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CHAPTER 7

LESSONS FROM SUCCESSFUL EXPERIENCES

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SUMMARY

Over the past eighteen years since its liberation, Bangladesh has been trying to achieve economic development and societal modernisation to alleviate widespread poverty. Unfortunately, the government's efforts have largely failed to extend benefits to a vast majority of the rural poor. The situation is not much different in the population sector. Although containing the high rate of population growth is considered a top priority by the government, achievements have been very modest. In the backdrop of such a disquieting scenario, extending benefits and services to the poor at the grass-roots level has increasingly become an abiding concern for the government and non-government organisations (NGOs) alike. "Special" programmes were undertaken by the government and various NGOs. Some of these were very "successful" in attaining certain objectives but others were not. In this chapter we have looked at six different projects which are either addressing the question of family planning exclusively or are involved with much wider development interventions.

The project run by the International Centre for Diarrhoeal Disease Research (ICDDR,B) in Matlab has been quite successful in increasing the contraceptive prevalence rate (CPR) and in reducing the fertility levels. The project of the Centre to replicate the Matlab experience in the normal government programme in two upazilas has so far achieved mixed results. In the Bangladesh Rural Advancement Committee (BRAC), family planning is not a priority but through the successful implementation of other programme elements such as female education, health, nutrition, income and employment generation, conscientisation and empowerment, women's development, etc., the proximate determinants of fertility are being effectively addressed. The question of activating the government system to provide better health and family planning services was addressed by the Munshiganj (GTZ) project. Different innovative programmes of Gonoshasthya Kendra (GK) are addressing the health, family planning and women's status questions. CARE is helping the government in its immunisation programme and Bangladesh Women's Health Coalition (BWHC) is concentrating on women's reproductive health and clinical contraceptives. The reasons behind the apparent "success" of these projects are discussed and their limitations pointed out.

I. INTRODUCTION

Bangladesh is well known for its poverty with a vast majority of its people living at the margin of life and continuing an unprecedented struggle for survival at a bare subsistence level. The efforts of the government to improve the quality of life of its people through economic development and societal modernisation over the past seventeen years have unfortunately earned little success. The modernising drive has neither spurred sufficient growth in the agricultural output nor encouraged adequate development in the non-agricultural sector. In fact, by most socio-economic indicators, the condition of the people has shown a marked deterioration.

In the agricultural sector, an increase in polarisation has led to an increase in the pauperization of the rural poor. While the poorest 70 percent of all cultivators owned 29 percent of the farmland in 1983/84, the richest 5 percent owned 26 percent (ILO/ARTEP, 1985). Further, the number of landless households has also grown significantly between 1960 and 1985 from 1.5 million in 1960 to 7.75 million in 1985 (ILO/ARTEP, 1985). The figures are much more revealing for the countryside. While in 1960, the families which could be called functionally landless (owning 0.5 acre of land or less) made up 35 percent of all rural households, in 1978 they represented more than one half (Ahmed and Hossain, 1985); the recent figure sugests 62 percent (Government of Bangladesh, 1989).

The available statistics suggest that employment in the agricultural sector has also declined over time. While about 16.8 million people were employed in the agricultural sector in 1975, the figure came down to 16.4 million in 1983/84 (Bangladesh Bureau of Statistics, 1984). The real wage also dropped from a unit of 100 in 1969/70 to 88 in 1973/74 (World Bank, 1983). The impact was evident in the per capita food intake of the people also. Between 1962-64 and 1981-82 the consumption of cereals has dropped by about 11 percent, of animal protein by 22 percent and other forms of food by 15 percent (INFS, 1984).

In the backdrop of such a disquieting scenario, extending benefits to the poor at the grass-roots became an abiding concern for the government and non-government organisations (NGOs) alike. Special programmes were undertaken both by the government and NGOs aimed at enhancing the income of the poor through development initiatives on the one hand and arresting the population

growth through population control and family planning on the other. Through such special programmes, innovative ideas were experimented with to find out their usefulness, applicability, acceptability and programmative feasibility at the macro level. Learnings from such experiments were expected to provide directions for their replicability at the macro level.

Since the early Pakistan days, several of these programmes were initiated, many of them by the government. One such special programme was started in Comilla in 1959 with distinctive development orientation which later came to be known as the well-known "Comilla Model."

The Comilla model comprised of a two-tier cooperative structure - the primary cooperative society at the village level called the Krishi Shamabaya Samity (KSS) (Agricultural Cooperative Society) and a federated structure at the thana level known as the Thana Central Cooperative Association (TCCA). The cooperatives were used as a useful mechanism to distribute credit and other inputs to their members and also encourage mobilisation of resources through savings. There was a training centre at the thana level called Thana Training and Development Centre (TTDC) to provide training to the chairmen and members of KSS to enhance their competencies in management, finance, administration, agricultural skills, etc. The Thana Irrigation Programme (TIP) was initiated to provide support in the area of irrigation and water management, and the Rural Works Programme (RWP) was initiated to provide employment opportunities to the unemployed and also promote infrastructural development. The Comilla programme was targeted to small farmers with the expectation of bringing the landless into the fold. The programme initially earned great success in its experimental area - Comilla Kotwali Thana - in enhancing agricultural output and in increasing the income of the farmers. But later, the infiltration of the rich into the cooperatives deprived the poor of their due access to facilities and resources, thus defeating the very purpose of the programme. Though the programme was replicated throughout Bangladesh through the Bangladesh Rural Development Board (BRDB), it never succeeded in achieving its intended impact (Adnan, 1988).

