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BANGLADESH
PRIVATE SECTOR ASSESSMENT

Of Long Acting and Permanent Family Planning Methods and Injectable Contraceptives

October 2011

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ACRONYMS

BCC	Behavior communication change
BDHS	Bangladesh Demographic and Health Survey
BGMEA	Bangladesh Garment Manufacturers and Exporters Association
BMA	Bangladesh Medical Association
BMMS	Bangladesh Maternal Mortality Survey
BPMCA	Bangladesh Private Medical College Association
BSc	Bachelor of Science
CPR	Contraceptive prevalence rate
CYP	Couple years of protection
DCA	Development Credit Authority
DCB	Development Challenges Bangladesh
DGFP	Directorate General of Family Planning
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
GDA	Global Development Alliance
GDP	Gross Domestic Product
GHI	Global Health Initiative
GoB	Government of Bangladesh
IUD	Intrauterine device
KAP	Knowledge, Attitudes, and Practice
LAPM	Long-acting permanent method
MIDAS	Micro Industries Development Assistance and Services
MoHFW	Ministry of Health and Family Welfare
MSCS	Marie Stopes Clinic Society
NGO	Nongovernment Organization
NPC	National Population Council
NTC	National Technical Committee
OB/GYN	Obstetrics and Gynecology
OGSB	Obstetrical and Gynecological Society of Bangladesh
PMPA	Private Medical Practitioners Association
SHOPS	Strengthening Health Outcomes through the Private Sector
SMC	Social Marketing Company
SSFP	Smiling Sun Franchise Project
TFR	Total fertility rate
UNFPA	United Nations Population Fund
UPHCP	Urban Primary Health Care Project
USAID	United States Agency of International Development

EXECUTIVE SUMMARY

Bangladesh has made remarkable progress over the past 40 years in addressing population growth through a committed family planning program that has strong support from the highest levels of government and society. The key measure of this success is the extraordinary drop in total fertility rate (TFR), from 6.3 births per woman in 1975 to 3.4 in 1994, only 19 years (NIPORT et al. 2009, henceforth referred to as BDHS 2007). This decrease slowed significantly and it took another 16 years for TFR to come down to its current rate of 2.5.

Over the past decade, the country has changed considerably in many ways – gross domestic product, gross national income, and education levels all have risen significantly – and the health system is changing as well. There has been an explosion in the number of private health providers, both graduate and nongraduate; the number of local manufacturers of family planning commodities (of oral and injectable hormonal contraceptives), and the number of private medical colleges and institutes training doctors, nurses, and paramedics. Importantly, the Directorate of Family Planning (DGFP) of the Ministry of Health and Family Welfare (MoHFW), which led the successful family planning program through the 1970s and 1980s has come to realize, as expressed in the Health, Population and Nutrition Sector Strategic Plan 2011-2016, that the role of nongovernmental organizations (NGOs) and the private sector needs to be emphasized in order to meet all the family planning needs of the population.

As the DGFP continues to adjust and optimize its family planning program, there is recognition of the important role that long-acting and permanent methods (LAPMs) must play in order to reach its goal of replacement-level fertility (2.2 births per woman) by 2016 (HPNSSP 2001-2016). Currently, the vast majority of couple years of protection (CYPs) and the most significant percentage of the contraceptive prevalence rate (CPR) are met through oral pills and condoms, short-term methods that have high discontinuation rates and require high levels of behavioral consistency to be even moderately effective. Bangladesh has not been successful, overall, in promoting large numbers of family planning users to shift to LAPMs at different points in their reproductive years. Even women who indicate they have completed their families continue to rely on pills and condoms to protect against unwanted pregnancy and on freely available and inexpensive menstrual regulation procedures when they become pregnant.

The United States Agency for International Development (USAID) supports the government of Bangladesh, the MoHFW, and the DGFP in several ways related to the family planning program. This support includes a long-standing and successful commitment to the Social Marketing Company (SMC), which has built its brands and sources to provide for approximately 35 percent of the total CPR (BDHS 2007); a long-standing commitment to NGO service delivery for family planning, and reproductive and child health through the Smiling Sun Franchise project (SSFP); and technical support through other strategic programs like the Mayer Hashi and MaMoni projects, which address both family planning and maternal health through capacity building, policy, behavior change communication (BCC), and community mobilization.

The Strengthening Health Outcomes through the Private Sector project (SHOPS) was asked to assess and identify challenges and opportunities for USAID to make additional strategic investments that will accelerate the reduction in TFR through a reprioritization of LAPMs, including injectables, and a refocusing of private sector engagement – including NGOs and especially for-profit health providers. This assessment undertook a

comprehensive literature review, which identified research and knowledge gaps, extensive engagement of more than 45 stakeholders in 30 Bangladeshi and international organizations, government and donor agencies, professional and industry associations, and for-profit and NGO health providers, and focus groups with family planning clients and potential clients.

The findings of this assessment are a clear case for investing in LAPMs. It will have the effect of reducing general rates of discontinuation, reducing unwanted pregnancies due to imperfect use of a selected method, and ultimately contribute to the reduction of the TFR. The case for investing in the private sector is also clear and will have the effect of increasing access to these services among all quintiles which are already seeking other health services through the private sector.

The findings and recommendations of the assessment team are summarized in Table ES-1, and detailed in the report. Key among the findings are issues related to the rural reach of facilities and a growing gap in the qualified workforce, a lack of commercially available LAPM products and supplies, provider and consumer biases, and multiple dynamics that distort the market and prevent the development of a sustainable private sector market for these services. The Global Health Initiative (GHI) Bangladesh Program Strategy 2011-2015 includes themes of empowering local organizations and agencies and the leveraging of public and private partnership, among others, which USAID wishes to see integrated into its program investments and approaches. These themes are closely considered in the recommendations of this report, as the context of Bangladesh's family planning program is well situated to benefit from these approaches.

The GHI Bangladesh strategy outlines a results framework composed of three main intermediate results: increased use of effective family planning and reproductive health services, increased use of integrated essential population, health, and nutrition services, and strengthened health systems and governance. Each result has sub-results that aim to achieve Bangladesh's ultimate goal of stabilized population and improved health and nutrition for the country. Annex B analyzes the assessment's key findings and recommendations against the appropriate GHI sub-IRs illustrating the potential impact each short term and longer term recommendation would have in assisting Bangladesh to meet their GHI strategic objectives.

In general the assessment team recommends that USAID make priority investment in activities that support injectables and implants. There is a surge in interest and use of these methods among clients and providers, which represents an opportunity that should be leveraged. While implants, which are relatively expensive per unit, represent a funding challenge to the government, these two methods will lead women to recognize the value of LAPMs that don't require a daily or event-based behavior like pills and condoms. Other LAPMs, like intrauterine devices (IUDs) and sterilizations also are important in achieving a broad method mix for women to choose from, and there are some opportunities for USAID to make relatively quick investments in these. But these methods demand longer-term strategies and capabilities – re-positioning in the minds of providers and consumers, clinical skills, quality assurance – that are more complex than those for injectables and implants. These recommendations could be taken up as part of a more comprehensive strategy with longer time lines.

Table ES-1. Summary of Findings and Priority Recommendations

Key Findings	Recommendations	Short Term/Long Term	Key Actors Bangladesh	Note on Prioritization of Short-term Recommendations
Significant gaps of qualified public, NGO, and for-profit facilities providing LAPMs in rural areas	Leverage available USAID partners to extend services to rural areas while building the capacity of experienced national and local institutions to provide services more sustainably.	**Short Term** Support scale-up of NGO outreaches and satellite clinics to extend availability of services in rural and hard-to-reach areas. **Short Term** Build the counseling and referral capacity of the extensive number of nonqualified health providers in rural areas – often referred to as nongraduate medical providers. **Long Term** Support the government to contract out to national-level NGOs to support the operation of vacant community-level clinics and eventually build the capacity of district- and *upazila*-level organizations to operate these facilities in a sustainable way.	Marie Stopes Clinic Society (MSCS), SSFP, DGFP	These short-term recommendations represent opportunities to address the unmet need in rural areas relatively quickly. They could be implemented through existing or readily available USAID agreement mechanisms. SSFP has a platform of rural-reaching satellite clinics providing most LAPM services, which could be extended for additional operating days per month. MSCS could be engaged (through SHOPS field support) to increase the number of roving IUD and surgical teams.
Insufficient investment in the training of public, private and NGO providers in LAPMs, including new doctors through medical colleges	Extend training opportunities to NGO and for-profit providers.	**Short Term** Restructure the modules of the DGFP's new single curriculum to shorter time blocks spread over more days, timeframes that are friendly to the needs of private providers. **Short Term** Identify public-private partnerships to extend trainings to for-profit doctors, nurses, and paramedics through private associations and other channels familiar to private providers. **Long Term** Roll out trainings structured to the needs of for-profit providers through channels they are familiar with – private sector institutions. **Long Term** Integrate LAPM clinical and counseling skills into public and private medical colleges and clinical internships.	DGFP, National Technical Committee (NTC), Mayer Hashi, Private Medical Practitioners Associations (PMPA), others TBD	A lack of qualified workforce skilled in providing these services is one of the most significant barriers facing private sector provision of LAPMs. Addressing this issue is essential to achieving this goal. The two short-term goals are necessary first steps to rolling out trainings. These trainings could be done in collaboration with PMPA. The work with medical colleges requires relatively extensive level of advocacy and institutional.
Significant lack of awareness and misunderstanding of the policies and regulations affecting private providers' delivery of LAPM services	Improve communication and orient private providers on LAPM methods, policies on provider and facility certification, and social requirements.	**Short Term** Host district-level dialogues/orientations to bring together public NGO and private providers to better understand policies and one another's needs, challenges, and interests. **Long Term** Explore additional forums for public-private dialogue to clarify policies and regulations, discuss and improve the communication and application of policies and regulations and improve understanding between public and private sector.	DGFP, Mayer Hashi, Bangladesh Medical Association (BMA), PMPA, Obstetrical and Gynecological Society of Bangladesh (OGSB)	This issue is a priority to encouraging for-profit providers to invest in the provision of LAPMs. In line with a sequence to engaging for-profit providers to participate in trainings for LAPMs, they would need to understand the case and the dynamics surrounding these issues.

<table>
<tr><td rowspan="3">Large clusters of factories in and around Dhaka and Chittagong represent an excellent opportunity for public-private partnerships</td><td rowspan="3">Work with manufacturers’ associations to identify strategies for public-private partnerships that improve access to LAPMs for their members’ employees.</td><td>Short Term
Expand Smiling Sun, MSCS and UPHCP mobile clinics in garment factories to quickly capitalize on existing relationships and operations and logistics</td><td rowspan="2">BGMEA elected and secretariat staff, USAID, GoB</td><td rowspan="3">This represents a high priority and a significant opportunity. The engagement of this type of institution will likely take considerable time and require extensive protocol; however, the potential reach, impact, and visibility of such a partnership could be tremendous.
The larger-scale thinking of a GDA should be an end result of the consultative process described in the short-term recommendation. The large-scale corporate partners of the BGMEA could provide excellent opportunities to leverage significant funding.</td></tr>
<tr><td>Short Term
Initiate a consultative process with Bangladesh Garment Manufacturers and Exporters Association (BGMEA) to engage in a public-private partnership that meets the needs of BGMEA members and USAID and the Government of Bangladesh (GoB) in extending LAPMs through existing and potentially scaled-up primary health care facilities already in place.</td></tr>
<tr><td>Long Term
Long term: Establish a Global Development Alliance (GDA) involving BGMEA’s network of large corporate buyers, USAID, and the GoB that would leverage the corporate partnership and BGMEA member network on a significantly larger scale</td><td>BGMEA elected and secretariat staff, USAID, GoB, corporate partners TBD</td></tr>
<tr><td rowspan="4">LAPMs, especially IUDs, require significant repositioning and mainstreaming in the minds of both consumers and providers to achieve increased demand</td><td rowspan="4">Expand demand for LAPMs through focused promotion targeting consumers AND providers.</td><td>Short Term
Perform client centered market segmentation and provider knowledge, attitudes, and practice (KAP) study to understand users, non-users, and providers and effectively design and implement targeted communication activities.</td><td rowspan="4">DGFP, USAID, local research partner TBD</td><td rowspan="4">The gaps in knowledge and research related to both consumers and providers attitudes and behaviors are very broad. Market segmentation research would provide information useful to multiple stakeholders and should be a high priority. Some level of provider KAP study is essential to designing a provider behavior change activity – an important step to overcoming the biases preventing the increased utilization of LAPM methods.</td></tr>
<tr><td>Short/Long Term
Design and implement a focused interpersonal health provider behavior change initiative targeting private, NGO, and public health providers and all actors in the referral chain.</td></tr>
<tr><td>Long Term
Support the scale-up of post-partum IUDs and tubal ligations in high-volume private sector maternity providers.</td></tr>
<tr><td>Long Term
Coordinate strategic communication activities with the audiences and messages of the BCC campaign implemented through Mayer Hashi.</td></tr>
<tr><td rowspan="2">There is no supply of LAPM/injectables products accessible to for-profit providers outside of SMC and the government supply</td><td rowspan="2">Support a commercial supply of LAPM products available to for-profit providers not participating in the public sector supply chain or network.</td><td>Short Term
Support SMC to operate as a wholesaler of IUDs and implants, and distribute to the for-profit sector.</td><td rowspan="2">USAID, Nuvista Pharmaceutical</td><td rowspan="2">The Nuvista plan to create a network of pharmacies providing its soon-to-be-released injectable product will be the first truly commercial (SMC Blue Star is subsidized) network of injectables. Establishing a partnership model that supports the size and reach of this</td></tr>
<tr><td>Short/Long Term
Engage Nuvista to explore public-private partnership to make their products available to lower-income levels through their planned marketing network.</td></tr>
</table>

