of Health Services; both the Directorates functioning under the Ministry of Health and Family Welfare. Immunization programme is carried out jointly by the health and family planning staff through a process of functional integration at different levels.

In addition to the overall programme, several specific measures have been adopted to promote family planning programme and family planning staff through a process of funtional integration at different levels. Moreover, some of family planning programme include a national training and supervision programme for 40,000 Traditional Birth Attendants (TBA) and the strengthening and expansion of service delivery infrastructure through provision of MCH/FP services at 1905 Union Health and Family Welfare Centres, 1200 Rural Dispensaries, 600 hired Clinics,

86 Maternal and Child Welfare Centres (MCWC), 347 Thana Health Complexes 64 District and Teaching Hospitals and more than 100 NGO clinics scattered all over the country. The field of activities of these NGOs include : (1) Community based distribution programme (CBD); (2) Clinical services; (3) CBD cum clinical services; (4) Family Palnning integrated with income generation, MCH and nutritional activities; (5) Research and evaluation; (6) Social marketing of contraceptives.

Many NGOs have been directly involved in population control activities for at least a decade, with an officially recognized role since 1976. There are 547 small and large NGOs currently engaged in family planning activities.

Population and Family Planning Policies

In 1982, the government undertook a review of the population control programme and identified the barriers and constants that were impending the progress of work. Following the review the government introduced a number of policy measures and administrative steps, such as : (a) introduction of a system of functional integration of Health and Family Planning Services; (b) Reconstitution of National Population Council into a powerful cabinet Sub-committee, headed by the chief Executive; (c) Decentralization of authority to various family planning committees set up at different levels; (d) Declaration of health and family planning as a transferred subject to the Upazila parishad; (e) Expansion of physical infrastructure for institutionalization of service delivery system; (f) Simplification of administrative and financial procedures; (g) Formulation and implementation of supervision guidelines; (h) Strengthening of logistic and supply systems; (i) Identification of three MCH priorities, such as EPI, ORS and TBA training; (j) Establishment of a system of quick monitoring of field performance in respect of service delivery and logistic supply; (k) Greater involvement of NGOs in family planning activities; (e) Declaration of 'National Population Day'

As a result of the above mentioned measures the programme efficiency and performance has improved. Despite slow progress in the first two years, the Second Five Year Plan Period (1980-85) registered nearly two million sterilization operations, one million IUD insertions, and achieved altogether 24 million couple years of protection (CYP). An estimated five million births were averted during the second plan period. The general population has now a largely favourable attitude to the programme, and awareness of atleast some contraceptive method is nearly universal among the adult population. One out of every three eligible couples in the country is found to be currently contracepting; and two out of every three are users of some contraceptive method. The demographic effect of such a scenario has begun to emerge.

However, it appears that the CPR level at the end of the Third Five Year Plan (June 1990) had remained somewhat below the original goal (40 per cent of eligible couples), with correspond-

ing consequence in terms of less rapid fertility decline than envisaged.

The implementation strategy for the Third Five Year Plan was : (i) Integration of health and MCH-FP service delivery system at the periphery, (ii) Provision of a wide variety of contraceptive choice on a voluntary basis; (iii) Adoption of a multisectoral approach aimed at meeting the basic needs and enhancing family welfare, child survival, reducing maternal mortality and malnutrition for creating and environment conducive to small family norm and lower fertility; (iv) Enlisting community support and participation through involvement of non-government voluntary organizations (NGOs); (v) Equipping the family planning personnel, particularly the service providers, with necessary knowledge and skills through appropriate training; and (vi) Emphasis on operations and evaluative research to monitor the programme implementation.

In principle these strategies will be pursued in the Fourth Plan as well. However, they need to be strengthened and broadened considerably in the light of the experience of earlier plans.

Goals of the Fourth Five Year Plan.

The Fourth Plan has commenced since July 1990. The overall development goal of the plan is to improve the quality of life of the people of Bangladesh. the main directions of the plan are : (1) Consolidation and further development of PHC and MCH-FP infrastructures; (2) Strengthening of quality, quantity and range of health and family planning activities; (3) Strengthening the technical and managerial capabilities to sustain and increase efficiency; (4) Increasing participation of private sector including NGOs in health an family planning activities; (5) Mobilization of resources -man, money and material- to achieve the goal of HFA/ 2000.

The overall goals of the MCH-FP programme during the plan period are : (1) To reduce maternal mortality rate from 5.7 in 1990 to 4.5 in 1995, infant mortality rate from 110 per 1000 live births in 1990 to 80 in 1995, and neonatal mortality rate from 80 per 1000 live births in 1990 to 60 in 1995. (2) To reduce the growth rate from 2.16 in 1990 to 1.81 in 1995, and corresponding CBR from 35.2 to 30.1 and CDR from 13.6 to 12.0 per 1000 population. (3) The target for CPR by the end of the plan period has been set at 45% ; this would correspond to the TFR level of 3.9 which would still be nearly twice as high as replacement level fertility (two child family, roughly speaking). (4) To reach the ultimate goal of net reproduction rate (NRR) of 1 by the year 2005.

Population pressure has been rightly identified as the number one problem of the country, and as such the Government of Bangladesh has taken a decision to launch a nationwide social movement and mobilization in the population field. The National Council for Population Control is one such mechanism. Further mechanism at national, regional, local, and individual levels will have to be evolved to translate the mission of mobilization in effective terms. This would be vital to bring 'less ready' segments of the population under the purview of the programme, and sustain the performance over time.

Family Planning Programme

As it might appear, the core of the national family planning programme consists of a few basic components and these are :

a. Organization and Management
b. Logistics and Supplies;
c. Information, education and motivation
d. Service Delivery including MCH; and
e. Management Information System

These five components have been brought together under the overall umbrella of the Directorate of Family Planning headed by Director General who is assisted by six Directors and a Superintendent of MCH Institute. The Directorate of Family Planning is a permanent set-up operation through officers at 5 Divisions, 64 Districts and 464 Thanas under revenue budget of the Government. The Director General, Family Planning (DGFP) as the chief Programme-Manager administers the programme through six Directors, each responsible for the area, namely, Administration, Logistics and Supply, IEM, MIS, Finance & Accounts and MCH Services as well as several Project Directors. The Programme extends beyond the horizon on Director General, Family Planning and has important components like Training, Research, Evaluatiuon, and Civil works (construction, maintenance etc.) The programme-functions of training and research (also evaluative studies) have been incorporated in the National Institute of Population Research and Training(NIPORT) of Ministry of Health and Family Welfare (MOHFW), while project evaluation, population projection and demographic analysis have been the main functions of Population Development and Evaluation Unit (PDEU) of Planning Commission; both the NIPORT and PEDU are still development project of the Government. Reimbursement of project aid and auditing of project expenditures are done by the Project Finance Cell of the Ministry.