Another special programme was launched during the seventies which came to be known as the 'Swanirvar Movement' (Self-reliance Movement). The programme aimed at alleviating poverty at the grass-roots through local level planning by a committee comprised of members drawn from various sections of the population. The programme particularly concentrated on forming cooperatives and providing credit support to income-generating activities. While the volume of credit disbursed increased significantly, the rich benefited more than the poor (Hossain and Afsar, 1988).

The lessons learnt from both the special programmes undertaken by the government suggested that mere formation of cooperatives and provision of credit support cannot ensure the participation of the poor in the development process and extension of benefits to them. In late seventies the Ulashi - Jadunathpur (UJ) project was launched in Jessore district. The project emphasised the mobilisation of resources from within the community to attain the objectives. The project sought to dig 2.65 mile long canal to connect a water logged area with a river which was thought to lead to a boost in agricultural output. With the leadership provided by the Deputy Commissioner (head of the district administration) of Jessore under the patronage of the then President of the country, the project was successfully completed with the assistance of local elites and landlord. Though the implementors insisted on calling it "self help," wrote Zaman (1984), it was not a case of voluntary mass participation. The project initially aroused wide interest and was incorporated in the Second Five Year Plan of Bangladesh as an important rural development strategy. However, it is now forgotten, partly because of the departure of the Deputy Commissioner and the death of its patron.

Though recent in origin, NGOs in Bangladesh have earned reputation in extending support and services to the poor at the grass-roots level. Their success has drawn official donors from developed countries and the volume of funds committed to NGOs, though much less compared to the amount of total foreign funds received by the government, is showing an increasing trend. The multilateral and bilateral donors have shown their interest in disbursing aid through NGOs which, if effected, could increase the volume significantly.

NGOs operating in Bangladesh are large in number and varied in activities. Officially, any organisation ranging from sports clubs and cultural groups to those addressing poverty of the people, registered with the social services department under the Social Welfare Ministry of the government, is usually termed as NGO. The current number of such NGOs stands at about 12,200. Out of this nearly 20 percent receive funds from foreign donors.

The NGOs have tried to address poverty through undertaking 'special' programmes drawing lessons from the past. In their programmes many of them have concentrated on organising the poor at the grass-roots into homogeneous groups and empowering them through a continuous process of education and concientisation. The whole focus of NGOs is to develop social, technical and managerial competencies of the organised poor to enable them to address their own problems and to undertake need-based programmes which they can plan, implement and manage. Such capacity development of the poor is expected to

ensure sustainability of the programmes they undertake. The NGOs are meant to conceive development in holistic terms and integrate health and family planning within its development programme. However, some NGOs are found to undertake 'special' programmes, specifically in the area of health and family planning.

On the basis of their nature and functions, NGOs in Bangladesh may be classified into distinctive types. Such types include: relief and welfare NGOs, service NGOs, funding NGOs, technical support NGOs, networking/coordinating NGOs, and development NGOs. The service NGOs are particularly engaged in delivering services ranging from health care and family planning to agricultural inputs and services.

Organisations like Radda Barnen, Gonoshasthya Kendra (GK), Bangladesh Women's Health Coalition, Bangladesh Association for Voluntary Sterilisation (BAVS), Concerned Women for Family Planning, Family Planning Association Bangladesh, etc. fall into this latter category. To ensure an effective delivery of health services and family planning to the poor, the NGOs have either strengthened the existing health care system or have developed appropriate institutional structures and mechanisms. Some NGOs have developed the system of providing health and family planning services to the poor through outreach centres, while some others have directed their efforts towards providing such services through static centres. The special programmes of NGOs have, in fact, developed systems and institutional structures for creating a sustainable health care system at the community level through people's participation. Contribution of GK, Radda Barnen, BAVS, Concerned Women for Family Planning, Bangladesh Family Planning Association, BRAC, CARE, etc. in providing maternal and child health (MCH) and family planning services is noteworthy. In the following section, case-studies on a few selected NGOs, achieving remarkable success in their own fields of specialisation, with particular emphasis on health and family planning, are briefly presented.

How to define success?

Scanning the documents available from different projects in Bangladesh puts one in considerable difficulty in deciding whether the particular project in question is a success story or not. In population related activities a project can be called "successful" if it brings an impact on fertility level. But in a situation like in Bangladesh where adequate information is scarce on most projects, reliable information on fertility is often unavailable. The alternative is to consider the

process related indicators - the so called "proximate determinents of fertility". As mentioned previously, the projects which focus on fertility reduction through family planning are only a few. Most other projects are of integrated type encompassing many developmental components such as education, consciousness raising, health, nutrition, income and employment generation, and family planning. Almost all these are expected to affect, directly or indirectly, the following four proximate determinants of fertility: proportion married, lactational infecundity, contraceptive use, and induced abortion. In our selection of projects we have chosen those which are reported to have an impact on one or more of these determinants towards fertility decline, often through increasing contraceptive use, raising female status or reduction of infant and child mortality. Availability of project level data on the relevant issues was also an overriding consideration in the selection.

II. CASE STUDIES

2.1 ICDDR,B - A Research Initiative

2.1.1 Introduction

The International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), formerly Cholera Research Laboratory (CRL), has been running a demographic surveillance system in part of Matlab Upazila since 1966. The population of Matlab according to the 1974 census was 276,000 who live in 233 riverine villages. A large number of epidemiological research as well as vaccine trials have been conducted in this area since CRL's inception in 1963.