chain		**Long Term** Encourage plans for local manufacturing of injectables and importers of implants to distribute to the commercial market accessible to for-profit providers.		network without interfering in the market dynamics of its launch and distribution would be an innovative activity for USAID and provide health competition for the Blue Star network.
Access to financing is a barrier to for-profit providers' ability to expand and improve services. Banks are not lending to the health sector in a significant way	Develop a multi-sectorial program to partner with financial institutions to expand access to finance for the health sector.	**Short Term** Identify local financial institutions and conduct analysis to develop a DCA guarantee. **Long Term** Provide a package of technical assistance to financial institutions to lend to the health sector and support a DCA guarantee.	USAID/DCA, selected banks TBD	Many for-profit providers will require some level of financing to expand their facilities/operations to include LAPMs to an integrated service package. The steps required to make this financing more available should be undertaken simultaneously with steps to encourage their exploration of the market.
Many private health providers have limited business skills, making adding LAPMs in a financially sustainable manner a difficult task	Develop training and advisory services for private health service providers on business and financial management with a focus on adding LAPMs.	**Short Term** Conduct preliminary steps required for a roll-out of a training program for for-profit providers. Including developing a list of investment requirements, conducting market research, conducting a training needs assessment, developing a training curriculum, and identifying an appropriate local training partner.	USAID, PMPA, other financial and training partners TBD	This is a step required to both encourage for-profit providers to enter the LAPM service market and make them credit ready to expand their businesses appropriately.
Private health providers need to better understand the market, demand, and investment requirements before they enter the LAPM market		**Long Term** Pilot the training and conduct a training of trainers to build the capacity of the local training organization to roll out the training. Provide oversight to local partner in rolling out the training.		
Private health providers have weak market linkages. They operate in isolation, which makes it difficult to update them with information about LAPMs, and assist them to access resources to grow and improve services.	Strengthen market linkages to assist private health providers to access the information and inputs that they will need to add LAPMs and grow and improve their practices.	**Short/Long Term** Work with local partners to host private sector trade fairs that can disseminate information about LAPMs and create a forum for isolated private providers to meet peers, pharmaceutical companies, medical equipment suppliers, financial institutions, representatives of the MoHFW, donors, and USAID-funded projects, among others. **Long Term** Create an online platform that provides the foundation of a "linked-in" community of practice for private health providers that offer LAPMs. **Long Term** Build the capacity of associations to serve as champions in rolling out LAPMs among for-profit providers.	DGFP, PMPA, BMA, OGSB, USAID, pharmaceutical and medical supply companies	The short-term recommendation of hosting trade fairs is an important step to getting a significant numbers of private sector providers interested in exploring the LAPM market.

1. BACKGROUND

1.1 INTRODUCTION

Bangladesh is the most densely populated country in the world. A rapidly urbanizing population of 160 million currently exceeds a density of 2,600 per square mile – three times more than India, five times more than China – and the population continues to grow by more than 2 million people per year. Family planning and the total fertility rate (TFR) have been a very high priority for the Government of Bangladesh (GoB) since the country's independence, and while significant progress has been made there is still much work to be done.

The U.S. Government's Global Health Initiative for Bangladesh supports the GoB Strategic Plan for Health, Population and Nutrition Sector Development Program 2011-2016, and the role of the Directorate General of Family Planning (DGFP) of the Ministry of Health and Family Welfare (MoHFW) to increase access to quality family planning and reproductive health services and reduce the TFR. To achieve this, USAID and the GoB are engaged in a concerted effort to improve the mix, accessibility and utilization of family planning methods in Bangladesh with the goal of achieving the National Population Policy target of reducing the current TFR of 2.5 (NIPORT et al., 2010, henceforth referred to as the Bangladesh Maternal Mortality Survey [BMMS] 2010) births per woman to replacement fertility rate of 2.2 births per woman by 2015.

Key to achieving this is expanding over all utilization of long-acting and permanent methods (LAPMs) of contraception by improving the performance of the private sector (nonprofit and for-profit) to provide LAPMs, including injectables. The GoB recognizes the important role of both nongovernmental organizations (NGOs) and for-profit providers and is eager to identify best ways to engage them and encourage their role in this important national goal.

1.1.1 Objective of the Assessment

In order to achieve the TFR goal, USAID engaged the Strengthening Health Outcomes through the Private Sector project (SHOPS) to conduct an assessment designed to identify and prioritize support that can be delivered to select nonprofit and for-profit actors, which will expand LAPM services availability and utilization.
Specifically, the assessment was designed to:

- Determine which private sector organizations are well positioned to become or expand quality LAPM services. This may include for-profit providers, NGOs (especially those with large national reach), professional associations, for-profit hospitals and clinics, and private teaching colleges. It will also include exploring what level of clinical professionals are appropriate for providing different types of services, including counseling and clinical procedures.
- Identify and define the potential barriers, gaps, and needs that NGO and for-profit providers may face in becoming effective providers of quality LAPM services.
- Assess the potential demand for LAPMs through private sector providers (real/potential demand or perceived) and determine the needs for quantifying and segmenting the market to target it effectively.

- Develop and prioritize recommendations to fulfill provider and demand-generation needs and gaps.

1.1.2 Methodology and Lenses of the Assessment

The methodology used in doing this assessment is a process that starts with selecting appropriate lenses through which to explore and understand the total health system as it relates to family planning, and to view the private sector in the context of that system and a total market of public, NGO, and for-profit actors and clients. These lenses were applied to the literature the assessment team reviewed and to the stakeholders with whom the team engaged. The lenses were selected to best meet the specific objective of the assessment, the country needs, and other dynamics relevant to the design of the assessment.

The lenses selected for this assessment focused on LAPMs of family planning in Bangladesh are:

- Availability of services – including workforce capacity, policy and regulatory issues, and the presence and reach of facilities and providers.
- Market and demand – including description and structure of the consumer market for LAPM services, the met and unmet demand, and the influences and barriers to utilization.
- Supply of LAPM products – including contraceptive procurement, locally manufactured and imported products, and supply chain of products.
- Access to financing and business capacity – including private health sector access to capital and business skills and other resources needed to add and improve services delivery

The assessment had four main components. First, the assessment team did a literature review of over 50 documents related to the Bangladesh health system, family planning services, private sector health, financial sector, and major donor-funded programs of relevance to the assessment objectives. See Annex A for a bibliography of documents reviewed in this assessment.

Second, the assessment team intensively engaged stakeholders representing the different areas covered by the lenses established for the assessment. This engagement comprised 40 meetings with over 60 different stakeholders from government, NGO and for-profit health providers, the pharmaceutical and financial industry, USAID, leaders of relevant USAID and other donor-funded projects, family planning users and non-users, and other key informants. See Annex C for a list of the institutions and individuals who provided perspective and information to this assessment. Throughout the report findings are stated as the composite opinion from the many stakeholder engagements made during the assessment.

Third was follow-up with specific institutions and individuals to fill specific information gaps and to draft the findings and recommendations. This began with a debriefing meeting with USAID at the end of the stakeholder engagement process, at which preliminary findings and recommendations were presented. It continued through the report drafting process as different issues and gaps in information emerged.

Lastly, the findings and recommendations were reviewed by individuals identified as "sounding boards" for this assessment based on their broad understanding of family planning, especially LAPMs, some from a global programming perspective and others from deep knowledge of family planning challenges and successes in Bangladesh. This last step informed a draft report for review for comment by USAID and its key implementing partners (and later the final report).

1.1.3 Definitions

For purposes of this assessment, the following definitions are applied consistently throughout the report:

Private sector: Includes nonprofit NGOs and for-profit providers and other actors in the health system. This term is used only when referring to both.

For-profit: Includes only for-profit providers and other health system actors who derive revenue and profit from their services and products. This term is used when referring to only these actors.

Public sector: Includes only GoB-funded and -managed agencies, facilities, and staff. This term is used when referring to only these actors.

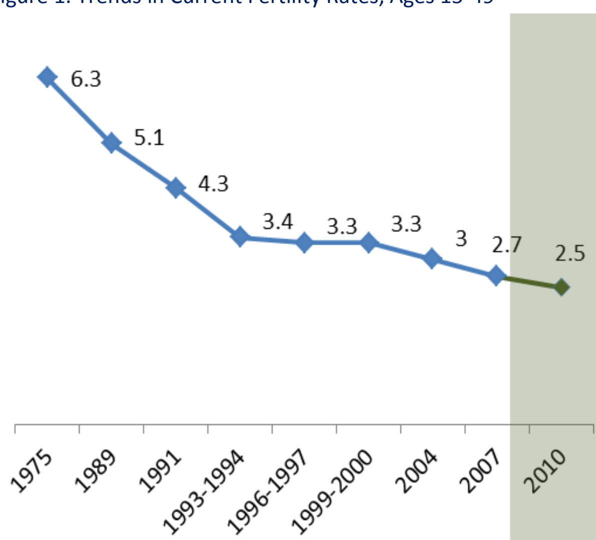
1.1.4 Organization of this Report

The next section of this report looks at family planning in Bangladesh, starting with the country's socioeconomic situation, its overall methods mix, its history of family planning efforts, with increasing focus on LAPMs, including clinical training and policy and regulatory obstacles to their use. A later section examines trends in the TFR and contraceptive prevalence rate (CPR) in Bangladesh. Chapter 2 enumerates assessment findings, and sets out steps that USAID and Bangladesh might take in the short and long term to encourage a private sector role in LAPM and other methods' use and more broadly in resolving the country's population issues. Chapter 3 concludes the report, with comments on sequencing of recommended activities.

1.2 BANGLADESH CONTEXT

1.2.1 Demographics and Economics

Figure 1. Trends in Current Fertility Rates, Ages 15-49



Data from 1975 to 2007 from BDHS. Data from 2010 from BMMS 2010

For many years, Bangladesh has been viewed as a family planning success story. The most densely populated country in the world achieved a reduction in TFR from 6.3 to 3.4 in just 19 years (Figure 1). This rate of reduction slowed and eventually plateaued for about 10 years before resuming its decline to the current rate of 2.5 births per woman (BMMS 2010).

The legal age to marry is 18 but many women marry at a younger age; the median age at first marriage is 16. Early marriage correlates positively with early childbearing, which in turn correlates with a high TFR (Population Dynamics Bangladesh 2010).

Average national population density of Bangladesh is 920/sq km. Rapid urbanization has made Dhaka the fastest-growing city in Asia and brought its population density close to 20,000/sq km. A rapid urban growth rate nationwide of 7 percent (GTZ 2010) also means that Bangladesh's urban areas have the fastest-growing number of people living in slums.

A full 40 percent of the population is below the poverty line and 40 percent is underemployed, despite an unemployment rate that fell from 5.1 percent in 2009 to 4.8 percent in 2010 and is expected to continue to fall. The three-year trend in gross domestic product (GDP) has been growth of between 6 and 7 percent per year, on par with the some of the best-performing economies in Asia – GDP was an estimated $1572 per capita in 2010 (IMF 2010), and gross national income was an estimated $580 in 2009 (World Bank 2010).

All of this economic growth represents a potential opportunity for a family planning program to make progress. There is a 17 percent unmet need for family planning services and products, coinciding with 63 percent of urban and 62 percent of rural women reporting they don't wish to have any more children and a phenomenal 99 percent of women who know of at least seven methods of family planning. Add to this the facts that less than 6 percent of women have accepted a permanent method and 8.3 percent are using ineffective "traditional practices" and it becomes clearer that conditions for improved private sector involvement in family planning and LAPMs exist. Nevertheless, adoption of these methods has been historically slow, and a tremendous amount of work is required to accelerate the pace.

1.2.2 Family Planning Method Mix in Bangladesh: The Importance of LAPMs to a Stubborn TFR

Different countries and cultures have historically adopted and evolved different family planning method mixes based on a variety of factors. Client needs and preferences are often thought of as the most influential factor, but often health providers are just as or even more influential. In Bangladesh this is certainly the case – assessments over the past several years, including the *USAID Family Planning Assessment 2010* and the *Long-Term and Permanent Methods of Family Planning in Bangladesh* report from 2007, link the evolution of the method mix to providers' attitudes toward and skills to provide different methods.

Oral Contraceptives: Pills continue to be the preferred modern methods among women of all education levels, and account for 30 percent of all CPR (BMMS 2010). The male condom was found to be the

second most preferred method among women with secondary or higher education (4.5 percent) (BDHS 2007).