The national programme stretches beyond the MOHFW. It has involved NGOs and a wide range of development agencies including Women Affairs, Rural Development, Cooperatives, Agriculture, Education, Information, Labour, Social Welfare and Voluntary workers Village Defence Party workers. The policy that guided the multi-sectoral approach along with NGO involvement was that, family planning is a "Social Movement" and should be by all means, community based.

A Division in the Ministry with the nomenclature of " Population Control and Family Planning Division" was created in August 1975. A Planning Cell in the Division for preparation of plan, and formulation of projects and ADP was set-up in 1976. Also, a Project Finance Cell attached to the Division of management, reimbursement of IDA credit and project aid and monitoring of its status was created. The Division was responsible for executing about 25 projects directly and co-ordinating the implementation of another 30 population projects under various development Ministries.

A Directorate of Population Control and Family Planning headed by a Director General was created and made responsible for implementation of the country-wide Population and MCH activities. District offices were also strengthened by creating two additional posts of Assistant Directors. The post of Sub-Divisional Family Planning officer was also created to

strengthen supervision. As already mentioned, 18,000 TBAs were trained by 1990.

The recognized District Organization became effective with its roots below, as contained in government Memorandum issued on September 29, 1978 for expanded family planning and MCH service delivery at the District level and debate below.

a. Training and Research: Massive training programme for training of paramedics, namely, Family Welfare Visitors (FWVs) and field staff, namely, FPAs (4,500) and FWAs (13,500) was taken up. As many as 12 FWV Training Institutes were established at the district Headquarters, and 19 Training Centres for field workers' training were set-up. Simultaneously, construction of 8 FWVTIs and 19 Training Centres were taken up with World Bank and NORAD's assistance. A National Institute of Population and Training (NIPORT) was established. Later, the scope of the organization was broadened to encompass Research and its nomenclature was subsequently changed to National Institute of Population Research and Training (NIPORT). The Government also took steps to integrate population related subjects including clinical contraception in the curriculum of medical students and internees at Medical Colleges. Among the major research undertakings, mention may be made of Bangladesh Fertility survey (BFS) in 1975 and 1989, Contraceptive Prevalence Survey (1979). And a good number of studies were contracted out to BIDS, ISRT, BFRP and other research organizations. It may also be noted that an External Evaluation Unit (EEU) in the Planning Commission was established to objectively evaluate all population related sectoral projects and programmes.

b. Service Delivery: The Plan for establishment of Union level Family Welfare Centres was centred around delivery integrated and comprehensive health care, MCH and Family Planning services. This strategy is a milestone in the implementation of a viable programme for the vast rural masses. The deployment of full time field workers at Union, Ward level, along with a broad range of contraceptive and other services including breast-feeding, and late marriage campaign added a new dimension to the Population Control Programme.

Further the establishment of 8 Model Clinics attached to Medical College Hospitals and Mohammadpur Model Clinic in Dhaka for training as well as service delivery was a step forward towards programme expansion both qualitatively and quantitively.

c. Information Education and Motivation (IEM) : IEM activities received special attention with the involvement of the Ministry of information. Every day a 70 minute programme on family planning was broadcast by Radio Bangladesh. Publication of feature stories and articles in national dailies, persuasive person to person communication, display of bill boards, distribution of booklets, pamphlets, film shows, seminers, syposium and orientation of religious leaders, community influential and extension agents were held with intensified efforts. Under a pilot project, 1900 Radio-sets were distributed to encourage the listening habits of model farmers and co-operative managers in 19 thanas. Folk Talent Teams were organized throughout the country in order to catch the imagination of the people towards the small family norm.

d. Multi-sectoral Programmes: During 1976-80 multi-sectoral population activities were organized in several sectors, namely, Labour and Social Welfare, Education, Agriculture, Local Government, Women's Affairs and also the Planning Commission. Activities included forma-

tion of mother's centres, women's cooperatives, introduction of population education in the regualar curriculum of educational institutions, orientation for industrial labourers, primary school, secondary school and Madrasha Teachers, Vocational and Training for Women's Groups, orientation and involvement of agricultural extension workers.

A Critique of the Population Policy

Bangladesh Population Policy has developed over the past few decades with a grave concern on rapid population growth, with the major focus being on population control and family planning motivation and service delivery. The policy was, however, marked by adhocism and based on uni-directoral approach in early 1970s. While the population problem was thought to be a social problem, the solution sought was more through an administrative approach than a sociological one.

Since the last decade and particularly during the 3rd Five Year Plan period, Bangladesh Population Policy encompassed a broad range of areas such as:

a. Health and MCH service delivery: greater emphasis was laid on Primary Health Care, maternal and child welfare, reduction of infant mortality along with maternal mortality.

b. Informal and out of school education and literacy: Promoting education and literacy particularly for females to contribute to the process of fertility decline.

c. Women's Development Programmes: promoting the cause of women's development through means including raising their status involvement of more women in labour force, income generation activities for women and main streaming of women in decision making processes;

d. Community paricipation: under the decentralization administration of the Thana Parishad and Union Parishad, develop local institutions with community support for their active participation in institutionalising small family norms, social legitimacy of contraceptive practice, late marriage, recognition of equal rights for women in every walk of life.

e. Socio-eonomic Measures: Adopt social and economic measures and innovative approaches including non-family planning measures for the benefit of the community in support of small norms and responsible parenthood.

f. Multi-sectoral approach: In order to cope effectively with the multi-faceted population problems, multi sectoral approach with the involvement of various Ministries & Agencies, was adopted and a co-ordination mechanism was developed for multi-sectoral activities.

g. Involvement of NGOs: Promoting the role of NGOs to complement and supplement the Government efforts.

h. Mobilization of political commitment: Promoting political support and social commitment to generate national consensus for transforming "FP as a Social Management".