2.1.2 The Contraceptive Distribution Project

In the backdrop of overpopulation problem of Bangladesh and the failure to increase contraceptive prevalence, a contraceptive distribution project (CDP) was started in Matlab Treatment Area in 1975 to distribute two selected non-clinical contraceptives, pill and condom, to fecund couples.

Within three months of inception of the project, contraceptive prevalence rate increased from a baseline of 1 percent to nearly 18 percent. However, it declined to 14 percent at the end of the first year and to 12 percent by the end of the second year. The share of condom was very low at less than 5 percent. The continuation rate was also low and at two years was 25 percent. The prevalence

rate in a comparison, area, however, remained the same at 3 to 4 percent (Stinson *et al.*, 1982; Rahman *et al.*, 1982).

The Family Planning Health Services Project

The CDP provided a wealth of information and experience. Based on the CDP experience, a new programme, called Family Planning Health Services Project or FPHSP, was launched in 1977. The basic objective was to incorporate in a new programme the lessons learnt from the CDP and to study its outcome. The salient features of this new programme in comparison to CDP were the following:

1. shift the priority from a method-oriented strategy to a client-oriented strategy;
2. provide ancillary health services; and
3. increase the status of the lowest level field workers.

New workers were recruited who were better trained, educated, young and came mostly from better-off families. Supervision was streamlined and more experienced and qualified people were posted for the purpose. In order to provide better health services, new MCH components were introduced which included vaccination of women against tetanus and of children against measles, promotion of oral rehydration therapy (ORT) for diarrhoea, training of traditional birth attendants (TBAs), and more recently posting of nurse-midwives to deal with maternal health problems. In order to provide a choice to the clients, a new range of three services, viz. copper-T (interuterine device), Depo Madroxyprogesterone Acetate or DMPA (injection) and menstrual regulation or MR were introduced. Both IUD and injectables were offered in the homes along with other contraceptives such as pill, condom, etc. At the time FPHSP started in September 1977, 7 percent of the eligible women were acceptors of family planning. It rose to 21 percent after three months and to 33 percent after 18 months. Proportion continuing the use of a method was 74% after 18 months. Recent reports speak of even higher prevalence rate at 52 percent (1989). In the comparison area, on the other hand, the rate remained low at 8 percent in 1982 (Phillips *et al.*, 1982).

There was a shift in the choice of contraceptives by couples. Previously pill was the most popular. But in FPHSP, DMPA was the most popular (49.7 percent of all users), followed by tubectomy (19.7 percent) and pill (12.7 percent).

The project also had a direct impact on fertility. At the time the project started, the total fertility rate (TFR) in the treatment area was 8 percent lower than that in the comparison area. But within two years, the TFR in the treatment area was approximately 20 percent lower than that in the comparison area. On the whole FPHSP reduced fertility by 22 to 25 percent within two years (Phillips *et al.*, 1982).

2.1.3 The Extension Project

The sharp increase in contraceptive prevalence rate and its consequent impact on fertility level in Matlab raised the question of its replicability in other areas of Bangladesh. In order to test the feasibility of incorporating in the regular government programme some of the lessons learnt from Matlab, ICDDR,B in collaboration with the government started a project, called MCH-FP Extension Project, in two other upazilas (sub-district) of Bangladesh which are Adhoynagar in Jessore district and Sirajganj in Sirajganj district (Phillips *et al.*, 1984).

The ICDDR,B intervention sought to strengthen the knowledge and supervisory capabilities of the mid-level government staff at the upazila level so that they could better control and supervise the implementation of the programme at the village level. The key objectives of the intervention were to (re)-impart technical knowledge and management skills to the government staff and to emphasise a client-oriented approach. This was done through a series of four-week training workshops for field level workers. In those training programmes family planning, oral rehydration for diarrhoea and tetanus immunisation were particularly emphasised. Household visiting pattern, motivational techniques, community relations, referrals, record keeping, etc. were emphasised through practical field demonstrations.

Following the training, the workers from ICDDR,B with years of working experience in Matlab helped establish a pseudo Matlab recording system in these upazilas.

Although no conclusive evidence is yet available about the project's impact on contraceptive prevalence rate or on fertility, it has however provided some important lessons and experience which in themselves may be helpful in future decision making and in streamlining the government programme. Over the initial two years of the project, the quantity of work done by various types of government workers increased, due mainly to the very presence of ICDDR,B staff. The project also identified many problems and constraints, which included

shortages of supplies and inadequacy of various essential facilities, non-integrated approach of health and family planning workers, etc.

2.1.4 Discussion

The ICDDR,B experience in Matlab showed promise by reaching an impressive contraceptive prevalence rate of up to 45 percent in 1984 compared to the national average of 21 percent. Such a result was significant particularly in the absence of any known socio-economic improvements. The ICDDR,B project is one of extensively researched projects. A number of factors have been attributed to its success. The record keeping developed in Matlab over the past 20 years or so facilitated the monitoring of various activities and identifying the determinants of success. The organisational ability of ICDDR,B was an important factor. Over the years, a cadre or workers was developed, whose motivation was further increased by higher salaries. The worker-population density was nearly 6 times higher than in the government programme and the workers were trained to treat minor side effects. The choice of other interventions such as immnisation, ORT, etc. was also a contributory factor. A cafeteria approach was introduced and implemented. Many contraceptives such as injectables, IUD, pills, condoms, etc. were offered in the home. This is particularly important in a society such as Bangladesh where the women find it culturally difficult to visit a distant clinic for IUD insertion or receiving injectables.