The huge preference for pills in Bangladesh is attributable to a variety of factors. They are incredibly inexpensive and local manufacturers have been producing them for several years. Providers and family planning program professionals interviewed indicated that providers tend to prefer pills as they believe pills are quicker and easier to counsel, screen, and distribute; once prescribed, women can go to easily accessible pharmacies to purchase them. The popularity of condoms has more to do with the interest of male control over a method if and when a man is involved, and it is further driven by significant misinformation about the side effects of pills and other hormonal contraceptives, especially about the time it takes to return to fertility among couples who intend to have more children.

These short-term methods require a high degree of behavioral consistency to be most effective and that translates to a higher risk for unwanted pregnancy and contributes to higher rates of menstrual regulation, abortion, and maternal mortality. Pills and condoms also have the highest rates of discontinuation (even when controlling for discontinuation due to wanting to have a child).

Injectable contraceptives: Injectables have become an increasingly popular method among women of all education levels, moving from 7.0 percent in the BDHS 2007 to 12.8 percent in the BMMS 2010. This is likely in part a result of the change in policy to allow nongraduate medical providers (drug sellers and similar pharmacy staff with specialized training) to provide the method through for-profit pharmacies participating in the Social Market Company (SMC) Blue Star network. Injectables provide a certain level of freedom from a daily behavior of taking pills or event based behavior like negotiating and using a condom. Side effects are a one significant reason for discontinuation of injectables. Key informants interviewed feel that this can be overcome to a certain degree by improving providers counseling related to side effects, even if distributed through pharmacies.

Intrauterine devices (IUDs): Evidence from other predominantly Muslim countries indicates that religion is not necessarily a dominant factor in consumers use of modern family planning or the popularity of particular methods. In Jordan and Iran, IUDs are positively viewed and a significant part of the method mix, while hormonal based methods in general are less so. Egypt has a relatively more balanced method mix across IUDs and hormonal methods. In Afghanistan, Pakistan and Indonesia there is a significant history of family planning programs working with Imams and national religious councils to inform families of their options. In Bangladesh, a predominantly Muslim country, most key informants interviewed – especially health care providers and family planning program professionals - indicated that IUDs are negatively perceived among health providers and the population, which results in a very low level of use (0.9 percent) and a relatively high level of dissatisfaction and discontinuation (BMMS 2010). Only vasectomies have a lower rate of use (0.7 percent) among the total method mix in Bangladesh over the past 30 years. While it is difficult to pinpoint why IUDS have never developed a positive reputation in Bangladesh, negative provider perceptions have contributed significantly and we can ascertain from the context of other predominantly Muslim countries and a lack of significant religious institutional objection to the highly visible government and donor support of family planning that religion is not a major obstacle.

Because Family Welfare Visitors (FWVs)/paramedics have been permitted to insert IUDs from the beginning, doctors have considered these methods as not worth their time. While most veteran doctors who were trained in IUDs in their basic medical training feel they could easily insert one, many family

program professionals believe that more practiced providers perform better insertions. Discomfort is often a leading cause of discontinuation of IUDs.

While there was once a huge cadre of FWVs in public sector facilities trained to insert IUDs, there is an increasing number of vacancies across the public sector upazila health complex system and the lack of a acceptors of this method means that many trained IUD providers in both the public and NGO facilities don't have opportunities to keep their skills well practiced. This could lead to lack of or inappropriate screening or counseling and less-than-perfect insertions and contribute to dissatisfaction and discontinuation. Perpetuating this lack of qualified IUD providers is the fact that none of the 18 public or 45 private medical colleges currently train doctors in IUDs. Very few doctors trained in these colleges go on to specialize in Bangladesh – which, other than specialized training from the government or NGOs is the only place a provider would be trained.

Attempts to increase the availability and use of this method in the for-profit sector have not been very successful – most notably SMC's attempt to pilot IUD delivery through OB/GYN's participating in the Blue Star network has resulted in very few acceptors and significant drop-out of providers due to a lack of interest among their clients. One individual provider told the assessment team she has inserted only five in the past three years, despite having a relatively high level of patient flow through her clinic and being well regarded in her community.

Implanted contraceptives: The DGFP has noted a recent spike in the popularity of single rod implants, although it is too recent to be supported by data other than distribution numbers from the DGFP supply chain data. This spike is of some concern to the MoHFW, as could be difficult for the government to sustain the cost of too large an increase without planning for it through a procurement cycle. This method (pictured below) is primarily available through public sector facilities and large NGO networks like Smiling Sun Franchise Project (SSFP) and the Urban Primary Health Care Project (UPHCP), which receive all of their commodities through the public sector supply chain. A small percentage of implants are reported to be sourced through private hospitals, but these are likely facilities that are out of reach to low-income populations.

Preliminary indicators among the DGFP service statistics from this first half of 2011 show a small increase in tubectomies and vasectomies. This is after a significant decline from their utilization peak in the late 1980s. The introduction of nonscalpel vasectomies does not seem to have made a significant difference in their acceptance among men. The recent increase may be attributable a small, localized study that found that positive deviators promoting the method had side effect and communicated being more "sexually powerful" after vasectomies (Mayer Hashi Rapid Review of Cox's Bazar Sadar Upazila) Again, this "trend" is limited and recent, and no real research has been performed to explain it.

Increasing the availability and utilization of LAPMs will have the effect of reducing general rates of discontinuation, reducing unwanted pregnancies due to imperfect use of a selected method, and ultimately contribute to the reduction of the TFR.

1.2.3 Historical Perspective on the Drop in TFR

The remarkable success in reducing the TFR in Bangladesh over the past 35 years is due to three main factors, all of which are largely driven by a public sector infrastructure and system:

- There was high-level political commitment and positioning of family planning as a priority issue at the founding of Bangladesh as an independent country. This is best represented by the creation of a Directorate General for Family Planning, on an administrative line with the overall Health Directorate, and the creation of a National Population Council, which is chaired by the Prime Minister and includes the participation of all development involved ministers.

- Active support for the national family planning program from doctors and other cadres of health providers from the early days of the independent Bangladesh was driven in part by a sense of national cause and social welfare. Family planning and population control was a significant call to action for these providers who wished to contribute to national development goals, and as a means to this end LAPMs were perceived positively. During the stakeholder engagement process, the assessment team repeatedly heard anecdotes from retired public sector doctors that providers would boast about the number of vasectomies and tubectomies they performed.

- During these years, the government built a very significant infrastructure of upazila health complexes and community-level mobilization and service capacity. The tremendous number of FWVs and Family Welfare Assistants (FWAs) trained over the years were a huge force for promoting and providing family planning services. Later, organizations like BRAC, NGO Service Delivery Project, and SSFP developed large-scale community health worker and service promoter networks.

In more recent years, the structure of the health system has changed. While political commitment to family planning remains high, the public sector force that drove the remarkable reduction in the TFR has not been sustained.

1.2.4 Private Sector Health and Family Planning at a Glance

In Bangladesh, implants, IUDs, and surgical methods of family planning are provided almost exclusively by public and NGO providers; the few private providers of these methods are high end, and as such are not accessible to low-income people. Some of these high-end providers do tubectomies – often post-partum at expensive maternity facilities – and vasectomies.

For-profit providers have been a significant force for growth in the overall CPR – especially with the proliferation of pills and condoms sourced through registered pharmacies and other shops, which account for 40 percent of the 44 percent of total contraceptive use sourced through for-profit channels

(BDHS 2007). Injectables are increasingly available in the for-profit sector, but currently only through for-profit pharmacies that participate in the SMC Blue Star network, which receives and sells the product at a subsidized price. For-profit providers interviewed by the assessment team could not name a valid commercial source from which they could procure IUDs even if they wanted to provide the method. For LAPMs to be more accessible through the for-profit sector, qualified providers at small outpatient facilities, medium and large hospitals, and private maternity centers need to be engaged in a significant way.

Other significant dynamics of the NGO and for-profit health sector include the following:

- There are approximately 40,000 active doctors in Bangladesh, of which approximately 22,000 work in the for-profit sector (Bangladesh Medical Association, BMA). Many public sector doctors also work part-time in for-profit facilities.
- There was incredible success in establishing a local market for pills and injectables through the NGO sector and to a certain but lesser degree the for-profit sector.
    - *Manufacturing:* There are at least five local manufacturers of pills and all are planning to add production capacity. Many brands are available in the commercial market at different price points, include points accessible to the poor. One pharmaceutical CEO estimated that within two years, there would be no need to import a single pill to meet the demand in Bangladesh. There currently is one local manufacturer of injectables. Three other companies plan to begin production in the next 18 months to two years. However all four are only really interested in competing for the public tender of injectables and have no plans to try to move their products to the commercial market.
    - *Distribution:* There is a wide commercial distribution of pills through pharmaceutical detailing and retailing. Injectables have a solid distribution in the NGO sector through the SMC Blue Star network, but their increasing popularity could likely support a commercial distribution as well.
    - *Promotion:* Pills are widely promoted by the commercial market and SMC (through the margin SMC makes on subsidized products). The popularity of pills doesn't require much consumer-targeted promotion. Injectables are promoted quite heavily as part of the SMC Blue Star network. That promotion, and increased availability of the method through accessible cadres of providers, is making a difference in its acceptance – use has increased from 7.0 percent of married women (BDHS 2007) to 12.8 percent (BMMS 2010).

- Private sector sources account for nearly 44 percent of modern family planning methods currently used. However, 40 percent of that 44 percent is through pharmacies where only pills, condoms are available (injectables are available through approximately 4,000 for-profit SMC Blue Star network members out of more than 200,000 pharmacies nationwide) (BDHS 2007). The for-profit health sector is making important contributions to other health indicators as well – it is responsible for the majority of the 10-year steady increase in facility-based births, which increased from 8 percent to 23 percent overall, and 2.7 percent to 11 percent in for-profit facilities (BMMS 2010). While the private sector provides nearly half of all modern methods, it provides just 7.3 percent of LAPMs (BDHS 2007). This represents a huge disconnect that could be leveraged to the great advantage of improved availability of LAPMs. The significant barriers to for-profit provision of LAPMs means this huge segment of the health system continues to miss opportunities.

- The private health sector, in particular private pharmacies, is often a person's first point of contact with the health system. There has been a huge growth in the presence and reach of for-profit facilities – private hospitals and outpatient clinics, diagnostic centers, and pharmacies, many with consulting physicians – throughout the country, but especially in urban and peri-urban areas, and many are priced out of reach for lower-income segments. However, few of these facilities are registered to provide family planning services – which is required to receive products through the public sector supply chain – and even fewer have staff who are trained in LAPM services and whose skills are kept current by a flow of interested clients. (See Section 2.1.1 for additional discussion.)

- The number of private institutions providing medical education has grown tremendously. Only 20 years ago, there were less than 10 private medical colleges in Bangladesh; now, there are 18 public and 45 private medical colleges. These institutions are training doctors, nurses, and paramedics for both domestic and international job opportunities.

- Despite the aforementioned growth in private sector training and services, the for-profit sector is an insignificant provider of LAPMs, and NGOs could be a larger provider. While some NGOs like Marie Stopes Clinic Society (MSCS) and others funded through the USAID SSFP and the Urban Primary Health Care Project (UPHCP) make significant contributions to LAPMs, their geographic reach is limited and LAPMs – especially IUDs and surgical methods – are marginal to the CPR.

- The large industrial base in Bangladesh has begun to develop facilities and some capacity to provide a basic level of health services to factory employees. The best example of this is the garment industry, which is required to meet international standards of working conditions, including basic primary health care. While NGOs like MSCS have been providing mobile services in a limited number of factories for several years, the Bangladesh Garment Manufacturers and Exporters Association (BGMEA) has more recently established outpatient and soon hospital facilities to serve members' employees. These facilities are funded through member dues and ad hoc donations from both members and international buyers.

- Many for-profit health businesses are run by clinicians who lack formal business training and skills. For-profit providers who were interviewed wanted to understand the market and investment requirements for LAPMs and were interested in adding these services as part of a comprehensive package of health services.

- Many for-profit health providers also lack access to financing for growing their health business. The assessment team interviewed several of Bangladesh's largest banks, all of which indicated that the private health sector is an insignificant part of their lending portfolio. Even BRAC Bank, which

focuses heavily on small and medium enterprises, doesn't lend to the health sector in a significant way.

- For-profit health providers are disconnected from market information and networks, especially related to family planning and LAPMs. They often operate in isolation from one another and have difficulty accessing important resources that would help improve and grow their businesses.

1.2.5 ENABLING ENVIRONMENT

As discussed above, the public sector in Bangladesh traditionally has been the force driving family planning. More recently, the MoHFW has taken the positive step of acknowledging that it cannot meet the existing or unmet demand for family planning services on its own. However, despite this political support and interest in engaging the private sector, there are significant policy and related challenges to an environment that will enable an increased role for the for-profit sector in providing LAPMs.

- While the DGFP claims that there is no policy preventing it, there is no commercial supply of LAPM products available to the for-profit sector, with the exception of for-profit pharmacies participating in SMC's Blue Star network distribution of injectables. This effectively prevents for-profit providers from providing LAPMs and therefore sustains a negative feedback loop preventing the development of a market – pharmaceutical companies don't see the consumer market so providers don't have access to product and so don't invest in providing these services.