It was, however, observed that the population policy lacked the required thrust for actionable interventions and a sense of urgency. More words were perhaps said, than action taken in providing due momentum to the national programme. Ever since independence, and even before in the Pakistan era, national leaders have provided strong support for the national family planning programme. Presidential speeches at the Parliament, Cabinet and the public places have extended clear support to the programme, and this has undoubtedly provided impetus for activities on the ground. What has been missing, however, is a politically supported chain of command that reaches from the President's office to the village to provide a backbone for multi-sectoral programmes that are otherwise spread over several ministries. Key factors in the programme lack mechanism for Marshalling political leadership for village development activities that villagers can relate to as a group. Strong support at the top has yet to be translated into a grass root movement with links to national parties, development programmes, or local government. And the conclusion was that political action in Bangladesh even with a positive and supportive family planning policy, followed over the several decades of the history of the nation.

The Organizational Structure of health and family planning poses serious structural problems in an anomalous situation relating to an overall integration of administrative, programmatic and also developmental planning. It has been observed that the organizational structure of health and family planning is complex. At the top a singular command of a Secretary and a Minister exist and at the bottom, there exist multi-purpose village level workers. Although efforts to streamline this structural anomaly had been made several times, no satisfactory outcome emerged . In fact, considerable overlap exists in the delivery of services relating to MCH, FP and Primary Health Care. Some studies (BRAC 1990) have reported that various attempts to create a unified chain of command have failed, not because health and family planning are separate, but because staff in the two wings have concerns about their relative bureaucratic rank, tenure, and authority. Independent international experts are of the view that the present administrative reality, however, is that lines of authority are confused, supervision is weak, and morale is low. Official exhortations to correct operational problems have had little impact on underlying systematic problems. In the overall scenario, the bureaucratic culture with past heritage (pre-liberation days) was attributed to be largely responsible for not being able to hasten the process of basic structural change towards integrated services, unified lines of authority, strong supervision and a sense of equity, security in services and equal opportunity in career planning. These are, however, not the only factors against quick changes towards improvement that required sacrifices.

Field Level Problem Identified

A group of experts drawn from government as well as non-governmental organizations was assigned to review and analyze the existing family planning and MCH programme, identify field problems, formulate strategies and design interventions to meet more effectively the challenges of accelerated growth of population and poor mother-child health status with high rates of maternal and infant mortality and morbidity.

The group of experts drew a detailed action plan. (See' A Report by Expert Group for Field Action-Plan 1993, Bangladesh National Family Planning and MCH Programme') The issues identified for the action plan are as follows :

Issues identified for action plan for field levels Family Planning and MCH Programmes are:

I. Improving performances of the Family Welfare Assistants (FWAs) :

1. The FWAs' work-load is disproportionate to their levels of operation. FWAs are currently assigned with 44 different jobs.
2. Levels of commitment and participation to work differ between FWAs Majority of the FWAs have not received adequate training.
3. Nationally, on an average, 36% of the households have been visited by FWAs in six months.
4. Some positions of FWAs are still vacant.

II. Strengthening assessment, planning and mobilization of logistics and service delivery :

1 (a) Physical Maintenance of FWCs are often not satisfactory

(b) Continuity of supply of essential drugs in FWCs are often interrupted.

2. Shortage of transport and funds, and lengthy financial procedures impede transportation of logistics at district, thana and at levels below.
3. Contraceptives not preferred by clientle are now in over supply :
   a) IUD CT- 380- is comparatively less preferred than IUD CT-200;
   b) NET-EN is preferred to DMP pharmacologically;
   c) Low dose pill with second generation progesterone like levonorgestrin and desogestrin is preferred though cost may be more in comparison to first generation pill like Norethindron.
4. Improve quality of service delivery by :
   a) strengthening clinic and follow-up counselling;
   b) reducing drop-outs ; and

c) enhancing better case management of complications and side- effects.

5. Increase coverage and use of FWC services in the community :
   a) FWCs are relatively underutilized;
   b) Combined management of FWCs by MA, FWV and Pharmacist is weak;
   c) Community is unware of all the services available from FWCs.
6. Pricing of Contraceptives to encourage cost sharing
7. Strengthen Monitoring: to check use of logistics, and reduce duplication of services at unit (ward) level.

III. Making field supervision problem-specific and timely :

1. Supervision is ineffective because :
   problems of the field are not identified as specific indicators to improve field performances; frequency and timely field supervision is absent; and feedback and interaction between supervisee and supervisor reflecting status of solution of field problems is also lacking.
2. Supervision of FWC, satellite clinics and EPI sessions :
   a) Sr. FWVs do not adequately supervise the satellite clinics,
   b) MO (MCH-FP) do not supervise the Sr. FWVs and FWCs systematically.
3. Action on supervisory reports are hardly followed-up :
   a) Disciplinary actions in the form of reward and punishment focusing on field supervision are seldom initiated and followed through.
   b) Monitoring the status of supervision at field level is not planned and systematically pursued.

IV. Training

a. (1) Inadequate interpersonal communication skill.
a. (2) Inability to segment clients
a. (3) inability to use IEC materials appropriately.
b. (1) Poor skill in the use of FWA register.
b. (2) Poor skill in report preparation
c. Lack of facilities for continuous training
d. Inadequate need based refresher training for FWA, FWV, FPI
e. Lack of motivation, specially for FPI towards job performance.
a. No systematic coordination between HA and FWA in EPI camps and between FWV and FWA in Satellite clinics.
b. Ineffective Coordination between NGO and FP at the Thana or Union level.

V. Local level target setting and MIS

a. Targets at the Union level are sometimes set with little or no participation of FWAs, FWVs and FPIs.

b. Irregular and improper submission of reports and returns.

c. Poor quality of data.

VI. Community participation

a. Non-functioning of Ward, Union and Thana FP/MCH committee.

b. Less programmatic efforts on community mobilization and participation.

Remarks: From our field experiences during the survey conducted during Oct-Nov 1994 we have observed few of the above mentioned issues. The JICA/JOCV team found that the proposed action plan yet achieved its objectives.

Percentage Distribution of Contraceptives Users by Method in Developed and Developing Countries and Bangladesh

Method	Developed Countries	Developing Countries	World	Bangladesh
Female Sterilization	10	33	26	8.5
Male Sterilization	5	12	10	2.1
IUD	8	24	19	1.9
Hormonal Pills	20	12	15	22.8
Condom	19	6	10	4.0
Hormonal Injectables	-	2	1	4.5
Vaginal barrier metods	3	1	2	-
Rhythm	13	5	7	7.9
Withdrawl	20	3	8	2.1
Other methods	2	3	2	12.6

Source: United Nations, 1989.
Bangladesh Demographic and Health Survey 1993-94 (Preliminary Report), 1994

Remarks:

The table above shows higher percentage of use of hormonal injectables and traditional methods. The use of IUD is markedly low. In comparison to other developing countries the rate of both male and female sterilization is also much lower.