The Matlab experience does not of course tell us specifically how this success can be replicated in a national programme. The MCH-FP Extension Project undertaken by ICDDR,B in two upazilas seeks to address this question. Our knowledge is not yet complete regarding the outcome of this new initiative, although some success has been reported in activating the local-level government system. The government has also responded favourably to some of the project findings and decided to increase the density of FWAs. The ICDDR,B project has, however, raised more questions than answers. The replicability has remained a critical issue. It is generally accepted that Matlab in its full cannot be replicated, particularly because of its high cost. No definite conclusion can be made in this regard in the absence of relevant information such as costs about Matlab and the government programmes. However, it may be that the Matlab model is still favourable when one considers its effectiveness compared to its costs. The MCH-FP project may be another alternative to replicating Matlab. We should watch how it progresses in replicating some of the essential Matlab experiences in the two upazilas. Only then the success of Matlab can be fully

assessed. Until then it will remain interesting only in itself as a research initiative.

2.2 *Munshiganj Project: Assistance to Government Programme*

2.2.1 Introduction

Another project which was carried out in Bangladesh between 1979 and 1987 tried to develop the existing government health and family planning services with particular emphasis on the development of union level static centres known as Family Welfare Centres (FWCs). The project, undertaken by the Ministry of Health and Family Planning (MOHFP) in collaboration with the German Technical Assistance Agency known as GTZ, was carried out in six upazilas of Munshiganj district in central Bangladesh (Allwardt, 1988).

2.2.2 Project Objectives

The project had the following objectives:

a. to assist MOHFP in achieving their goal of improving health services and reducing infant and maternal mortality;

b. to improve the management capability of health services;

c. to identify major health services barriers and evaluate cost effectiveness of the strategies.

2.2.3 Project Strategy and Results

Though the project started in 1979, it did not have a clear strategy until about 1983. During this period, the project established 14 new FWCs (Family Welfare Centres) at the union level, and upgraded 22 others out of a total of 44 in the project area.

In 1983 the project formulated an operations research strategy and tested various interventions which will be discussed below. It emphasised streamlining of the management system from the grass-roots to the upazila level which included health information system, training and supervision, monitoring and evaluation, and management of supply. Most of the interventions had four components in common : on the job training of MOHFP local staff, monthly staff meeting, supportive supervision and logistics.

The project emphasised the utilisation of local MOHFP staff at all levels upto upazila. However, a number of key supervisory staff were added from the project side. Also, supply of contraceptives was ensured by the project. Not much information about how the interventions were carried out in practice is, however, available. At the baseline in 1981 the CPR was 12% which rose to 44% in 1987. In a comparison area the CPR rose to 32% (For a comparative study of the Munshiganj and ICDDR,B's Matlab Projects, see: Banu *et al.*, 1988).

Regarding the sources of supply/services, approximately 75% of the women in the intervention unions mentioned the FWC compared to 33% in the control unions.

2.2.4 Discussion

In this project, the interventions relied mostly on strengthening the service points and streamlining other systems such as supervision by providing additional supervisory staff, fostering inter-staff interactions through staff meetings and meeting shortage of supplies. The project has shown that the existing MOHFP programmes in Bangladesh can be substantially improved, at least in respect of increasing the prevalence rate, with some additional efforts. Unfortunately, little information on the impact of this project on fertility is available.

The project was stated to spend only 5 percent over the MOHFP expenditure for the ongoing programme. However, it did not consider the costs incurred by hiring additional supervisory staff which may have been substantial. Because of the paucity of costs information, the cost-effectiveness of this initiative cannot be determined. The replicability of the project will largely depend on this. It may be pointed out that the hiring of additional supervisory staff was crucial to its outcome. It would be of interest to observe what happens in the absence of these supervisory staff. The project has, however, shown that with the introduction of the four elements such as on the job training, supportive supervision, monthly staff meeting and logistical support, considerable increase in CPR can be made. The project was closed down in 1987 and it may now be worth following the progress in Munshiganj without GTZ input. More experiments of this type with in-built mechanism for assessing additional costs incurred are called for to examine its replicability in other upazilas.

2.3 *BRAC: Family Planning in the Context of Overall Development Approach*

2.3.1 Introduction

The Bangladesh Rural Advancement Committee (BRAC) is a Bangladeshi rural development organisation. Registered in 1972 in the aftermath of the Liberation War, BRAC has evolved as one of the largest non-governmental organisations (NGO) in the world with 3,600 full-time staff. Family Planning was one of its priority programmes in the early days but later on BRAC decided to concentrate on other sectors of development such as education, health and income generation activities. In this case study we describe how this transition came about and what BRAC is now doing to hasten population control activities.

2.3.2 The Sulla Experience

Sulla is a remote rural area in northest Bangladesh and was one of the areas devastated during the Liberation War. BRAC was founded to rehabilitate the war affected people, particularly the returning refugees who were trekking back from India. But soon it was realised that providing relief was not the ultimate solution to people's multifarious problems and hence a community development programme was developed with particular emphasis on family planning, health services and functional education in 220 villages of Sulla region with a population of about 130,000.