- All family planning products received through the DGFP supply chain must be distributed free of charge, as mandated by law. This creates a subsidized segment of the market and makes it difficult for for-profit providers to compete. NGOs are allowed to charge a service fee to clients for consultation and procedure, but cannot charge for the vast numbers of commodities distributed through their facilities

- There are increasing gaps in both the public and private sector health workforce and no system for tracking which cadre is employed where and what skills they may have been trained in and when.

    1. Every day more and more FWVs retire from public service as is required at age 57 (59 for freedom fighters). The government has not trained a new class of this very important health professional cadre in over 12 years.
    2. Recently the National Nursing Council licensed private training institutes to create programs for Bachelor of Science (BSc) in Nursing and to train FWVs, and the State Medical Faculty certified 13 private training institutes to train paramedics (a cadre similar to FWVs; however, the scale of these programs and the numbers of new health professionals they are producing will not be adequate to fill vacancies, known and unknown, in the public or private health sectors.
    3. Based on job security, nonsalary compensation and the permission to also work in the for-profit sector in off hours, there is a huge preference among health professionals to have a public sector position. Last year the government announced 5,000 open positions, and nearly all of them were filled with doctors who had been working in the for-profit sector. This regularly leaves gaps in the qualified workforce available to for-profit facilities.
    4. While NGOs are increasing the number and opportunity of trainings available to providers, the currently approved curriculum for basic and refresher skills of LAPMs is not conducive

to the participation of for-profit providers, who often find it difficult to be away from their clinics for several days at a time (Table 1).

Table 1: Family Planning-related Training

Method	Basic Training	Refresher Training	Available To
IUD	12 working days	6 working days	Nurses, paramedics, doctors (GP)
Sterilizations	18 working days	12 working days	Doctors (OB/GYN), GPs
Implanon, 1 rod preloaded	2 days	--	Doctors
Injectables	No specific	No specific	Nurses, paramedics, non-graduate medical providers

- A system of per procedure/per unit reimbursement distributed to the client, provider, referrer, and other staff in the facility where implants, IUDs, or surgical methods are provided is directly linked to the public sector projection and procurement of supplies funded through the common donor basket. This system is relied on by the system of clinic and community-level public and NGO staff – for some of whom the compensation represents a greatly needed complement to their regular salaries, especially community-level service promoters. Annex D presents a translated version of the DGFP circular itemizing the payments for clients, several cadres of providers and support staff, and different types of referrers at the community and other levels.

- The law maintains social requirements for LAPMs. These typically include a number of children a couple must have before using a LAPM and a post-partum wait period. While some of these requirements can be supported by cultural sensitivities related to the public's sense of family size and priority of child bearing to marriage, the justifications that are typically made in the name of medical science are not completely supported by the current research. These requirements have recently been revised (Table 2), but despite existence of a government circular on the new requirements, most health providers are unaware of the details.

Table 2: Revised Policies on Family Planning Methods

Method	Previous Policy	Revised Policy
IUD	Must be married, have one child. Wait 6 weeks post-partum wait	Must be married, have 1 child. No post-partum wait
Sterilization	Must be married, have two children. 2-year wait after second child	Must be married, have 1 child. No post-partum wait
Implants	Must be married, have 1 child. No post-partum restriction	Must be married. No child requirement
Injectables	Must be married, have 1 child. No post-partum wait	No change

- Policy dictating which health cadres can provide which methods are not consistent with global best practices. There are two priority issues:
    1. In most countries, doctors and degreed nurse/midwives are allowed to insert IUDs. In Bangladesh, doctors and BSc nurses but also paramedics – the level of FWVs – are allowed to do so. While it seems counterintuitive to suggest that fewer cadres be allowed to perform a procedure in the interest of expanding access, if a procedure is performed poorly and results in high levels of client dissatisfaction and discontinuation – not to mention risk of potentially severe complications – it will perpetuate the negative perceptions about the procedure.

2. In most countries, degreed nurse/midwives and doctors are allowed to insert implants, In Bangladesh, only doctors are allowed to perform this procedure. With the release of single rod implants, which come with a simple tool for subcutaneous insertion, this procedure has become greatly simplified over the previous multi rod products.

Both of these issues of cadre are related to a significant shortage of BSc nurses in Bangladesh, and their relatively low status among other health professionals in the country. FWVs/paramedics could easily insert implants and be trusted with the performing the clinical screening correctly.

In regard to surgical methods, there is no workforce policy issue related to the cadre permitted to provide surgical methods – doctors alone are permitted to perform these procedures, while FWVs/paramedics screen and prepare the procedure. Instead, the workforce issue that most affects these methods is a lack of doctors trained with actively practiced skills. While the Mayer Hashi project and others train doctors to perform vasectomies, the procedures are not regularly performed. Because doctors go for long periods without using these skills, the few procedures they perform may not go well and this contributes to the poor perception of the method.

- Low quality of services in public sector facilities, both actual and perceived by the population, is a pervasive problem. Reportedly, people fear infections from any complicated procedures performed in public sector facilities – a perception that would affect people seeking IUDs and surgical methods. While there also are reports of real and perceived low quality at NGO and for-profit facilities, people still see them as a safer option. In rural areas where there are few or no qualified private sector facilities, people opt for unqualified providers and NGO facilities – which are often only available at the upazila level and which may require traveling great distances. All of this adds up to significant gaps in access to services (SIDA 2009).

- Bangladesh has strong and active professional medical associations, including the BMA, Private Medical Practitioners Association (PMPA), Obstetrical and Gynecological Society of Bangladesh (OGSB), and the Bangladesh Private Medical College Association (BPMCA). These associations and other have representation in the National Technical Committee (NTC) – which is responsible for most significant decisions made related to health care regulation. The explosive growth of the for-profit primary health care, diagnostic, and other health areas is well supported by these associations and they could be better leveraged in supporting their members in the provision of family planning, especially LAPMs.

- There is poor communication and awareness of the policies and regulations related to provider and facility registration – particularly among for-profit providers. Most for-profit providers interviewed by the assessment team repeated they were not sure what the actual social requirements for LAPMs were, or their recent revisions. There was also extensive misunderstanding of the requirements for individual provider and facility registration required for participation in the public supply chain or the provision of LAPMs.

- This lack of awareness and understanding of key policies related to family planning and LAPMs is exacerbated by the DGFP's inconsistent implementation of these policies and regulations among public, NGO, and for-profit sectors.

1.3 TRENDS IN THE CONTRACEPTIVE PREVALENCE AND TOTAL FERTILITY RATES

Various assessments performed by USAID and other donors over the past few years, including this one, have attempted to explain the sharp reduction, then stall, then slower reduction in TFR and increase in CPR. However, there is a significant gap in comprehensive research to explain this comprehensively, from both the supply and demand side. After a spectacular decline in TFR from 6.3 in 1975 to 3.3 in 1994 the rate of decline slowed dramatically, taking until 2010 to reach 2.5. Contraceptive prevalence had an equally spectacular rise – correlating to the decline in TFR – from 5 percent currently using modern methods in 1975 to 36.2 percent in 1994. The increase in CPR then slowed dramatically to reach 47.5 percent in 2007 (BDHS 2007) and now to 54 percent in 2010 (BMMS 2010).

The three major forces seem to have contributed to the slow progress in recent years:

- *Method mix.* The mix of family planning methods has historically been heavily weighted to short-term methods with high discontinuation rates. As discussed above, this is influenced in part by provider attitudes toward long-term methods, which have a significant impact on the decisions of women, and in a compounding way, the development of markets for LAPMs.

- *Gaps in the qualified workforce*. The most important qualified public sector health cadres that delivered LAPMs, FWVs and FWAs, are not being replaced at the rate they are retiring. Trainings for providers are not designed in a way that is friendly to the schedules of for-profit providers and none of the public or private medical colleges teach LAPM clinical skills or provide internship opportunities to practice these methods.

- *Market distortions.* These include a legal requirement to provide all family planning commodities distributed through the public sector supply chain for free, an effective lack of commercial supply of IUDs, and implants and injectables (outside of the SMC Blue Star network) available to for-profit providers, and a reimbursement scheme that drives interested clients to the public and NGO sector.

In response to the factors that have slowed Bangladesh's progress in improving its TFR and CPR, the next chapter sets out specific findings and recommendations for increasing the provision and utilization of family planning methods and especially LAPMs, so that it can meet its 2015 targets, such as a replacement fertility rate of 2.2 births per woman.

2. FINDINGS, RECOMMENDATIONS AND OPPORTUNITIES

The findings and recommendations presented here are based on information from the literature review and stakeholder engagement process discussed in Chapter 1. Chapter 1 introduced many of the assessment team's findings. Those findings are expanded upon the here, to provide context for the recommendations. Recommendations are presented in two ways, short term and long term. The short term opportunities represent two things: 1) investment opportunities for USAID that could result in relatively quick outcomes of LAPM users and leverage existing relationships and funding agreements; and 2) initial steps necessary to set up many of the long term recommendations, which are larger scale activities that will have greater impact on CPR and TFR.

In general, the assessment team recommends that USAID make priority investments in activities that support injectables and implants. There is a surge in interest and use of these methods among clients and providers, which represents an opportunity that should be leveraged. While implants, being relatively expensive per unit, represent a funding challenge to the government, these two methods will serve as a gateway to women recognizing the value of LAPMs, which don't require daily or event-based behavior like pills and condoms. While IUDs are important to ensuring that women have a broad method mix from which to choose, the issues surrounding IUDs will require longer-term strategies and capabilities that are more complex than those for injectables and implants: re-positioning in the minds of providers and consumers, clinical skills, quality assurance. These recommendations could be taken up as part of a more comprehensive strategy with longer time lines.

2.1 AVAILABILITY OF SERVICES

2.1.1 Key finding: Nationwide, there are significant gaps of qualified public, NGO, and for-profit facilities in rural areas.

It comes as no surprise that in a country with the economic and development challenges that Bangladesh faces significant gaps in health services in rural areas, especially family planning and LAPM services. This is well illustrated by a mapping exercise of health facilities in 21 districts completed by the Mayer Hashi Project. The study found that out of 172 private (non-NGO, for-profit) facilities surveyed, less than one percent had registered for approval to provide family planning services, and while 56 percent were providing tubectomies, less than 2 percent were providing vasectomies and fewer than 10 percent were providing IUDs. NGOs are providing a significant percentage of the LAPMs that are being accepted – in the Mayer Hashi study, 76 percent of NGO facilities provided IUD services – but only 29 percent provided implants or surgical methods (Mayer Hashi Facility mapping, 2010).

There is a lack of data indicating the real number of qualified health providers in rural areas in Bangladesh. The World Bank Private Sector Assessment of 2003 estimated that, while there are some for-profit hospitals and clinics in rural areas, there are twice as many unqualified, traditional health providers than qualified providers in those areas. It further indicated that the public often does not

distinguish between qualified and unqualified providers. These unqualified providers are often in pharmacies and drug shops.

While public and NGO facilities provide coverage in rural areas, there are significant gaps in their coverage, and considerable vacancies in the staffing of active facilities; among NGO facilities, 23 percent of FWV positions were found vacant, 15 percent of FWA positions were found vacant, only 16 percent were found to provide all four LAPM services (Mayer Hashi Facility mapping, 2010).

In order to improve access to family planning and LAPM services in rural areas, the SSFP operates satellite clinics. Each participating NGO is required to operate 20 of these, mostly in rural areas. However, these facilities are staffed for only one day per month, during which they report high levels of client flow, supported by local service promoters that inform the community of when facilities will be open. Likewise, MSCS operates roving IUD and surgical contraceptive teams that are also supported by local service promoters and reach into rural areas and report high levels of clients. These teams are efficient and contribute to nearly 40 percent of the total sterilizations performed annually.

Recommendation: Leverage available USAID partners to extend services to rural areas while building the capacity of experienced national and local institutions to provide services more sustainably.

USAID's family planning investments in Bangladesh represent a substantial network and platform that could be leveraged to make initial increases in the availability of services. Recent interest among family planning users in longer-acting methods like injectables and implants should be stoked by increasing the availability of these methods and avoiding supply-side discontinuations. Leveraging the organizations that operate existing networks of satellite clinics and roving LAPM teams with which USAID has or could easily establish relationships would achieve this objective in the short term.

The GoB made a significant investment in a plan for the creation of nearly 18,000 community health clinics, approximately 12,000 of which have been created or refurbished to date. The full value these facilities could provide to the communities in which they are located is far from realized. USAID has strong working relationships with national-level NGOs that have vast experience providing quality health services in rural and urban areas. Organizations like the Population Service and Training Center, a USAID partner since 1981, Bangladesh Association for Maternal and Neonatal Health, Paribar Kallayan, and others, are well positioned to support the staffing and operation of community facilities.

Short term: Support scale-up of NGO outreach and satellite clinics to extend availability of services in rural and hard-to-reach areas.

- Open SSFP satellite clinics more than one day per month for either all services that these facilities currently provide or special family planning only services
- Support MSCS to operate additional roving vasectomy and roving IUD teams in rural areas.

Short term: Build the counseling and referral capacity of the extensive number of nongraduate (nonqualified) health providers in rural areas using the SMC Blue Star network model. These providers could be trained to counsel, refer, and provide injectables (continuing doses after screening and prescription at qualified providers).