Section D

Role of NGOs and Private Sector in Health Development

Role of NGOs and Private Sector in Health Development

Presently, a large number of NGOs are working in Bangladesh and their role in accelerating the process of social and economic development is well recognized; government considers the NGOs and private sector as partners in national development. this collaborative effort was started in late 1950s by the Family Planning Association. it played a vital role in motivating the government to take up family planning activities as an official progamme. In the area of health, a number of NGOs have provided very useful assistance to the government programmes, such as EPI, diarrhoeal disease control, distribution of vitamin A capsule for blindness prevention, tuberculosis and leprosy control, nutrition, environmental sanitation, etc. The private sector is also playing an active role, particularly in curative health care although their efforts are concentrated mostly in urban areas. Its potential in the promotive and preventive health care and financing of health services is yet to be mobilized.

The non-government sector of Bangladesh represents vast potential resources to expand health and family planning services and to improve the internal efficiency of both the systems. A strong non-government sector is particularly important because of the fact that it can be instrumental (i) to substitute private resources for currently used public resources and re-allocate the public resources to areas of greater priority, (ii) to use the competitive influence of the private sector to further improve the efficiency of the public services, and (iii) to expand total resources devoted to health care. Since the private sector has the potential to supplement limited public resources, a collaborative government and non-government delivery of health services and FP-MCH programmes are encouraged. In addition to the existing services at the tertiary and secondary levels, the non-government sector should be encouraged to extend their services to the rural areas.

Beginning in the mid seventies, the activities of NGOs in the field of health and family planning began to expand. They mainly supplement and complement the government health development efforts. Their activities were mainly directed towards promotive, preventive, curative and rehabilitative health care and promotion of family planning services. Some NGOs have independent programes, while others are helping in strengthening the government programmes. The activities of the NGOs in the community have created an impressive rapport with the people. It is well recognized that the NGOs with their operational flexibility and concentrated focus at the grass-root level, have the ability to reach the poor effectively through need-based programmes.

Categories of NGOs

Voluntary health agencies operating in Bangladesh can be grouped as : (1) Groups that focus on specific diseases (e.g., Diabetic Association, Tuberculosis Association, Cancer Society, Opthalmological Society, Bangladesh Cardiac Society etc.) or on specific population groups

(e.g., Family Planning Association, Association for the Aged, Pediatric Association etc.); (2) Professional Associations (e.g. Bangladesh Medical Association, Public Health Association, Nursing Association etc.); (3) A more service oriented group (e.g. Rotary Club, Lions Club, Red Crescent, Bangladesh Rural Advancement Committee, Gonoshasthya Kendra, Bangladesh Association for Voluntary Sterilization, etc.; (4) Funding agencies (e.g., Rockefeller Foundation, Ford Foundation, Sasakawa Foundation etc.)

On the basis of their nature functions, NGOs may also be classified into other distinctive types. Such types include: (i) Relief and welfare NGOs; (ii) Service NGOs; (iii) Funding NGOs; (iv) Technical support NGOs; (v) Networking/coordinating NGOs, (vi) Development NGOs. A categorical list of selected NGOs working is health and family planning sectors is given in Table 1.

Table 1.

Categorical list of selected NGOs working in health and family planning sectors

Community Health/ Nutrition	**Health and Family Planning**	**Maternal and Child Health & FP**	**Family Planning**
A. Foreign NGOs	*A. Foreign NGOs*	*A. Foreign NGOs*	*A. Foreign NGOs*
1. Helen Keller International	1. The Asia Foundation	1. Save the Children Fund (USA)	1. The Path Finder Fund
2. Concern Bangladesh	2. Family Planning International Assistance (FPIA)	2. Save the Children Fund (UK)	1. Association for Voluntary Surgical Contraception (AVSC)
3. CARE		3. Save the Children Fund (Australia)	
4. Food for Hungry International		4. Radda Barnen	
5. Rangpur Dinajpur Rural Service (RDRS)		5. Enfants DU Monde (EDM)	
B. Local NGOs	*B. Local NGOs*	*B. Local NGOs*	*B. Local NGOs*
1. Aga Khan Community Health Care Project (AKCHP)	1. Bangladesh Women's Health Coalition (BWHC)	1. Kumudini Welfare Trust of Bangladesh Ltd.	1. Bangladesh Association for Voluntary Sterilization (BAVS)
2. Community Health Research Association (CHRA)	2. Family Development Services & Research (FDSR)	2. Bangladesh Association for Prevention of Septic Abortion (BAPSA)	2. Concerned Women for Family Planning (CWEP)
3. Bangladesh Rural Advancement Committee (BRAC)	3. Community Health Care Project (CHCP)	3. Bangladesh Association for Maternal & Neo-natal Health (BAMANEH)	3. Family Planning Association of Bangladesh (FPAB)
4. Ganoshasthya Kendra (GSK)	4. Menstrual Regulation Training and Services Programme (MRTSP)		
5. Voluntary Health Services Society (VHSS)			
6. Bangladesh National Society for the Blind (BNSB)			

To ensure effective delivery of health and family planning services to the poor, the NGOs have either strengthened the existing health care system or have developed appropriate institutional structures and mechanisms. Some NGOs have developed the systems of providing these services to the poor through outreach centres, while some others have channeled their efforts through static centres. The special programmes of NGOs have in fact, developed systems and institutional structures for creating a sustainable health care system at the community level through people's participation.

NGOs achievements.