The family planning component of the project began in 1974. Local family planning workers were recruited to supply contraceptives to eligible couples. Trained paramedics attended to the cases of side effects and provided other health services. Oral pill was found to be the most popular method, followed by condom and foam tablets. By 1976, approximately 20% of the eligible couples became acceptors of family planning. The result on the continuation of contraceptives was more encouraging. Nearly 52% of the users of oral pills were found continued users at 18 months which was the highest for any project in Bangladesh at that time, including the Matlab project which was run by the former Cholera Research Laboratory (Chowdhury *et al.*, 1978).

The coverage rate plateaued at 20% and did not increase much further. In 1978 BRAC reconsidered its strategies vis-a-vis experience gained in various development components, including family planning. It was revealed that the benefits of BRAC efforts were not reaching the poorest sections of the community, and the middle and richer classes were taking advantage of the

BRAC inputs. Improved agricultural methods were being adopted by the landowners and the health insurance scheme was taken mostly by those who could afford the premium (Zaman, 1984; Briscoe, 1978). It was the disadvantage of working for the whole community and BRAC decided to concentrate its effort to working only with the landless and near landless who afterwards formed BRAC's target group. In respect of family planning, the plateauing of coverage at 20% was frustrating, despite BRAC's efforts to increase it. It was then concluded that people would not, probably, adopt family planning unless some other basic needs - such as health, social and economic - were met.

With this experience and the then government policy of restricting NGO activities in family planning to only urban areas family planning remained a low priority in BRAC. Instead they diverted their attention and efforts to effect structural changes so that those basic needs are met. It was assumed that if such structural changes occur, family planning and a lower birth rate would automatically follow (Chowdhury, 1978).

2.3.3 The Existing Programme: Manikganj Example

Manikganj is an upazila approximately 65 kilometres west of Dhaka. Since 1977 BRAC has been running an integrated development programme in Manikganj.

The core of the programme is the organisation of village level target groups, separately for males and females. The process starts with the initiation of (adult) functional education courses which is an effort to conscientise the target group as well as to provide them some literacy and numeracy. The conscientisation part deals with almost all aspects of life including health and family planning which is exclusively covered through four of its 30 lessons. Following the formation of the group, the members take part in regular weekly meetings and a statutory saving. In these meetings the members discuss the problems which they face individually as well as collectively. Problems related to overpopulation is always high on the regular agenda (BRAC, 1987).

In each group a member is trained on a specified skill. For example, a member is trained on how to immunise the cattle, another is trained on how to provide health care or to provide functional education to fellow target group members. Another may be trained on how to run and look after an irrigation asset owned by the group. The member who is primarily responsible for health and family planning is called *Shasthya Shebika* (SS) or Female Health Worker. Most

women's groups have an SS who is trained by BRAC's doctors and paramedics. Their training includes both preventive health care as well as curative care for some common ailments such as diarrhoea, dysentery, common cold, worms, etc. They charge a fee and sell drugs which they receive from BRAC at cost prices. They are also trained to immunise children and mothers. The SS work for family planning motivation by helping the government family welfare assistants (FWAs) in recruiting new acceptors and providing follow-up serivces for side effects. They also help in organising sterilisation camps and share the referral fees with FWAs.

In Manikganj BRAC is working in 235 villages with a population of about 220,000. Nearly 30,000 target group members have been organised, 60% of whom are females. A total of 256 SS are working and BRAC has trained nearly 500 traditional birth attendants (TBAs) who also provide family planning motivation.

In order to provide education to children, nearly 200 non-formal primary education schools have been set up enrolling 6,000 children, 70% of whom are females. A total of 15 million taka has been disbursed as credit to target group members and the on-time recovery rate has been more than 90%.

2.3.4 Other Programmes

In the above, we described the programme in Manikganj which encompasses a large number of development interventions such as education, conscientisation, credit and health. Family planning, though not in the forefront as a major programme, is promoted through different forums. We now briefly describe some other BRAC programmes which are largely vertical in nature.

The *Rural Development Programme (RDP)* organises male and female target groups. Credit is provided to them for profitable income generating activities. RDP is now working in 40 upazilas with a membership of more than 300,000, half of whom are female. A total of over 300 million taka has been disbursed as credit with repayment rate of nearly 95%. If the present rate of expansion continues, a quarter of the country will be covered through this programme before the turn of the century.

The *Oral Rehydration Programme* was started in 1980. Health workers were trained to teach mothers how to save the lives of their children from diarrhoeal dehydration by preparing and using a simple solution made with home ingredients. Mothers in 12 million households (75% of rural Bangladesh) have

already been individually instructed on how to make and use this solution at a cost of 72 US cents (1984) per household visited (Chowdhury *et al.*, 1988). BRAC is also helping the government in its expanded programme on immunisation in 147 upazilas in vaccinating children against six diseases and women against tetanus.

The *Non-formal Primary Education (NFPE)* is a new programme to educate the millions of children who drop out or never go to formal schools. Nine hundred of these schools have already been opened in many upazilas with 27,000 children, 70% of whom are females. Details are being worked out now to open 9,000 such schools during the next two years.

The *programme to train 5,000 government family planning workers* (viz., the FWAs) is a new dimension to BRAC programmes. Through this training BRAC is trying to diffuse its own experience on the problems faced by these workers in a field situation and means to deal with them in increasing their effectiveness. Another programme has been started in six upazilas to activate the government health and family planning activities at the grass-roots level.