Long term: Support the government to contract out to national-level NGOs to support the operation of vacant community-level clinics and eventually build the capacity of district- and upazila-level organizations to operate these facilities in a sustainable way.

- Work with the best-positioned national NGOs to staff and operate community clinics, if possible with a percentage of costs recovered. An additional step could be to work toward transferring operation of these facilities to district- or lower-level organizations that would serve their own communities.

2.1.2 Key finding: There has been insufficient investment in the training of public, private, and NGO providers in LAPMs, including new doctors at the medical colleges.

There is an increasing number of public sector vacancies of providers who can perform LAPM procedures – for example, reports of hundreds of vacant FWV positions due to retirements – and unfortunately few qualified providers to fill the vacancies. The NGO and private sectors will not able to make up the service gaps these vacancies will create. The Mayer Hashi facility mapping study reported that only 18 percent of NGO service providers were skilled in tubectomy, 13 percent in implants, and 6 percent in vasectomies, and only 20 percent of for-profit sector service providers were skilled in performing tubectomies, 4 percent in performing vasectomies, and 4 percent in inserting implants.

Currently none of the public (18) or private (45) medical schools teach LAPM methods as a clinical skill or offer the opportunity to practice the methods in internship. The GoB and donors have not supported training of existing private sector providers in these services at a scale sufficient to fill vacancies. Although there are recent improvements in the availability of general training for paramedics and degreed nurses, many of these are headed to openings in the growing for-profit sector in urban areas – where LAPMs are not being provided. Paramedics and nurses are an important cadre in for-profit clinics – in for-profit facilities, there were 3.8 physicians and 4.2 nurses/paramedics per facility. Increased access to skills and LAPM products will translate into more access to LAPMs for the public.

However, trainings in LAPMs as currently designed and approved are not useful for for-profit providers. While the government, supported by the Mayer Hashi project, has made significant progress in streamlining the training curriculum, the blocks of time required are too long for a private provider to be away from the clinic; his or her absence often means revenue and income are lost.

Recommendations: Extend training opportunities to NGO and for-profit providers.

As all LAPMs require some level of procedure, the increase of availability of LAPM services requires an increase in the number of qualified providers. There are several opportunities that USAID could leverage to achieve this in the short term and long term.

Working with the DGFP and the NTC, USAID could break the new streamlined LAPM training curriculum into shorter time blocks to enable for-profit providers to access the training in timeframes that fit their needs. Once this is completed, the variety of channels that private providers are familiar with – especially provider associations and private training institutions –could be leveraged to deliver these

trainings effectively. Many of these organizations regularly work with pharmaceutical, medical supply, and other related companies to sponsor medical seminars, clinical trainings, and other events. These relationships could be very useful in deferring the costs of training providers.

Senior doctors interviewed by the assessment team recalled a time when all public sector doctors were required to complete the Association for Surgical Contraceptives' LAPM training course. Overall, training new doctors in LAPMs and providing them the opportunity to practice these clinical and related screening and counseling skills in their clinical internships is the best way to ensure that the overall health system is prepared to meet the family planning needs of the country.

Short term: Restructure the modules of the DGFP's new single curriculum to shorter time blocks spread over more days – timeframes that are friendly to the needs of private providers. While the Mayer Hashi project has a related activity planned it was not clear that this was prioritized in the project work plan sufficiently to meet the urgency this issue.

Short term: Identify public-private partnerships to extend trainings to for-profit doctors, nurses, and paramedics through private associations and other channels familiar to private providers. Potential partners include PMPA/College of General Practitioners, BCMPA, OGSB, private training institutions licensed by Bangladesh Nurses Council, and select private medical colleges.

Long term: Roll out trainings structured to the needs of for-profit providers through channels they are familiar with: private sector institutions. While the curriculum restructuring and the partnerships with private training partners could be established in a relatively short timeframe, rolling out these trainings should be considered a long-term activity.

Long term: Integrate LAPM clinical and counseling skills into public and private medical colleges and clinical internships. In collaboration with the BMA/College of Physicians and the BPMCA, USAID should work to design and implement a full family planning curriculum that includes clinical, screening, and counseling skills for short-term and long-term methods.

2.1.3 Key finding: A significant lack of awareness and misunderstanding of the policies and regulations affecting private providers' delivery of LAPM services.

For-profit providers lack awareness of the policies and regulations that pertain to their required registration and certification for provision of family planning and LAPMs. This is not necessarily surprising, as they have not had interest in this subsector of the health market in the past. However, it does represent a significant barrier to greater involvement. While the DGFP has created and distributed a circular explaining revised policies on social requirements for LAPMs, and another circular exists on the requirements for registration and certification, this does not seem to have reached many providers or filled the gap in correct knowledge of these issues. This issue is exacerbated by a pervasive inconsistency in the application of polies and regulations among public, NGO, and for-profit facilities.

Recommendation: Improve communication and orient private providers on LAPM methods, policies on provider and facility certification, and social requirements.

This gap in awareness and understanding of policies and procedures, and disparity in their application could be addressed through a simple and relatively inexpensive series or an ongoing schedule of public-private dialogues/orientations that target private provider participation. Providing a platform for private providers to learn and engage regulators, district- and national-level officials, and each other is often an invaluable way to establish quick gains in public-private relationships – if done well with a clear, results-oriented agenda.

Short term: Host district-level dialogues/orientations to bring together public NGO and private providers to better understand one another's needs, challenges, and interests. The focus of these dialogues/orientations would be effective distribution and discussion of certification and reporting and method-by-method social requirements. These dialogues/orientations should follow in the spirit of the successful stakeholder meeting in Chittagong in March 2011 in which government, NGOs, private providers, and others had a genuine dialogue about issues affecting private sector provision of LAPMs in Bangladesh. These dialogue/orientation sessions could be used to vet research, market segmentation, and information and be funded in part or in entirely by relevant sponsorship from pharmaceutical and medical supply companies leveraging partners like the BMA and PMPA.

Long term: Explore additional forums for public-private dialogue to clarify policies and regulations, discuss and improve the communication and application of policies and regulations, and improve understanding between public and private sector.

2.1.4 Key finding: The large clusters of factories and employees in and around Dhaka and Chittagong represent an excellent opportunity for public-private partnerships to extend LAPM services to intended populations.

USAID, the U.K. Department for International Development, and the Asian Development Bank funded projects have done extensive groundwork to establish direct working relationships with manufacturers' associations to reach their employees for improved access to health services. The BGMEA is one of the best-positioned associations for family planning and reproductive health, as approximately 2.8 million of the 3.6 million employees employed in the BGMEA's 5,100 member factories are women of reproductive age.

The BGMEA has begun to scale up the health services it provides itself. It currently operates 12 outpatient clinics (10 in Dhaka and two in Chittagong) providing free services to member employees, and funded entirely by member dues and corporate sponsorships from major buyers like Walmart and H&M. It is in the process of completing a 100-bed hospital in Chittagong with full inpatient services including surgical and emergency capacity, of which 30 beds are already open, and it recently began construction on a 150-bed hospital in Dhaka. Much of this interest in providing basic health services is driven by market forces – large international buyers require a set of international standards that all factories must meet in order to participate do business. These hospitals are also funded through member dues, complementary contributions, and piecemeal donations from major international buyers.

Many NGOs are already engaged in providing mobile clinics directly to factories, including different SSFP and UPHCP NGOs and MSCS (since 1997). The United Nations Population Fund (UNFPA) has sponsored a women's empowerment and health services program in some of the clinics operated by the BGMEA.

MSCS has operated a scheme with factories in which it charges 12tk (approximately approx. $ 0.20) per employee to provide a twice-weekly mobile clinic and free referrals to MSCS clinics. This recovers 100 percent of clinical operating costs and at one time worked in over 180 clinics.

Recommendation: Work with manufacturers' associations to identify strategies for public-private partnerships that improve access to LAPMs for their members' employees.

In meeting with the assessment team, the BGMEA made a significant point to express that among all the different schemes and partnerships that it or its members are engaged in, never has a donor, NGO, or other entity treated them as a full partner in the development of a program or project that meets the interests of their members and their member's employees. They typically feel that donors and NGOs approach them with preformed plans that they wish to apply to or through the platform of the BGMEA membership.

There are two significant dynamics that represent an exceptional opportunity for USAID: first, the desire for the BGMEA to be engaged as a full partner in developing a program, and second, the extensive relationships the BGMEA has with large international corporations, which until now have contributed to specific aspects of the BGMEA initiative. For example, Wal-Mart may sponsor the surgical theater in one of the hospitals under construction. However, these corporate buyer contributions are often done on a piecemeal basis without any large-scale planning or thought to potential scale-up.

In addition to the BGMEA, there are many other manufacturers and exporter associations that could provide platforms for reaching intended markets for LAPMs, including embroidery, electronics, and handicrafts.

Short term: Initiate a consultative process with the BGMEA to engage in a public-private partnership that meets the needs of members and of USAID and the GoB in extending LAPMs through existing and potentially scaled-up primary health care facilities already in place. This process should include some potential short term activities and work toward the long term recommendation described below: two levels of thinking:

- Short-term opportunities that would improve access to LAPMs quickly, but to a limited degree:
    - Training BGMEA and factory-owned clinics staff on LAPM counseling, provision of injectables, and other cadre appropriate methods
    - Extending current USAID partner presence in additional factories. SSFP, MSCS, and UPHCP all fund varying numbers of mobile clinics in individual factories. This could be scaled up relatively quickly.
    - Scale-up of the UNFPA's women's awareness and empowerment campaign to additional BGMEA clinics – currently only in four of 12 facilities

Long term: Establish a Global Development Alliance (GDA) involving BGMEA's network of large corporate buyers, USAID, and the GoB that would leverage the corporate partnership and BGMEA member network on a significantly larger scale i.e., doubling the number of outpatient clinics and their clinical capacity to deliver LAPMs.

2.2 MARKET AND DEMAND

2.2.1 Key finding: LAPMs – especially IUDs – require significant repositioning and mainstreaming in the minds of both consumers and providers to achieve increased demand.

USAID has made significant investment in consumer-targeted promotion of family planning behaviors, methods, and products – both through generic campaigns and indirectly through promotion of SMC-branded products. The GoB has also made long-standing investments in promoting family planning to consumers. By many accounts, there has been a significant gap in large-scale behavior change campaigning over the past several years.

More recently, the Myer Hashi project has launched a behavioral campaign involving two TV commercial messages, radio, billboards, leaflets, posters, and other print formats and attempting to revitalize promotion through community health worker networks. The audience reach of the campaign is not at scale to affect nationwide exposure and there are gaps in connecting to available services outside of select districts.

Also, the DGFP itself has designed a leaflet promoting implants and vasectomies, and plans the use of community-level loudspeakers to further broadcast messages. The theme of the DGFP flier is consistent with the messaging the government has used for many years, based on a population control message platform. The basic message states that a woman should have no more than two children and that one is better than two.

Recommendation: Expand demand for LAPMs through focused promotion targeting consumers AND providers.

Providers have a very strong influence on a woman's choice of method, both at the interpersonal level and through the compounded effect on how the method popularity, availability, and accessibility have evolved historically in Bangladesh. To meet and leverage the high level of women's knowledge of family planning methods, including injectables, implants, IUDs, and surgical methods, a concerted effort must also be made to change the behaviors of providers.

While providers have significant influence over the method, there was a consensus among some veteran health programmers interviewed by the assessment team that the educational and financial empowerment women have gained in recent years was a significant factor in users' decision to begin to use a method. There is limited recent in-depth research to understand how these users and non-users think, believe, and consume – and to provide the type of understanding necessary for targeted communication.

Short term: Perform client centered market segmentation and provider knowledge attitude and practice (KAP) study to understand users, non-users and providers and effectively design and implement targeted communication activities. Done properly, this cluster analysis research provides an invaluable depth of data as the basis of audience profiles. USAID should consider a broad-based study that explores:

- Users – how they think, believe, and consume. Their influencers, barriers, trusted sources of information, decision-making processes, willingness to pay, and the markets they form.
- Providers – current gaps in skill, knowledge, beliefs, and biases. Their professional and civic networks and financial and reputational interests.

This information will be important market evidence to inform policymaker, health programmer, and for-profit provider investment in extending their practices to LAPMs. The GoB Health, Population and Nutrition Sector Strategic Plan 2011-2016 calls for the segmentation of the market to better target people based on specific characteristics. The findings of the client-centered market segmentation should be widely distributed through a broad stakeholder consultation that provides a platform for concurrence on key dynamics of the market; roles of the public, NGO, and for-profit sectors; and ways of applying the data for improved programming. This work will be performed in coordination with the knowledge management and behavior change communication (BCC) work that Johns Hopkins Center for Communication Programs is performing for USAID to coordinate and improve the MoHFW's operationalization of BCC strategies.