Many NGOs have been directly involved in family planning and MCH activities in Bangladesh; some are also involved in the overall health development. the government initially only allowed NGO activities in the urban areas, but of late, NGOs have been allowed to work in rural areas. NGOs are generally engaged in community based distribution (CBD) type of activities, but a few of them are carrying out specialized functions. For example, Bangladesh Association for Voluntary Sterilization (BAVS) is focusing its activities on surgical contraception; Bangladesh Association for Maternal and Neonatal Health (BAMANEH), Bangladesh Association for Prevention of Septic Abortion (BAPSA), Bangladesh Women's Health Coalition, etc., are mainly engaged in reproductive health care, providing services and training on menstrual regulation (MR) and prevention of septic abortion. BRAC and CARE are engaged in training and universal child immunization. The Swanirvar family planning project, which focuses on community development through self-reliance, works primarily in rural areas.
NGOs account for around 37% of the contraceptive distribution/supply in Bangladesh. The bulk of that contribution is by two agencies: The Social Marketing Company (SMC) and BAVS. SMC provides around 45% of the NGOs contraceptives. It supplies around two-thirds of all condoms and 18% of all oral contraceptives through a network of 89,000 outlets for commercial distribution. BAVS performs around 30% of all sterilizations, thereby accounting for around 38% of the NGOs contribution. Menstrual Regulation Training and Services Programme (MRTSP) provides most of the menstrual regulation training to doctors and paramedics through their existing 12 MRTSP centres located at medical colleges and selected district hospitals.

Determinants of services of NGOs.

From review of selected NGOs evaluation reports, several important factors responsible for success of NGOs could be identified. These include, flexibility, effective control on employees through flexible policy of hiring and firing, good training, supportive supervision. close monitoring, uninterrupted supplies, community involvement, better worker population ratio, better incentives to service providers and others.

Brief Description of a Few NGOs Operating in Bangladesh

Bangladesh Rural Advancement Committee (BRAC). Establishment in 1972, BRAC has emerged as the largest national level NGO, and with its 5205 (2974 full-time and 2231 part-time) workers claims itself to be one of the largest NGOs in the world. Initially it started with rural development activities, but later on it diversified its operations to include major efforts in health and education. Its contribution to the development of cost-effective programmes of service delivery is well known. Many of its programmes have been replicated elsewhere in the country. It is now working in 147 thansas of the country. BRAC has provided technical assistance to the government in pertinent areas. By December 1990 BRAC had 93 branches with a membership of over 300,000, half of whom were female. The outreach workers had reached 12 million household comprising 75 percent of the rural population.

The main programme areas of BRAC include; (i) Community health; (ii) Family planning; (iii) Agriculture; (iv) Education; (v) Income generation; (vi) Credit disbursement. The family planning, which was one of its priority programmes in early days, has been discontinued. BRAC has been implementing a new programme, the Women's Health and Development Programme (WHDP) since the period 1991-1993.

Its community health programme consists of ; (i) Nutrition (nutrition education, monitoring and surveillance, motivation for cultivation of nutritious foods, vit. A capsule distribution); (ii) Immunization ; (iii) MCH (Registration of pregnant mothers, birth registration, growth monitoring, promotion of breast feeding training of TBAs); (iv) Rural; sanitation.

Gonoshasthya Kendra (GK). GK, which began operations in Savar, close to Dhaka in 1972, has over the period of time extended its activities to cover many parts of Bangladesh. It has, 1,106 (378 males and 728 females) full-time workers on its pay roll. Its primary focus has been the development of an integrated low-cost and sustainable health care system in the country catering to the rural poor, and run mainly through para-professionals and TBAs from the local community. At present it covers a population of 319,860 in 299 villages under 8 upazilas (subdistricts).

The programme areas covered by GK include: (a) Community health services, MCH and family planning, (b) Agriculture; (c) Small scale industry; (d) Rural development; (e) Income generation; (f) Primary and adult education; (g) Relief and rehabilitation; (h) Drug manufacturing; (i) Printing and publishing; (j) Consumer monthly magazine.

The components of health sector programme run by GK are : (i) Health education; (ii) Nutrition

(nutrition education, promotion of breast feeding, nutritional; surveillance, distribution of vit. A capsule) (iii) Family Planning (promotion and distribution of contraceptives community and clinic based services, training of field workers); (iv) MCH (registration of pregnant mothers, nutrition of education, screening of at risk mothers and referral, training programme for TBAs, clinical services, ante natal and postnatal care, promotion of breast freeding, growth monitoring and nutrition); (v) Immunization, (vi) Safe water and sanitation ; (vii) Provision of essential drugs.

Some of the project approaches of GK have been replicated in other parts of the country by other agencies and GK itself.

Bangladesh Fertility Research Programme (BFRP). BFRP established in 1976, contributes to the national programme by conducting acceptability studies and recommending introduction of advanced contraceptives methods in the programme. In addition, BFRP conducts operations research on clinical family planning programme and on reproductive healt issues in the context of Bagladesh. They also conduct training to promote incountry biomedical research capability among medical personnel and mid-level NGO personnel, and generate their interest in indigenous research in the reproductive health field. Over a period of 14 years, BFRP has developed an efficient mechanism for the introduction and scientific evaluation of newer contraceptive technologies through its nation-wide network of investigators. BFRP is entrusted with the responsibility to identify and test fertility control procedures that are simple, less costly, and can ensure satisfaction. BFRP is capable of providing qualified facilities to test pilot interventions, developing surveillance and reporting systems for family planning and MCH care and, evaluate other clinical systems for government and non-government organizations. BFRP shares its research findings through publication of technical reports, newsletter, proceeding of conference, policy reviews and international journals.

Cooperatives for American Relief Everywhere (CARE). The CARE was created in 1946 for the purpose of sending foods from American donors to war-devasted Europe. After the war, its programme area was enlarged and extended to other countries Established in 1949 in Bangladesh, it has a total of 1408 full-time workers. In addition to the main office in Dhaka it has 15 sub-offices in the country.

CARE's health sector programmes in Bangladesh include : (1) Health education; (ii) Nutrition; (iii) Immunization; (iv) MCH; (v) Family planning. It is also involved in other programmes, sich as agriculture, education, income generation programme, institution building and rural development.

Diabetic Association of Bangladesh. The Diabetic Association , established in 1956, was renamed as Diabetic Association of Bangladesh (DAB) in 1971.
DAB runs by a 26-member National Council. The day -to-day management is carried out by a Director General under the guidance of the President and the Secretary General of the Association. The Council takes decisions on policy, planning, finance and development.

The objective of the association is provide comprehensive diabetes health care which would enable a diabetic to live a full and socially productive life The ultimate goal is to ensure prevention and control of diabetes and rehabilitation of poor and unemployed diabetics.

The activities of the association include : (1) Delivery of free clinical and laboratory services; (2) Education and training program for diabetes and their family members; (3) Social welfare service which takes care of social, economic, and other problems of the patients; (Rehabilitation services particularly for the poor juvenile diabetics, and young and widowed women without families and employment; (5) Conduct basic and applied research; (6) dissemination of information through the publication of journals and bulletins.