2.3.5 Discussion

Over the years, a lot has been tried out and much has been achieved through BRAC programmes. Awareness of the target groups has been raised quite substantially and they earn more and live better lives than their fellow others who did not join BRAC organised groups (BRAC, 1988a, 1988b). Mothers have been successfully trained on how to save the lives of their children through homemade oral rehydration solutions and initial results indicate a substantial reduction in the mortality levels of children aged one to four years (Chowdhury, 1987). Immunisation programme should also be saving large number of child and maternal deaths. An education programme focussed towards the females ("the future mothers") is gaining ground with a low drop out rate of less than 5% over a three year period. This is quite impressive compared to the government schools where 80% drop out before completing five years of schooling. All these have been done with the active participation of the target people.

If the "beyond family planning" hypothesis should hold, the above initiatives by BRAC should have a positive effect on the birth rate and also on the acceptance of family planning. A recent survey done in Manikganj found a contraceptive prevalence rate of up to 38% (Chowdhury, 1987a), much higher than the national average. We, however, do not know for sure whether the initiative started by BRAC in the late 1970s did bring the birth rate down nor we

know whether family planning acceptance is better in areas where other development programmes such as credit, health or education have been successfully implemented. Current research undertaken by BRAC will throw more light on the hypothesis.

The other question is how much such efforts can be replicated over the whole country. Some of these programmes, such as the oral rehydration programme, have already been implemented nationally. The immunisation programme is covering a third of the country. Other programmes are, however, time intensive. For example, it will take several years for BRAC to cover the whole country through its credit programme. However, it does not have to be only BRAC to do it all over the country. And indeed others are coming forward to replicate this or similar programmes. For example, Grameen Bank has so far opened 500 branches to extend easy credit to the landless and is expanding even faster than BRAC.

The other related question is whether an effective programme such as the one on ORT could be implemented on family planning by BRAC or any other agency. ORT had an advantage that it was only a matter of providing knowledge and skill to the mother to prepare it at home with home ingredients. But it is quite different for family planning which requires a constant supply and service line from beyond home and sensitivity to various socio-cultural factors. However, training to FWAs and a facilitation assistance programme to further activate the health and family planning field staff are already underway in different upazilas of the country. It is expected to favourably affect the performance of the government programme.

2.4 Gonoshasthya Kendra: Building Local Capacities

2.4.1 Introduction

Gonoshasthya Kendra (GK), meaning People's Health Centre, began operating in Savar, Bangladesh, in 1971. From the very beginning GK focused on evolving an integrated and sustainable health care system in Bangladesh, catering to the needs of the rural poor.

2.4.2 The Focus

The central focus of GK was directed towards women. The programme included, among others, (a) education programme concentrating on literacy and

numeracy and other subjects such as birth planning, health education, etc. that critically affect their lives; (b) skills development programme, aiming at improving various skills of women to generate employment opportunities to enable them to earn income for improving their social status; and (c) health and family planning, aimed at providing health care and family planning support to women and emancipating them in the long run (Chowdhury, 1987).

The aim of GK was to extend family planning and health care services to the doorsteps of the rural poor. Based on its prolonged field-level lessons and learnings, GK realised that it could be possible only through developing a group of para-professionals drawn from among the people of the community who could command confidence, trust, credibility and acceptability in the community. The paramedics were given intensive training on various aspects of health and family planning including skills of performing menstrual regulation, ligation and vasectomy. Their job included among others, motivation of women in family planning through regular visits to their homes, registration of births and deaths and immunisation of children; antenatal checks; supplying contraceptives and making necessary follow-up visits; etc.

Further, to reduce the incidence of maternal and infant mortality, GK worked on upgrading the skills of traditional birth attendants (TBAs) who usually attend to all the deliveries in the rural areas. These TBAs, besides performing safe delivery, were also used for motivating women in family planning, and provide education on the importance of immunisation and nutrition. GK's focus on the use of the paramedics and the TBAs has succeeded in extending the medicare and family planning services to the doorsteps of the rural poor without having to make significant financial investments. Another innovation in GK is its health insurance scheme. A graduated system of premium favouring the poor was designed and is being implemented. GK has succeeded in covering over 66 percent infants with DPT and Polio immunisation and over four-fifths of the child bearing women with tetanus toxoid. In case of BCG immunisation the coverage was 83 percent. The total cost incurred by GK in immunising a child against 6 EPI diseases is estimated to be only Tk. 47.94 (US $ 1.6) which is much less than the WHO estimate of $ 5-15 for such immunisation (Ray, 1986).

2.4.3 Discussion

The existing health care system in Bangladesh is curative and urban biased. GK has played a pioneering role in introducing the concept of integrated outreach health care for the poor with the help of para-professionals drawn from

the community. Much of its work has been replicated by the government, other NGOs and by itself. GK is now working in many other areas of rural Bangladesh with similar programmes as in Savar. Similar to many other NGOs, however, the documentation system in GK needs to be strengthened and its experience further disseminated. The other question often metioned is the sustainability of the whole effort.

2.5 *CARE: From Relief to Health Care and Development*

2.5.1 Introduction

CARE, an American NGO, has been operating in Bangladesh since 1955. Prior to independence in 1971, CARE's involvement was confined to relief, school-feeding, construction of ware houses and low-cost houses. However, a shift in its strategy took place in 1974. CARE started working closely with the government and local agencies in income-generating and health activities. Today, CARE's programmes in Bangladesh include integrated food-for-work (IFFW), landless owned tubewell users support (LOTUS), women's development (WD), women's health education (WHE), and training immunisers in the community approach (TICA).

This case-study focuses on the TICA programme of CARE which features a unique approach of an NGO complementing government efforts in undertaking a nationwide programme through facilitating and effecting needed systematic changes to ensure a successful implementation of the programme (Tsitoulis *et al.*, 1987).