Short/Long term: Design and implement a focused interpersonal health provider behavior change initiative targeting private, NGO, and public health providers and all actors in the referral chain. This initiative should be focused on improving their perception of LAPMs, and discuss and dispel biases based on incorrect or dated medical information. Potential forums could be included in the agenda of dialogues/orientations as discussed in Section 2.1.3 or specifically designed peer discussion groups. These should be done at different levels in the health system from upazila family planning officers, facility doctors, paramedics, and nurses to community-level cadre like family welfare assistances, health assistants, community health workers, and other service promoters

Long term: Support the scale-up of post-partum IUDs and tubal ligations at high-volume private sector maternity providers. NGOs and for-profit maternity service providers are missing an opportunity to reach women during this health event. This would require training and planning to engage the counseling process as part of neonatal care.

Long term: Strategic communication activities coordinated to the audiences and messages of the BCC campaign implemented through Mayer Hashi. These activities should use social networks, news, and fact-oriented media channels to support broader nationwide exposure and place, triangulate audiences' experience of messages and information about LAPMs, and create a mainstream context of these methods for different market segments. They should also increase awareness of the availability of methods in the NGO sector, and later the for-profit sector (when availability has been established in that sector). Activities could include:

- Increase the recruitment of champions among acceptors AND providers – peer-to-peer outreach
- Increase focus on male involvement and couple counseling
- Coordinate with new government and NGO community health worker networks and promoters – BRAC, SSFP – to refer to for-profit providers where available
- Initiate a significant public relations/strategic communication to include news and other fact-based media; get well-known personalities, government, method acceptors in news and other validating information channels

2.3 SUPPLY OF PRODUCT

2.3.1 Key finding: There is no supply of LAPM/injectable products accessible to for-profit providers outside of SMC and the government supply chain.

The average for-profit provider has no access to a supply of injectables, implants, or IUDs. There is no representation of locally produced or imported products to for-profit providers outside of injectables distributed through Blue Star pharmacies. This is an essential element that must be addressed as a priority in the sequence of support for for-profit provision of LAPMs. There is some good news for the medium-term future:

- Nuvista Pharmaceutical will begin producing injectables in 2012 and plans a marketing and distribution scheme based on the Blue Star model.
- In addition to Techno Drug (currently providing injectables to the public supply chain) and Nuvista, Renata Pharmaceutical and Incepta Pharmaceutical will begin producing injectables in the next 18 months.
- Techno Drug is planning to produce a single rod implant in the next few years.

However, Renata and Incepta are only interested in producing to compete for the public tender. While they will need to produce product for at least two years to qualify for World Health Organization production experience requirements, neither are currently planning any effort to release their products on the commercial market during this time period.

Recommendation: Support a commercial supply of LAPM products available to for-profit providers not participating in the public sector supply chain or network.

Short/long term: Engage Nuvista to explore a public-private partnership to make their products available to lower-income levels through their planned marketing network. USAID should explore opportunities to support the release of a lower-cost brand of their injectable and to support a quick roll-out of a broad-reaching pharmacy network.

Short term: Support SMC to operate as a wholesaler of IUDs and implants, and distribute to the for-profit sector. This will act as an interim step to engage a small set of for-profit providers in the provision of LAPMs and provide evidence to the commercial pharmaceutical industry to inform its investment in making these products available on the commercial market, as opposed to only competing for the public family planning commodities tender.

Long term: Encourage plans for local manufacturing of injectables and importers of implants to distribute to the commercial market accessible to for-profit providers. This would segue from the supply made available through SMC as described above.

2.4 ACCESS TO FINANCE, BUSINESS CAPACITY, AND MARKET LINKAGES

2.4.1 Key finding: Access to financing is a barrier to for-profit providers ability to expand and improve services. Banks are not lending to the health sector in a significant way.

Access to finance is an important ingredient in the for-profit provider's ability to expand and improve services. Interviews with financial institutions indicated that they are not lending to the health sector in a significant way. Banks cited a number of reasons for this. One constraint was risk, with several banks expressing concern about the political risk of foreclosing on a health clinic or hospital, and the political connections of some health providers, who may have served in the public sector. Banks also expressed concern about collateral that health care businesses offer and the low level of business skills and financial management capacity. Despite these concerns, banks, including BRAC Bank, Dhaka Bank, and Prime Bank, expressed an interest in expanding into the health care market. Banks suggested that a Development Credit Authority (DCA) guarantee and training in health sector lending could help manage the risk of entering a new market, and business training to health providers could address some bank concerns about the management capacity of health providers.

Interviews with private health care businesses indicated that there are varying degrees of access to finance with some higher-end facilities being able to obtain loans and mid to lower-income ones having more difficulty. There appears to be a trend in private health care businesses starting out in diagnostics and expanding into comprehensive care. All of the private health care businesses that were interviewed have expansion plans and would consider adding LAPMs as part of a comprehensive package of care. In fact, one of the doctors interviewed had opened a small clinic that provides diagnostic and specialist care and was in the process of constructing a new site that will offer comprehensive care. He has already obtained certification to offer family planning services. While the investment requirements to add LAPMs are not large, they could be packaged as part of a broader expansion plan that would be appealing to both banks and health care businesses.

Recommendation: Develop a multi-sectoral program to partner with financial institutions to expand access to finance for the health sector.

It is recommended that USAID develop innovative public-private partnerships with financial institutions in Bangladesh to expand access to finance for private health providers that are interested adding LAPMs and other essential health services. USAID should consider structuring a package of technical assistance to financial institutions, such as BRAC Bank or Dhaka Bank, to help them to expand lending to the health sector. Technical assistance could include market research on the health sector. Financial institutions expressed interest in learning more about the health sector's financing needs and repayment capacity. The market research could be used to assist financial institutions to develop health sector loan products and strategies for marketing to the health sector. This assistance could be complemented with training of loan officers in analyzing and structuring a health sector loan and training of bank managers on the health care market to ensure their buy-in and support. USAID should also consider working with banks to create market linkages to private providers that are adding LAPMs. This could include developing

memoranda of understanding between banks and provider associations that are championing the introduction of LAPMs in the for-profit sector to create a referral mechanism, as well as trade fairs, which will be discussed below.

USAID should also consider structuring a DCA guarantee as a type of GDA that leverages local, commercial resources to support the development of the private health sector**.** By sharing risk, the DCA guarantee encourages banks to use their own capital to enter the health care market.

Short term: Identify local financial institutions and conduct analysis to develop a DCA guarantee.

Long term: Provide a package of technical assistance to financial institutions to lend to the health sector and support a DCA guarantee.

2.4.2 Key finding: Many private health providers lack business skills. They are owned by clinicians who have limited business and financial management capacity.

Key finding: Private providers would like to have a better understanding of the market demand, and investment requirements for LAPMs before they enter the market.

In order to be sustainable, it is important that private health care businesses understand the market and investment requirements, and are able to integrate the delivery of LAPMs and other family planning services into their practices in a sustainable manner. Interviews with for-profit health care businesses revealed that a variety of ownership structures exist. Some of the larger hospitals and medical colleges are owned by business people or a group of investors. A large number of private health service providers, however, are owned by clinicians, who have gone into private practice as a second career or are still working in the public sector and operate their private practice in the evening and on weekends. These clinician/health care business owners have limited financial and business management skills. Interviews revealed that while many of them are interested in expanding their businesses, they lack important knowledge in market analysis, business planning, and how to access financing. Most of the private health care businesses that were interviewed expressed an interest in adding LAPMs as part of a move toward adding a more comprehensive package of health services or out of a sense of social responsibility. In order to make this investment, however, interviews revealed that they would like to have a better understanding of the market for different methods, market demand, and the investment requirements for LAPMs.

Recommendation: Develop training and advisory services for private health service providers on business and financial management with a focus on adding LAPMs.

Training and advisory services on business and financial management with a focus on adding LAPMs can assist private health care businesses to add these services in a financially sustainable manner. The assessment team proposes conducting market research and a training needs assessment that will inform the design of a training program. Topics that may be covered can include investment requirements for

offering LAPMs, understanding the market for LAPMs (with a presentation of market research findings), break-even analysis, pricing, and marketing services and access to finance. We propose to build the capacity of a local training partner, such as the Micro Industries Development Assistance and Services (MIDAS), or other business development service providers to offer this training. The team also recommends providing follow-on advisory services to a select group of private providers to assist them to add LAPMs, in a financially sustainable manner.

Short term: **Conduct preliminary steps required for a roll-out of a training program for for-profit providers.** This includes developing a list of investment requirements, conducting market research, conducting a training needs assessment, developing a training curriculum, and identifying an appropriate local training partner.

Long term: Pilot the training and conduct a training of trainers to build the capacity of the local training organization to roll-out the training. Provide follow-up business advisory services to private providers that are adding LAPMs.

2.4.3 Key finding: Private health care providers have weak market linkages. They operate in isolation, which makes it difficult to update them with information about LAPMs, and assist them to access resources to grow and improve services.

The private health sector is highly fragmented in Bangladesh. Private health providers operate in isolation, without access to information about family planning, LAPMs, and important resources to grow and improve their practices. The PMPA estimates that there are 34,000 private doctors but only 10,000 are dues-paying members. There is an opportunity in Bangladesh to create market linkages and build a community of practice for private providers that offer LAPMs.

Recommendation: Strengthen market linkages to assist private health care providers to access the information and inputs that they will need to add LAPMs and grow and improve their practices.

Short and long term: Work with local partners to host private sector trade fairs. Private health sector trade fairs are an innovative public-private partnership that creates a forum for isolated private providers to meet peers, pharmaceutical companies, medical equipment suppliers, financial institutions, and representatives of the MoHFW, donors, and USAID-funded projects, among others. Trade fairs consist of a panel of presentations on topics, such as LAPMs, public-private partnerships, and quality assurance, and an exhibition hall that provides opportunities for networking and information sharing. A trade fair is a great way to launch information about LAPMs in the for-profit sector and can help create some of the market linkages necessary to roll this out. Commercial sponsors can be tapped to contribute to the cost of the trade fairs. Trade fairs can be held in a number of different geographic locations and can be offered on a yearly basis. Evidence from other countries also shows that trade fairs can help increase access to finance for private health providers.

Long term: Create an online platform that provides the foundation of a "linked-in" community of practice for private health providers that offer LAPMs. This platform will provide private health care

businesses with access to information about supply, training, information and education materials, and other resources. It will create an online forum for providers to share information and seek advice about offering LAPMs.

Long term: Build the capacity of associations to serve as champions in rolling out LAPMs among for-profit providers. This will include working with associations, such as the PMPA and OGSB, to assist members to add LAPM services. It also comprises building their capacity to advocate for for-profit providers on issues related to LAPMs, assist in organizing trainings, and provide a platform to reach out to the for-profit sector to encourage the provision of LAPMs.

3. CONCLUSION

There are numerous opportunities on which USAID could build to achieve a significant impact on the availability of LAPMs through the private and NGO sector and improve the utilization of LAPMs in the overall family planning method mix in Bangladesh. This report prioritizes several recommended short- and long-term investments.

Some of these priority investments could bring relatively quick results; for example, expanding existing NGO relationships to extend satellite clinic days of operations through SSFP or additional MSCS roving IUD and surgical teams. Several of these priority investments require careful sequencing of activities, starting with short-term tasks that are required for long-term, larger-scale activities and impact. For example, in order to roll out trainings of private sector providers in a timeframe useful to their needs using channels that offer public-private partnership funding, the curriculum must first be restructured and extensive engagement with select partners like the PMPA and others as necessary. Overall, the engagement of for-profit providers will first require engaging this sector and providing evidence and a bottom-line business case for why they should be involved in the LAPM market. Issues of capacity building, access to finance, supply of related products, and others need to be carefully sequenced in order to ensure that supply and demand are well matched.

There are a variety of knowledge and information gaps about several dynamics and barriers that need to be filled to truly understand what path to take in addressing them, and some of the recommendations made here will either directly fill those gaps or require some level of formative research that will contribute to filling them.

While the market for LAPMs in Bangladesh has some unique and significant barriers the entry of for-profit providers and the development of a commercially viable and sustainable LAPM market, the time for making strategic investments is now. The surge in interest in longer-acting methods like injectables – among consumers, providers, and local manufacturers – should be seized upon by family planning programmers with a careful eye to how facilitate the development of a commercially viable market and interest in other long-acting methods.