The principal health care service center of DAB is the Institute of Research and Rehabilitation in Diabetes, Endocrine and Metabolic Disorders (BIRDEM), located in the capital city of Dhaka. In addition, DAB has established 21 branches in the country.

Helen Keller International (HKI) Established in 1979, the HKI in close collaboration with the institute of Public Health Nutrition, impart nutrition education and rehabilitation programme. They are involved in the distribution of vitamin A capsule, and promotion of consumption of vegetables rich in vitamin A, health education by using IE materials through mothers, health workers and other trainees. It is also involved in the assessment of nutritional status through survey in selected areas of the country.

Bangladesh Association for the Aged. Established in 1960, the association moved to its permanent headquarters in 1985.

The aims and objectives of the association are : (1) To look after the health and welfare of the aged persons so that they may remain physically healthy and mentally cheerful; (2) To arrange for meeting their basic needs, such as food and nutrition, shelter and clothings and recreational requirements, (3) To raise public awareness and promote development of a community-based system of care for the aged; (4) To assist the government in the formulation of a national policy for the elderly; (5) To on uct surveys/studies to define the magnitude and nature of the problems of the elderly in the counter, and to plan and conduct field operational research covering the

various facets of the old-age problem; 96) To conduct seminar/workshop and other training programmes for those who are involved to provide necessary care to the elderly at different levels-primary, secondary and tertiary levels; (7) To provide free health care services to the aged people; (8) To arrange dissemination of information and education through publications of periodicals and magazines.

In order to achieve the above objectives the association has been and implementing various activities for the welfare of the elder by in Bangladesh. it has established branches in several districts and has plan to extend its activities all over the country.

The association is a member of the Australian Association of Gerontology, and of the International Federation on Aging.

Future Work Plan of NGOs in Bangladesh.

The Third Five Year Plan of Bangladesh laid great emphasis on introducing innovative NGO activities in order to make family planning and health programmes more dynamic and to generate additional demand for MCH-FP services. The government followed a policy for the promotion of NGO and looked at it as a partner in progress. This has continued into the Fourth Five Year Plan

At present the growth of local NGOs at the district and upazila levels is quite encouraging. The Government of Bangladesh is supportive of such development. the Ministry of Health and Family Welfare (MOHFW) has set up district level coordination commottee for better coordination of NGO activities relating to health, FP and MCH. At the upazila level, the upazila coordination committee and the upazila family planning committee encourage the participation of NGOs and ensure coordination of activities. Large NGOs receive their supplies and commodities from the central warehouse of the Family Planning (FP) Directorate through direct lifting systems. Small NGOs generally receive supplies from local district FP stores.

During the Fourth Five Year Plan, the government policy is to promote the participation of private sector including the NGOs in various health and family planning activities, and the existing mechanism for coordination at various levels will be further strengthened for this purpose.

An NGO affairs Bureau has been set up to provide service to foreign funded NGOs, and it is expected to simplify and hasten the registration and project processing system. Other NGOs not receiving foreign funds will, however, continue to follow the existing procedure laid down for them. It is expected that an depth study will be undertaken for assesing the range and coverage

of health services being provided by the NGOs and private sector and to identify gaps that need urgent attention . A joint effort of the public, private and NGOs will be of extreme importance to facilitate the best use of available resources for health development in the country.

On this premise, NGOs in health can play very important role in the promotion an development of community health care in Bangladesh to meet the critical health needs of the rural population. In addition, they can promote various policy decisions of health care, and respond to major events shaping or effecting the health system of the country. They can help also government set up activities or systems which are innovative in nature and pilot testing of implementation plans. These activities may include a wide spectrum of health planning and management system, and dissemination of health issues, problems and interventions to sensitize various groups, such as general public, medical and paramedical personnel. NGOs can organize forum on selected issues of health care which has significant bearing on the health of the people living in both urban and rural areas; these may include women and health, health and welfare of the elderly and handicapped, strengthening of rehabilitation efforts, environmental health, and traditional system of medicine.

In order to avoid duplication of community based distribution (CBD) type of work , the NGOs should rather specialize in specific areas and be innovative in strategies, service delivery and demand creation. The areas may include intensification of health education activity, delayed marriage movement, education on breast-feeding, nutrition, and training/orientation of religious leaders or some other innovative and pioneering work including income-generating activities for women which government organizations cannot quickly undertake.

NGO Services and activities in Bangladesh

Community -based Distribution of Contraceptives (CBD)	Door to door distribute pills and condoms, referral of clients for clinical GOB an NGO clients, MCH and nutrition and education collaboration with EPI for immunization of children and women and follow-up services, limited home delivery of IUD and injectables.
Clinical	Provision of clinical contraceptions-VSC (Vasectomy and tubectomy), IUD, Inj. and immunization of children and women, treatment of side-effects, ante-natal, post-natal care and other care.
CBD and Clinical	Both distribution of contraceptive methods and provision of selected MCH services.

Training and Orientation	Training of program managers, physicians, paramedics, TBAs,fireworkers and supervisors, both basic and refresher, of GOB and NGO, orientation of GOB officials and elected representatives of local bodies.
Research and Evaluation	Trial and Introduction of new methods, research on various contraceptive technology, OR studies, evaluation of service delivery and management both by CBD an d clinical approaches.
IEC for Increased Acceptability Family Planning and Building Norm for 2-Child Family	Door to door education of women, production of training and information materials, booklets, documentary films, mass media-radio, television program in family planning, involvement of community leaders including religious leaders, promotion of 2-child families by holding receptions for 2-child couples at national and local levels, Street Rally on Family Planning, and Family Planning Fair on Population Day; promotion of delayed marriage, FP Caldar, Field worker's Guide. Field worker's guide has been replicated in the national program since November 1989.
Coordination and decentralization	Coordination amongst NGOs and between NGOs and Govt. orientation of elected public leaders towards decentralization of effective implementation of the population policy by holding seminars, conferences and workshops.
Involvement of Youth,	Imparting population educated to out-of-the drop-out.
Women, Religious leaders	Youths, promotion of delayed marriage, family life education and small family norm in the context of religion; vocational training and income-generation for women; religious leaders and graduates are involved and employed

NGO Contributions and Accomplishments :

NGOs contributed to the introduction of the concept of family planning and of contraceptive technology in Bangladesh, After the NGOs were successful in having the government adopt a population policy in 1976, they continued to work more aggressively with the government in making family planning services increasingly available at the community level and in educating the clients and the community in accepting and using available family planning services.