2.5.2 The Immunisation Programme (TICA)

CARE initiated its TICA programme in 1987-88 to assist the government in implementing its expanded programme on immunisation (EPI) more effectively through working closely with the government personnel at all levels. CARE's efforts were geared towards developing the competencies of the government personnel and specifically assisting in the planning of the EPI activities and in the training, management and supervision of the EPI staff, facilitating implementation through staff duty assignments, logistical support, monitoring, social mobilisation and awareness building in the target communities. To date, CARE has concentrated its efforts in 96 upazilas under the Khulna division. From the evaluation of the (TICA) programme, it appears that within a span of only one year and a half, the coverage of the programme has expanded

remarkably. The coverage for DPT-1 and TT-1 has gone up to 100 percent. Even for the third dose of Polio and DPT, the coverage is more than 50 percent. It also appears that the outreach programme has contributed to a widespread dissemination of knowledge and a high degree of understanding of the EPI. One hundred percent of the community leaders and 95 percent of the mothers are familiar with the EPI, and nearly three-fourths of these leaders and more than a half of the mothers could correctly identify three or more diseases against which immunisation is effective (Wilson-Moore, 1989; CARE, 1989).

2.5.3 Discussion

The six diseases for which vaccines are available are amongst the major causes of childhood morbidity, mortality and disability in Bangladesh. Although the expanded programme on immunisation (EPI) was started in Bangladesh in 1979, its performance has been very modest and until 1984 the coverage was less than 2 percent. In 1986 the government launched an intensified EPI with a target to achieve "universal child immunisation" (UCI) by 1990. Such as ambitious target required assistance to government in different aspects of the programme. Several NGOs particularly CARE and BRAC came forward to help the government in training and social mobilisation. CARE is working with the government is 96 upazilas and BRAC in 147 upazilas, representing more than half the upazilas of the country. Initial results indicate success of the programme in immunising children and mothers.

The outcome of this collaborative project with the government is being constantly monitored through regular service statistics and independent coverage surveys. It appears to have added a new dimension to NGO activities which may also be extended to other development activities, particularly family planning.

2.6 *Bangladesh Women's Health Coalition (BWHC) : Providing Reproductive Health Care*

2.6.1 Introduction

The Bangladesh Women's Health Coalition (BWHC) was established in 1980 through setting up of two clinics in the metropolitan areas of Dhaka and another in a district town to provide clinic-based contraceptive services and other methods of contraception meant for women. In the course of time, its services were expanded to include maternal and child health care and family planning services through establishing three more clinics.

2.6.2 Present Activities and Results

Presently the BWHC provides a package of services which includes counselling on family planning; performing menstrual regulation; IUD insertion; providing injectables and other contraceptives; and providing treatment to various diseases related to maternal and child health. Besides, the BWHC is engaged in motivating women in adopting contraceptive methods and immunising their children and educating them on various social and health issues affecting their lives through regular home visits. It also trains government Family Welfare Visitors (FWVs) to enhance their skills in extending family planning services. During the period between September 1986 and June 1987, the BWHC was able to train 109 FWVs. The training, including menstrual regulation, lasted for three weeks. BWHC also provides one-week refreshers training to the FWVs (Kabir, 1988).

Available statistics suggest that through each clinic, BWHC provides health, family planning services and child health support to as many as 1000-1500 clients a month. One third of these services are provided in the area of family planning, one third in the area of women's health, and one third in children's health and immunisation. From the experience of the BWHC, it appears that there is a great unmet demand for menstrual regulation and other contraceptives, and acceptance of family planning could be increased through personalised services and sustained contacts and motivation.

An evaluation done recently found out the costs of the programme. The average cost per post-MR contracepting client was $ 3.75 and the average cost per returning client was $ 5.68, which are less than the range of costs reported by other programmes in developing countries (Kay and Kabir, 1988)

2.6.3 Discussion

The initiatives undertaken by the Bangladesh Women Health Coalition in the field of health and family planning are comparatively recent ones. These started with mere menstrual regulation services, and then extended to include maternal and child health, attesting to the fact that the relationship between maternal and child health on the one hand and family planning on the other is demographically an inseparable one. It should be mentioned here that BWHC intends to expand its scope of activities so effectively as to make a shift from provision of high quality reproductive health services through clinics, to community development through education and empowerment of women.

III. GENERAL DISCUSSION

3.1 Introduction

In most analyses, examples of successful experience, be it in family planning or any other, come from small efforts. Such projects are traditionally conducted in small geographical areas and are typically non-governmental in nature, often done by some non-governmental organisation (NGO). The cases we have presented here came from selected NGO experience in Bangladesh, including ICDDR,B which is an international centre of research, with status of an international NGO.

With a particular focus on the prospects of reducing birth rates and fertility, we chose projects which had a direct family planning and/or health component as well as those which dealt with overall development approach. Many of these projects were large and conducted all over Bangladesh. The activities of the projects dealing with overall development included poverty alleviation, female literacy and preventive and promotive health care.

Linked with the nature of activities, the indicators used to measure success have varied. While direct impact on fertility is available for only one project, proxy indicators such as improved income or reduced death rate, etc. are available for others. In situations where none of these is available, impressionistic evaluations have been indicated. The major purpose, of course, is what we learn from all these. The case studies presented here show examples of "successes". Some of these projects were geared to reducing fertility through family planning efforts. Most others have been successful in raising the quality of life of their target groups through a variety of programmes. If the "beyond family planning" hypothesis should hold, such efforts should have an impact on fertility. Their success has been brought about by the interplay of a number of specific factors which we wish to discuss now.