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Annex B. Analysis of Priority Recommendations' Alignment with Bangladesh GHI Principles and Focus

Key Findings	Recommendations	Short Term/Long Term	Key Actors Bangladesh	Bangladesh GHI Strategy Analysis
Significant gaps of qualified public, NGO, and for-profit facilities providing LAPMs in rural areas	Leverage available USAID partners to extend services to rural areas while building the capacity of experienced national and local institutions to provide services more sustainably.	**Short Term** Support scale-up of NGO outreaches and satellite clinics to extend availability of services in rural and hard-to-reach areas. **Short Term** Build the counseling and referral capacity of the extensive number of nonqualified health providers in rural areas – often referred to as nongraduate medical providers. **Long Term** Support the government to contract out to national-level NGOs to support the operation of vacant community-level clinics and eventually build the capacity of district- and *upazila*-level organizations to operate these facilities in a sustainable way.	Marie Stopes Clinic Society (MSCS), SSFP, DGFP	**Sub-intermediate Result 1.2: Increased access to quality family planning and reproductive health services** Working with already existing programs to extend services, including counseling and referrals, to rural areas increases the access of FP and RH services to those who are unable to travel to urban/peri urban centers for health services. The long term objective of scaling up rural clinics increases the likelihood that these FP and RH services will influence a behavior and cultural change in family planning. Improved counseling services increases the likelihood of heightened LAPM use in these areas. Using existing programs and contracting out to national-level NGOs to strengthen country led processes supports the GHI principle of country ownership.
Insufficient investment in the training of public, private and NGO providers in LAPMs, including new doctors through medical colleges	Extend training opportunities to NGO and for-profit providers.	**Short Term** Restructure the modules of the DGFP's new single curriculum to shorter time blocks spread over more days, timeframes that are friendly to the needs of private providers. **Short Term** Identify public-private partnerships to extend trainings to for-profit doctors, nurses, and paramedics through private associations and other channels familiar to private providers. **Long Term** Roll out trainings structured to the needs of for-profit providers through channels they are familiar with – private sector institutions. **Long Term** Integrate LAPM clinical and counseling skills into public and private medical colleges and clinical internships.	DGFP, National Technical Committee (NTC), Mayer Hashi, Private Medical Practitioners Associations (PMPA), others TBD	**Sub-Intermediate Result 3.2: Improved Health Support Systems for Efficient Service Delivery** Separating the large training blocks into multiple sessions over time will allow private sector providers to train in LAPM methodology and counseling with minimal interference to the operation of their business and livelihoods. The Long Term integration of trainings into medical colleges, clinical internships, and private sector institutions will allow for a sustainable model preventing a stall in training that occurs with this time frame barrier. These recommendations support the GHI strategic focus of a Research and Learning Agenda which focuses on applying previous research to current approaches in an attempt to increase efficacy and efficiency of service delivery in Bangladesh.
Significant lack of awareness and misunderstanding of the policies and	Improve communication and orient private providers on LAPM methods, policies on	**Short Term** Host district-level dialogues/orientations to bring together public NGO and private providers to better understand policies and one another's needs, challenges, and interests.	DGFP, Mayer Hashi, Bangladesh Medical	**Sub-Intermediate Result 3.1: Improved leadership and management of the health sector** Misunderstanding and lack of knowledge on LAPM

regulations affecting private providers' delivery of LAPM services	provider and facility certification, and social requirements.	**Long Term** Explore additional forums for public-private dialogue to clarify policies and regulations, discuss and improve the communication and application of policies and regulations and improve understanding between public and private sector.	Association (BMA), PMPA, Obstetrical and Gynecological Society of Bangladesh (OGSB)	policies is a barrier to private sector investment in delivering these services. Encouraging LAPM service delivery through the private sector requires an improved dialogue between policy makers and providers that integrates the needs, challenges and interests of both parties to create an enabling environment for increased LAPM use. These recommendations support the GHI focus on establishing Strategic Partnerships and Alliances which is intended to support the GOB's mission of providing basic health services to the Bangladesh population.
Large clusters of factories in and around Dhaka and Chittagong represent an excellent opportunity for public-private partnerships	Work with manufacturers' associations to identify strategies for public-private partnerships that improve access to LAPMs for their members' employees.	**Short Term** Expand Smiling Sun, MSCS and UPHCP mobile clinics in garment factories to quickly capitalize on existing relationships and operations and logistics	BGMEA elected and secretariat staff, USAID, GoB	**Sub-Intermediate Result 2.2: Improved service delivery through effective Public/Private Partnerships** There are several strong examples of partnerships between donor funded health programs, including family planning, and industry associations and individual factories in Bangladesh. Many of these partnerships are small scale and could be leveraging the larger resources of third parties, the international buyers working with industry associations. Larger scale partnerships would conceivably deliver larger scale impact. These recommendations support the GHI interest in establishing effective public private partnerships both with national level Bangladeshi and international corporate entities.
		Short Term Initiate a consultative process with Bangladesh Garment Manufacturers and Exporters Association (BGMEA) to engage in a public-private partnership that meets the needs of BGMEA members and USAID and the Government of Bangladesh (GoB) in extending LAPMs through existing and potentially scaled-up primary health care facilities already in place.		
		Long Term Long term: Establish a Global Development Alliance (GDA) involving BGMEA's network of large corporate buyers, USAID, and the GoB that would leverage the corporate partnership and BGMEA member network on a significantly larger scale	BGMEA elected and secretariat staff, USAID, GoB, corporate partners TBD	

LAPMs, especially IUDs, require significant repositioning and mainstreaming in the minds of both consumers and providers to achieve increased demand	Expand demand for LAPMs through focused promotion targeting consumers AND providers.	**Short Term** Perform client centered market segmentation and provider knowledge, attitudes, and practice (KAP) study to understand users, non-users, and providers and effectively design and implement targeted communication activities. **Short/Long Term** Design and implement a focused interpersonal health provider behavior change initiative targeting private, NGO, and public health providers and all actors in the referral chain. **Long Term** Support the scale-up of post-partum IUDs and tubal ligations in high-volume private sector maternity providers. **Long Term** Coordinate strategic communication activities with the audiences and messages of the BCC campaign implemented through Mayer Hashi.	DGFP, USAID, local research partner TBD	**Sub-Intermediate Result 1.3: Increased information of FP and RH through Behavior Change Communication; and Sub-intermediate Result 2.1 Increased Access to Integrated Quality Population, Health and Nutrition Services** This and other assessments in Bangladesh have determined that LAPMs and IUDs in particular suffer from poor perception among providers and consumers. These methods require a significant repositioning in the minds and culture of Bangladesh. This will require extensive understanding of consumer and provider attitudes, practices and decision making and discovering and leveraging strategic opportunities like maternity services to increase post-partum access to LAPMs. These recommendations support the GHI focus on Research and Learning Agenda to increase efficacy and efficiency of service delivery in Bangladesh.
There is no supply of LAPM/injectables products accessible to for-profit providers outside of SMC and the government supply chain	Support a commercial supply of LAPM products available to for-profit providers not participating in the public sector supply chain or network.	**Short Term** Support SMC to operate as a wholesaler of IUDs and implants, and distribute to the for-profit sector. **Short/Long Term** Engage Nuvista to explore public-private partnership to make their products available to lower-income levels through their planned marketing network. **Long Term** Encourage plans for local manufacturing of injectables and importers of implants to distribute to the commercial market accessible to for-profit providers.	USAID, Nuvista Pharmaceutical	**Sub-Intermediate Result 2.2: Improved service delivery through effective Public/Private Partnerships; and Sub-Intermediate Result 1.2: Increased access to quality family planning and reproductive health services** The near complete lack of LAPM commodities available to for-profit providers through a commercial market creates a "chick and egg dilemma – the private sector manufacturers don't see a market for these products and private providers aren't investing in providing these services or growing a market for them because they don't have access to products. Working directly with manufacturers to encourage their investment in a commercial supply of LAPM products is an essential step to increasing and improving LAPM services through the private sector. These recommendations support GHI focus on strategic partnerships and alliances as well as health systems strengthening for commodity and logistics systems.

Access to financing is a barrier to for-profit providers' ability to expand and improve services. Banks are not lending to the health sector in a significant way	Develop a multi-sectorial program to partner with financial institutions to expand access to finance for the health sector.	**Short Term** Identify local financial institutions and conduct analysis to develop a DCA guarantee. **Long Term** Provide a package of technical assistance to financial institutions to lend to the health sector and support a DCA guarantee.	USAID/DCA, selected banks TBD	**Sub-Intermediate Result 3.1: Improved leadership and management of the health sector; and Sub-Intermediate Result 2.2: Improved service delivery through Effective PPP** Lack of access to financing can be a barrier for private health businesses that require it to grow their service offerings. By developing partnerships with financial institutions to expand access to finance for the health sector, providers are better positioned to make investments in growing their business and improving access to LAPM services in Bangladesh. These recommendations support the GHI focus on country ownership and strategic partnerships and alliances.
Many private health providers have limited business skills, making adding LAPMs in a financially sustainable manner a difficult task Private health providers need to better understand the market, demand, and investment requirements before they enter the LAPM market	Develop training and advisory services for private health service providers on business and financial management with a focus on adding LAPMs.	**Short Term** Conduct preliminary steps required for a roll-out of a training program for for-profit providers. Including developing a list of investment requirements, conducting market research, conducting a training needs assessment, developing a training curriculum, and identifying an appropriate local training partner. **Long Term** Pilot the training and conduct a training of trainers to build the capacity of the local training organization to roll out the training. Provide oversight to local partner in rolling out the training.	USAID, PMPA, other financial and training partners TBD	**Sub-Intermediate Result 3.1: Improved leadership and management of the health sector** GHI Bangladesh IR 3.1 GHI is focused on improving leadership and management of the health sector, and this shouldn't be limited to the public sector. By improving the business and management skills of private providers, private health businesses will be more willing and able to invest in expanded service offerings like LAPMs and strengthen their health businesses to be financially sustainable private These recommendations support the GHI focus on country ownership and strategic partnerships and alliances.
Private health providers have weak market linkages. They operate in isolation, which makes it difficult to update them with information about LAPMs, and assist them to access resources to grow and improve services.	Strengthen market linkages to assist private health providers to access the information and inputs that they will need to add LAPMs and grow and improve their practices.	**Short/Long Term** Work with local partners to host private sector trade fairs that can disseminate information about LAPMs and create a forum for isolated private providers to meet peers, pharmaceutical companies, medical equipment suppliers, financial institutions, representatives of the MoHFW, donors, and USAID-funded projects, among others. **Long Term** Create an online platform that provides the foundation of a "linked-in" community of practice for private health providers that offer LAPMs. **Long Term** Build the capacity of associations to serve as champions in rolling out LAPMs among for-profit providers.	DGFP, PMPA, BMA, OGSB, USAID, pharmaceutical and medical supply companies	**Sub-Intermediate Result 2.2: Improved service delivery through Effective PPP** By operating separately, private health providers are unaware of the opportunities and benefits partnerships and networking can provide to their businesses, the quality of their services and the larger private Bangladesh health sector. Through various networking channels and connecting private providers with public organizations, the health sector is better equipped for assessing the needs of the entire population and health market, and informing effective business decisions. These recommendations support the GHI focus on strategic alliances.

Annex C: STAKEHOLDER MEETINGS

	Name	Title	Organization
	Mohammad Shahjahan	CEO and MD	Bangladesh Center for Communication Programs BCCP
	Adnan Nafis	Deputy Secretary	Bangladesh Garment Manufacturers and Exporters Association (BGMEA)
Prof.	Mahmud Hasan	President	Bangladesh Medical Association
	Prabir Kanti Das	Addl. Secretary	BGMEA
Dr.	Mostafizur Rahman	Secretary	BGMEA
	Faruque Ahmed	Director Health Services	BRAC
	Joynal Abedin		Bushra Clinic-2
Dr.	Nasima Begum	Secretary General OGSB	City Hospital
Dr.	Mahbubur Rahman	Line Director	Clinical Contraception Services Delivery Program (DGFP)
	Afzalul Hoque		College X-Ray Clinic
	M.M. Neazuddin	General Director	DGFP
Dr.	Jalal Uddin		Famous Blood Bank
Dr.	Kazi Golam Rasul	Director Programe Director	Marie Stopes Clinic Society
Dr.	Reena Yasmin	Director Services	Marie Stopes Clinic Society
	Anil P. Tambay	Managing Director	Marie Stopes Clinic Society
Dr.	Faisel	Project Director	Mayer Hashi Project
	Shajalal		New Medicom Services
	Alamgir Kahn		New PC Lab Ltd.
Dr	Shahed Ahmed Siddique	Marketing Manager	Nuvista Pharma Limited
	Milon Bikash Paul	Executive Director	Population Services and Training Center/Smiling Sun
	Rashed Reza Chowdhury	Project Director	Population Services and Training Center/Smiling Sun
Dr.	Bipul Sarker	Chief Medical Coordinator	Prescription Point
	Mubin Khan	VP; Cofounder/Deputy Managing Director	Priave Medical College Association; International Medical College
Dr.	Moazzem Hossain	President; Chairman	Private Medical College Association; East West Medical College
Dr	Jamal Uddin Chowdhury	Secretary	Private Medical Practitioners Association of Bangladesh
	Kaiser Kabir	CEO and MD	Renata Limited Pharmaceutical
Dr	Kabir	CEO	RTM International

	Name	Title	Organization
Dr.	Salah Uddin Ahmed	Manager	SMC Blue Star
Dr.	Monowara Begum	Provider	SMC Blue Star
	Juan Carlos Negrette	COP	Smiling Sun Franchise (SSF) Project, USAID
Dr.	Ali Reza Khan	Deputy MD	Social Marketing Company
	Toslim Uddkin Khan	GM Programs	Social Marketing Company
	Ashfaqur Rahman	Managing Director	Social Marketing Company
Dr.	Zubayer Hussain	COP	Stengthening Pharma Systems (SPS) of MSH
	Eman Uk Karim	CEO	Techno Drugs
	Muhammadul Haque	ED Marketing	Techno Pharmaceuticals
Dr.	Hashina Begum	Asstt. Representative RH	UNFPA
	Marcos Arevalo	FP Advisor	USAID Bangladesh
	Khadijat Mojidi	Office Director	USAID Bangladesh
Dr.	Sukumar Sarker	Senior Clinical Officer	USAID Bangladesh
Dr.	Mohammad Nasiruzzaman	Clinical Officer	USAID Bangladesh

Annex D: CIRCULAR ON REIMBURSEMENT FOR CLIENTS AND SERVICE PROVIDERS

TRANSLATED VERSION

Government of the People's Republic of Bangladesh

Ministry of Health and Family Welfare

Family Welfare Section- 1

No.-MOHFW/FW-1/Cir-5/imprest-F/01/118 Date: 20/03/2011 AD

Subject: Regarding approval of the proposals to increase spot payments (allowances and fees) for client, government and non-governmental service provider, referrer, assistant and manager in relation to clinical family planning methods- sterilization (Tubectomy & Vasectomy), IUD and Implant; and to increase other associated expenses.