The MIS Unit of the Directorate of Family Planning, in its October 1989 report, showed that, overall, NGOs contribute 36.5 per cent to the total CYP in Bangladesh. In terms of method specific contributions, the NGOs contribute 24.6 per cent in the performance of voluntary surgical contraception, 13.4 percent in IUD, 19.4 percent in injectables, 40.0 percent in pills and 70.0 per cent (including Social Marketing) in condoms.

The most recent external evaluations (conducted during 1986-1990), report a range of contraceptive prevalence rate (CPR) from 45 to 56 per cent in the NGO project areas, with CPRs of over 60 per cent in some urban areas (Table 2).

Table 2 :

Recent Contraceptive Prevalence Rates in NGO Project Areas Estimated by External Evaluators, 1986-1990 an dCPS 1990.

Evaluators and Year	NGO	CPR	Sample Size
Mitra Assoc., 1986	FPSTC Projects	45.3	1, 397
Mabud, 1986	Swanirvar Bangladesh	47.0	450
Alam, 1987	EDM	50.0	200
Rahman, et al 1989	GOBand NGO Project	44.9	1, 600
Kamal, et al 1989	TAF Subprojects	50.1	1, 650
Kabir, 1989	PF Projects	46.2	1, 511
E-W Centre, 1990	NGO Projects	56.3	12, 986
CPS, 1991	National Programme	39.9	9, 745

The secular trend of increase in CPR during 1981-1990 in NGO family planning project areas is very impressive : in 1981 the NGO project areas had a CPR of only 19.5 percent which rose to 34.4 percent in 1986, and again in 1990 it rose to 56.3 percent (Table 3).

Table 3 :
Trend of Coverage of Population, Eligible Couples, Active Users (Figures in thousand) and CPR in NGOs Projects, 1981-1990

Coverage	1981	1986	1990
Total Population Covered	4, 939	16,355	20,000
Eligible Couples	539	2,945	4,000
Active Users	105	1,012	1,707
Contraceptive Prevalence Rate	19.5	34.4	56.3

The 1991 CPS reports a national CPR of 40 percent. Compared with the national CPR, the NGO CPRs are much higher. Though the NGO activities are concentrated in limited assigned geographic areas, they are making an important contribution to the national FP programme in terms of provision of services and added as much as 25 percent to the overall national CPR.

Following an NGO demonstration that intensive field worker outreach could produce significant acceptable of FP, both government and other NGOs adopted the labour-intensive home-visit model. As a result, field workers account for 42.4 percent of all non-clinical methods users in 1989, up from 30.6 percent in 1986 (1989 CPS). Accoding to 1991 CPS, field workers account for 42.4 percent of all non-clinical methods users in 1989, up from 30.6 percent in 1986 (1989cps.). According to 1991 CPS, field workers account for 64.3 percent of all non-clinical methods. Use of non-clinical methods was significantly higher among women who received field worker visits than those who did not in both urban and rural areas. More significantly. women who received field worker visits were also more likely to use Family Planning methods not supplied by the field worker and less likely to be non-users of any method than women who were not visited by field workers. Policy makers and program managers strongly feel that maintenance of prevalence depends on maintenance of outreach (Foreit and lacey, 1991).
Despite of the substatial increase in contraceptive prevalence, many observers still qualify the demand for family planning as "fragile". The most important characteristics of demand for contraception in Bangladesh is in its FP services. NGOs have demonstrated that effective delivery of family planning services can turn "fragile" or "latent" demand into effective demand.

NGOs train their own clinical and community based program staff and in addition, offer

training to the goevrnment program staff. BAVS trained its own physicians, counsellors, paramedics, nurses, field workers, volunteers and government physicians. As of 1989, EPSTC trained 3,809 NGO staff-its own 3,181 and 628 from other NGOs. The staff include management supervisors, office assistants volunteers and field workers. The Concern Women for Family Planning (CWFP) provided training mainly to its own and other NGO field workers. FPAB trained 867 Imams (religious leaders), 3,926 volunteers and 300 staff of its own. The Pathfinder Internatioinal provided orientation and training to 313 Upazila Family Planning Officers, Family Welfare Visitors Training Institutes instructors, Medical Officers (MCH) and NGO program officers during 1988-1989.

The NGOs have done pioneering work implementing the government's policy of community involvement in family planning. implementation of family planning projects by the local level voluntary organizations are direct evidence of community participation in the family planning program.

In keeping with their tradition of greater community involvement, the NGOs have made a very good beginning and demonstrated their capabilities by activating the local Family Planning Committees.

The NGO evaluation in the area of making the local socio-political institutions such as Upazila and Union Parishad Chairman contributed significantly towards increasing the local level participation in the implementation of family planning program.

The NGOs have demonstrated that community-based female workers are efficient and cost-effective in the delivery of family planning and MCH services. the family planning NGOs played an important role in women development at teh community level. NGO family planning activities resulted in the creation of job opportunities for women at the community level : 7 out of every 10 staff are female. most of whom would be without work in the absence of the NGOs family planning programs.

The NGOs have contributed enormously to popularize the 2-child family goal of the national family planning a social movement.

MCH and Immunization : NGOs extended cooperation to the EPI in providing immunization to women and children, provide antenatal care, safe delivery, child care and nutrition education and distribution of vitamin A, iron tablets and ORS. to contribute to the effective use and continuation of contraception, the treatment of side-effects and other minor gyneacological problems is offered to women. Minor medical care and treatments are also provided to children.

The following list represents in sum the significant accomplishments of NGOs in terms of innovative family planning activities :

- Introduction of family planning and contraceptive technology in the country,
- Community involvement and strengthening decentralization efforts of the government,
- Management efficiency including effective system of supervision facilitated by all levels of field staff,

- Localizing family planning goals,
- Setting up of a Management Information System (MIS) which ensures accountability within a project for clients, commodities and funds,
- Development of field guides for field staff containing comprehensive information on contraceptives and contraceptive delivery, as well as side effects management, which is now being replicated in the national program,
- Training of different catagories of program staff, both NGO and Government,
- Utilization of professional groups and volunteers for cost-effective family planning promotion and delivery of services,
- Involvement of religious leaders in family planning,
- Demonstration that village-based female field workers (including part time workers) are efficient and cost-effective in the delivery of family planning services, and
- Reception to 2-child families to integrate small family norm into the social fabric. this reception provides an opportunity to give the 2-child family concept national prominence.