Reference: DGFP/HNPSP/Clinical Services/Accounts/Sl.-445 (Part-1)/2005-2006/7933, date: 28/02/2011

With reference to the above subject and memo, this is to inform you that as per provision of the approved Operational Plan of Clinical Contraception Services Delivery Program under the Directorate General of Family Planning, along with the list of the hard-to-reach areas the proposal of spot payments of allowances and fees to the clients, those who are involved with providing services in relation to permanent family planning methods (Tubectomy & Vasectomy) and long acting FP methods (IUD and Implant); and other associated expenses has been approved as follows:

(a) Sterilization Program (per client)

Sl. No.	Head of expenditure	Current payment rate	Proposal to pay as per provision of 3rd revised operational plan

		Male sterilization	Female sterilization	Male & Female sterilization	
1	**2**	**3**	**4**	**5**	**6**
1.	For Clients:				
	i. Wage compensation allowance	450/-	450/-	1400/	*
	ii. Food allowance	250/-	250/-	300/	*
	iii. Travel allowance	300/-	300/-	300/	*
	Sub-total (i-iii):	1000/-	1000/-	2000/	*
2.	Travel allowances (per client) of the referrer if s/he accompanies the sterilization client to the sterilization centre	200/-	200/-	300/	*
3.	Contingency expenses per client (Kerosine, soap, slender wick of Stove, washing of towel and linen etc.)	75/-	75/-	80/	*
4.	Surgeon's fee per client	200/-	200/-	300/	*
5.	Surgical Assistant (client screening and lab test)	50/-	50/-	60/	*
6.	Operation theater in charge (Including monitoring during operation)	50/-	50/-	60/	*
7.	Stretcher carrying, autoclaving under supervision of FWV, night stay	20/-	30/-	40/	*
8.	Aya for shaving, for cleaning of OT and post operative room	15/-	15/-	15/	*
9.	Sweeper	15/-	15/-	20/	*
10.	Record keeping and report writing (Family Planning Assistant)	15/-	15/-	20/	*
	Sub-total (2-10):	645/-	655/-	895/	*

Sl. No.	Head of expenditure	Current payment rate		Proposal to pay as per provision of 3rd revised operational plan	
		Male sterilization	Female sterilization	Male & Female sterilization	
11.	For Management, Motivation and Counseling works of Managers:				
	A. At the GOB level				*
	i. Medical Officer (MCH-FP)			95/	*
	ii. Upazila Family Planning Officer	75/-	75/-	95/	*
	Or				
	iii. Other Government Institutions- 1st Class or equivalent 2 officials in the relevant subject (MCHTI, MFSTC and Model FP Clinics, Medical College Hospitals) who are involved in this task (As mentioned in A-i & ii)				
	Or				
	B. Non-GOB- 1st Class or equivalent 2 officials in the relevant subject who are involved in this task (concern non-GOB organization will determine it) (As mentioned in A-i & ii)				
	C. Assistant Upazila Family Planning Officer/Non-GOB equivalent officials (concern non-GOB organization will determine it)	50/-	50/-	55/	*
	D. Assistant Family Welfare Officer (MCH-FP)/Non-GOB equivalent officials (concern non-GOB organization will determine it)	50/-	50/-	55/	*
	iv. Family Planning Inspector/ Non-GOB equivalent officials (concern non-GOB organization will determine it)	50/-	50/-	55/	*
	Sub Total (Managerial support):	225/-	225/-	355/	*

Sl. No.	Head of expenditure	Current payment rate		Proposal to pay as per provision of 3rd revised operational plan	
		Male sterilization	Female sterilization	Male & Female sterilization	
	Total expenses per sterilization client:	1870/-	1880/-	3250/	*

(b) IUD Program (per client):

Sl. No.	Head of expenditure	Current payment rate	Proposal to pay as per provision of 3rd revised operational plan
1.	Travel cost for IUD client	100/-	150/
2.	Insertion fee per client (for service provider)	60/-	60/
3.	Travel cost for referrer	50/-	50/
4.	Associated expenses per IUD client (Kerosene, soap, washing of towel, linen etc.)	50/-	50/
5.	Travel expenses of the client to attend the insertion centre for post IUD insertion follow-up visit as per following schedule: No. of visit | Period | Taka 1st | 1 month ± 7 days | 50/- 2nd | 6 months ± 1 month | 50/- 3rd | 12 months ± 1 month | 50/-	50X3=150/- (for 3 visits)	80X3=240/- (for 3 visits
	Total expenses per IUD client	410/-	550/

(c) Implant Program (per client):

Sl. No.	Head of expenditure	Current payment rate	Proposal to pay as per provision of 2nd revised operational plan
1.	Travel cost of Implant client	150/-	150/-
2.	Implant insertion fee	60/-	60/-

<table>
<tr><th>Sl. No.</th><th>Head of expenditure</th><th>Current payment rate</th><th>Proposal to pay as per provision of 2nd revised operational plan</th></tr>
<tr><td>3.</td><td>Fee for clinic Aide</td><td>30/-</td><td>30/-</td></tr>
<tr><td>4.</td><td>Travel allowences (per client) for the referrer if s/he accompanies the client to the service centre</td><td>60/-</td><td>60/-</td></tr>
<tr><td>5.</td><td>Contingency expenses related to Implant insertion/removal (Kerosene, soap, washing of towel, linen etc.)</td><td>50/-</td><td>50/-</td></tr>
<tr><td>6.</td><td>Travel cost of the implant client to come to the insertion center as per following schedule for follow-up services:
<table>
<tr><th>No. of visit</th><th>Period</th></tr>
<tr><td>1st</td><td>1 month ± 7 days</td></tr>
<tr><td>2nd</td><td>6 months ± 1 month</td></tr>
<tr><td>3rd</td><td>12 months ± 1 month</td></tr>
</table></td><td>50X3 =150/ (For 3 visits)</td><td>70X3 =210/ (For 3 visits)</td></tr>
<tr><td>7.</td><td>Record keeping and report writing (Family Planning Assistant)</td><td>20/-</td><td>20/-</td></tr>
<tr><td>8.</td><td>Sweeper</td><td>20/-</td><td>20/-</td></tr>
<tr><td></td><td>Total expenses per Implant client</td><td>315/-</td><td>600/-</td></tr>
</table>

(d) Recanalization Program:

Sl. No.	Head of expenditure	Current Payment rate	Proposal to pay as per provision of 2nd revised operational plan
1.	Expenses of the client regarding food, wages compensation etc.	3000/-	3000/-
2.	Seat rent (Ceiling for private hospital/clinic)	3000/-	3000/-
3.	Recanalization surgeon’s fee	6000/-	6000/-
4.	Anaesthesiologist’s fee	2000/-	2000/-
5.	Recanalization assistants’ fee (two person)	4000/-	4000/-

6.	OT charge (In case of non-government hospital)	4000/-	4000/-
7.	Drugs and MSR	4000/-	4000/-
	Total expenses for recanalization (per case)	26000/-	26000/-

(e) Special Sterilization Program (per program):

Sl. No.	Head of expenditure	Current payment rate	Proposal to pay as per provision of 2nd revised operational plan
1.	Logistics carrying and other contingency expenses for special sterilization services program Two or more special sterilization services programs can be arranged at Family Welfare Centers (at other than permanent sterilization centre) in every month.	1500/-	2000/

(f) Others:

Sl. No.	Head of expenditure	Current payment rate	Proposal to pay as per provision of 2nd revised operational plan
	All expenses for management of side-effects/ complications after receiving family planning methods	Actual expenses may be reimbursed.	Actual expenses may be reimbursed.
	Spot payment to the client's legal successor for expenses of funeral of the client if s/he died of side-effects/complications arises from receiving family planning services provided by any government service centre or by a non-government organization approved by Directorate General of Family Planning.	10000/-	15000/-

02. This would be effective from the date of circulation of this order.

Sd/- 20/03/2011

(Kulsum Begum)

Deputy Secretary, Section- FW-1

Phone- 7170109

Director General

Directorate General of Family Planning

6, Kawran Bazar, Dhaka-1215.

No.-MOHFW/FW-1/Cir-5/imprest-F/01/118 Date: 20/03/2009 AD

Copies for kind information and necessary actions:

1. Line Director, Clinical Contraception Services Delivery Program, Directorate General of Family Planning, 6, Karwanbazar, Dhaka-1215.
2. Director (Primary Health Care) and Line Director (Except Reproductive Health), Directorate General of Health Services, Mohakhali, Dhaka.
3. Chief Accounts Officer, Ministry of Health and Family Welfare, Segunbagicha, Dhaka.
4. Private Secretary to the Minister, Ministry of Health and Family Welfare.
5. Private Secretary to the Secretary, Ministry of Health and Family Welfare.
6. Deputy Director (Family Planning), District…………………..................... .

Sd/- 20/03/2011

(Kulsum Begum)

Deputy Secretary, Section- FW-1

Government of the People's Republic of Bangladesh

Directorate General of Family Planning

Clinical Contraception Services Delivery Program

6, Karwanbazar (11th floor), Dhaka-1215.

No. DGFP/HNPSP/Cl. Ser./Accounts/Sl.-445 (Part-1)/2005-2006/2010-2011/8009(2900) Dated: 23/03/2011

Copies sent for kind information/necessary action:

(Not according to the warrant of precedence)

(A) Ministry:

1. Joint Secretary (Family Welfare and Programs), Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka.
2. Joint Secretary and Line Director (Financial Management and Development), Financial Management and Audit Unit, Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka.
3. Joint Secretary (Planning), Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka.
4. Deputy Secretary (Family Welfare, Section-1), Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka.

(B) Directorate General of Family Planning (National and Divisional Level):

1. Director/ Line Director (All), ... Directorate General of Family Planning.
2. Director, Family Planning (All), Office of the Divisional Director, ... Division.
3. Superintendant, MCHTI, Azimpur, Dhaka.
4. Director, MFSTC, Mohammadpur, Dhaka.
5. Additional Director (Drugs and Store), Central Warehouse, Family Planning, Mohakhali, Dhaka.
6. Deputy Director/ Program Manager (All), ..., Directorate General of Family Planning.
7. Assistant Director/ Deputy Program Manager (All), ..., Directorate General of Family Planning.
8. Personal Assistant to the Directorate General, Directorate General of Family Planning.

(C) Directorate General of Health Services:

1. Director General, Directorate General of Health Services, Mohakhali, Dhaka.
2. Director (Primary Health Care) and Line Director (Except Reproductive Health), Directorate General of Health Services, Mohakhali, Dhaka.
3. Civil Surgeon (All).. District.

(D) Directorate General of Family Planning (District Level):

1. Deputy Director, Family Planning (All), Distict……………….................... .
2. Assistant Director (CC) and Regional Supervisor, FPCST/QAT (All) .... Region.
3. Assistant Director (CC/FP)/ Medical Officer (CC) (All), ...District Family Planning Office, ... District.
4. Medical Officer (Clinic) (All), MCWC, ...District.

(E) Directorate General of Family Planning (Upazila Level):

1. Upazila Health and Family Planning Officer (All), Upazila Health Complex, Upazila ...., District ....
2. Medical Officer (MCH-FP)/Upazila Family Planning Officer (All), Upazila ...., District ....
3. Assistant Upazila Family Planning Officer/ Assistant Family Welfare Officer (MCH-FP)/ (All), Upazila ...., District ....

(F) Accounts Office:

1. Chief Accounts Officer, Ministry of Health and Family Welfare, Segunbagicha, Dhaka.
2. Divisional Controller of Accounts (All) ....Division.
3. District Accounts Officer, ...District.
4. Upazila Accounts Officer, Upazila ...., District ....

(G) NGOs and Others:

1. Dorector General, FPAB, 2, Nayapalton, Dhaka-1000.
2. Executive Director, BAVS, Mirpur, Dhaka.
3. Country Representative, EngenderHealth, Dhanmondi, Dhaka.
4. Chief of Party, SSFP, House # 15(A), Road # 35, Gulshan-2, Dhaka.
5. Managing Director, Marie Stopes Clinic Society, Mohammadpur, Dhaka.
6. Dr./ Mr. ....

* Due to having no final list of hard-to-reach areas, money should be paid in accordance with the same increased rate.

The Director General has approval on it.

Sd/- 23/03/11

(Dr. A K M Mahbubur Rahman)

Line Director

Clinical Contraception Services Delivery Program

Phone- 8152311 (Office)