The NGO contributions have been recognized by the government.

To acknowledge and recognize the contributions of the NGOs in the field of family planning and MCHand to encourage them further, the government has given awards to 5 NGOs- one national level and 4 local level NGOs for their outstanding contributions to the progress of family planning program.

Future Challenge: Substainability

To-date, the NGOs rely on donor funds; they operate and implement projects with the financial support from their donor agencies. With the increase in the success of the family planning program, there has been a corresponding increase in costs resulting in a wide gap between the funds available and the cost involved. Moreover, the competing priorities and scarce resources may make it difficult for the NGO's a to continue to get the present level of funding in the future. Thus the widding gap between the cost and the available funds now presents a challenge to the NGO's sustainability for making their current and future plans to increase financial self-reliance imperative.

The NGOs have began to prepare themselves to face the challenge and be sustainable as soon as possible. While total financial self-sufficiency is not a realistic short-term goal, NGOs, nevertheless, have begun efforts to move towards financial self-sufficiency in two more immediate ways : (1) by reducing costs and becoming more efficient and (2) by generating revenues and recovering cost.

In a recently held workshop on sustainability of family planning NGOs participants divided into two groups held "brainstorming" sessions; one group generated cost-saving ideas and another group generated cost recovery and revenue production ideas.

The group that dealt with cost-saving generated the following ideas for further management efficiency :

- improving in the efficiency and impact of service delivery models by altering the worker-client ratio, expanding the range of methods, expanding the catchment area, investigating different staffing configurations;
- improving the quality of counselling and service care;
- mobilizing local resources in the form of in kind and cash contributions;
- improving collaboration and cooperation among NGOs and the government programs maximize the family planning resources by minimizing counterproductive competition and duplication; and
- using managment audits as an analytical tool to identify waste and inefficiencies in NGO operations.

It was encouraging to have found in the workshop that "cost consciousness" prevailed among NGOs and that efforts to reduce costs and increase efficiency had already begun by the NGOs. The group that pursued the area of revenue generation and cost recovery generated the following ideas :

- contraceptives sales and registration and service fees;
- the sale of laboratory services, technical expertise, family planning newsletter and publications, and NGO memberships;
- acquiring free land, medicine, labour, and buildings through community donations and NGO staff members;
- engaging in such commercial ventures as weaving, catering services, psciculture, and handicraft production; and
- maximizing revenues through investment income and bank interest.

Most of the family planning NGOs have started revenue generation activities through sale of contraceptives and fees for services with enthusiasm and seriousness. Some NGOs have generated donations of land, money, materials from the community donors

Focussing their efforts on issues such as cost effectiveness and self sustainability brings a number of related challenges for NGOs.

For example, should family planning NGOs undertake non-family planning, non-health, commercial ventures for income generation? Past experience suggest that unless NGOs can obtain the additional skills necessary to cope with the demands of income generation activities outside the scope of health and family planning, they should keep such activities consistent with the goals of the program.

Can more be done with less? The existing program can target hard to reach and special target groups, improve the quality of services and continued use, and prepare the young population for responsible parenthood.

NGOs have begun targetting hard-to-reach and special groups-newlywed couples, post-partum mothers, drop-outs, young and low parity couples, and non-acceptors (of contraception). Development of client-specific IEC and counselling material , for example, would facilitate serving these special target groups. The family planning program, both government and NGO, can benefit by mobilizing support from the satisfied users/acceptors groups, 2-child families who have received certificate and awards, influential male and female community levels among the hard-to-reach and special groups.

Continuation rates for various methods and method-mix must be improved. Improvement in quality of services and care are likely to serve as key to achieve improved continuation an dmethod-mix. The available family planning services must expand to include more services for addressing side-ef-fects and MCH services for immunization, pregnancy care and managment. safe delivery, post-natal care and medical care to children.

Bangladesh population age structure is heavily weighted by young population, every year a significant pool of young population enters into reproductive life without adequate orientation towards planned family. Population education activities including development of IEC materials for the youths, especially soon-to-be married youths need to be undertaken with high priority attached to it. The youths should be oriented to plan their future to include delaying marriage, spacing births and having no more than 2-children.

There are areas in the country, for example Chittagong division, which are still underserved and have significantly lower contraceptive prevalence than the other three Divisions of the country. NGOs-local, national, and international need to face the challenge of making family planning and MCH services as effectively available in Chittagong Division as they have done in other areas where they have been operating.

The dynamism of the NGO programme is contributing to the progressive reduction of three gaps-between knowledge and practice, between desired family size an dactual family size, and between the level of CPR and the expected level of TFR. However, there is no room for complecency and much more to do towards closing these gaps further in the NGO project areas. Its even more challenging for the NGOs to replicate their experience for a nation-wide impact in closing the gaps.

The above gaps shall continue to remain until the need for family planning services completes the transition from being supply-driven to demand-driven. To shorten the transition period is vital. In doing so, along with the attempt to achieving the goals of administrative and fiscal sustainability, rigorous efforts have to be continued to institutionalize the concept of small family-socially, culturally, politically, virtually in all facets of life and in every groups of the society. When such institutionalization is well grounded in the society, the "fragile" and "latent" demand shall have become crystalized and effective demand and contraceptive practice will increase and be demand-based rather than passive recipients of services and supplies.

The NGOs have proven to have a comparative advantage in developing and implementing effective and innovative approaches to service delivery. "NGO programs have played an important role in the national FP program, both in terms of its coverage and innovative approaches to service delivery. The government has adopted several of the NGO innovations such as reduction in worker-client ratio of 1:750; use of teh NGO-developed Field Guide; and improved record-keeping systems.

Nevertheless, as discussed above, NGOs face a number of challenges for the future : assuring that the NGO efforts for revenue generation an dcost recovery do not compromise quality of care and services for those who cannot afford to pay; increasing their method mix among clients; reaching hard-to-reach and special target groups; making family planning and MCH services available to underserved areas; closing the gaps between knowledge and practice, between desired an dactual family size, and between CPR and TFR; preparing the young population for responsible parenthood; and ultimately coping with the need for self-sustainability.

Section E

Working Bibliography on Health and Population Policy

List of Books, Report and Manuals etc., collected so far, and necessary for population control projects in Bangladesh

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