3.2 Determinants of Success

Leadership: The NGOs are normally run by dedicated and committed leadership with a clear vision and objective. Unlike the public sector programme, the NGO leadership does not change over a short period.

Flexibility: One of the major advantages of NGOs is the flexibility, which the public sector programmes hardly enjoy. With new experience gained, NGOs can quickly change their strategies and adopt and experiment newer and innovating

ideas. The other flexibility is the control they exercise through, for example, "hiring and firing". Unlike in the government, NGO staff can be replaced immediately.

Training: Task-oriented training for workers is an important element of NGO programme. Training is considered an ongoing activity.

Management and supportive supervision: NGOs are normally small which makes the management much easier. On the other hand the supervision is strict and supportive. All these make the management much easier and effective.

Record keeping: Some NGOs have specialised in maintaining records which has been fruitfully used in programme implementation and monitoring.

Uninterrupted supply: Most of the NGOs which have been able to substantially increase the CPR ensured an uninterrupted supply of contraceptives. Although claimed otherwise by the government, supply limitation is a serious problem in the public sector programme. NGOs, by using own influence or additional resources, have been able to ensure contraceptive supplies.

Mobilisation of resources: The NGOs have been very successful in mobilising both local and outside resources for their programmes. Because of strict formalities, the government programme takes a much longer lead time in this regard. Utilisation of resources in NGOs is considered high and effective.

Community participation and accountability: Because of their work at the grass-roots level, the NGOs very easily mobilise community participation in the project, increase demand and generate local accountability which is very difficult for the government programme to achieve under the existing situation.

Integrated approach: In most cases, the NGOs take an integrated approach to development and have included a number of components which has been facilitated, to a great extent, by the small size of the projects. The government programmes (e.g., health and family planing) are struggling to do this at all levels particularly at the grass-roots level but have not been very successful. The NGO programme comes as a package with poverty alleviation and other "felt need" components with tangible gains. Fmily planning programme finds a better sailing under such a situation.

Client-oriented approach: Most successful NGO projects have taken a client-oriented approach in family planning. On the other hand, the public sector programme has largely remained method-oriented. The NGO programmes offer a much wider range of contraceptives and provide better care to their clientele than are generally offered by government programmes.

Worker density: The worker-client ratio is much favourable in NGO projects which facilitates better coverage and care of the target clients.

Better incentive to workers: Many NGOs pay higher salaries to their workers and have innovated other methods of recognising their good work.

3.3 *Drawbacks*

NGOs are, however, not without drawbacks. We discuss some of these below.

Replicability: One of the major drawbacks of NGOs, which is often mentioned, is their lack of replicability. Because of the particular nature of management and resource allocation, most NGO efforts remain unreplicable. Efforts at replicating some of these in a public sector programme have been fraught with problems. Recent experience has, however, shown some successes in transferring some elements of NGO programmes with necessary adaptations.

However, if the project is replicated to other areas by the same NGO, the problems are probably much fewer. For example, BRAC conducted an ORT programme on a pilot basis. Later on it replicated itself over the whole country. The plans to replicate BRAC's non-formal primary education programme is yet another example in this regard.

One important problem in replication is the high cost of many NGO programmes. If one considers both cost and effectiveness, the NGO programme may turn out to be more cost-effective. However, cost information is hardly available. Where available, it is difficult to decompose different components. Such a problem renders the cost-effectiveness analysis difficult.

Isolationism: Many NGOs prefer to remain isolated in their own domain. Their activities are mostly experimental in nature and hence documentation and dissemination of their experience are of much importance for others to learn. Unfortunately, most NGOs are either not interested or weak in this respect. In this way many valuable experiments have been forgotten (e.g., Companyganj Project or Zero Population Growth experiment). An added disadvantage is the lack of well-designed evaluations to look at the impact of such interventions, for which objective conclusions cannot be drawn. Failures are even less documented, thus making it impossible for others to avoid such failures in their operations and learn from such failures.

Charisma: Many NGOs or special projects are centred around a charismatic leadership, and most of them are dominated by the individual founders. This makes sustainability difficult. The case of the once-wellknown Dashi project in Jessore is an example.

Duplication of efforts: A close look at the geographical distribution of NGO presence indicates a clustering of activities. In many areas a multiple of NGOs are active, often with similar programmes, along with the government programmes. On the other hand, there are areas where there is no NGO working. The government has a role in this regard in spreading out NGO work, specially in inaccessible, outlying, and disadvantaged areas.

Question of sustainability: A major question about NGO projects is their sustainability. In many instances, the projects disappear following the departure of its leader or the withdrawal of support from the central system or from the donor(s). This is because many NGOs do not try to institutionalise their activity and some even keep a top-down approach; and are excessively dependent on funding from donors.

IV. CONCLUDING NOTE

It is clear that NGOs can go a long way in fulfilling the objectives of development programmes. Family planning is no exception. In fact, the family planning activity in Bangladesh was initiated by NGOs much before the government stepped in. However, as mentioned before, the NGO projects are mostly interesting in themselves and unless efforts are made to replicate the positive aspects of NGO activities to the rest of the country, either by itself or by others including the government, the impact of such efforts will remain only marginal. The government may incorporate in its programmes some of the crucial elements responsible for the successful implementation of NGO projects. The government is already working along this direction which should be further intensified to foster a closer government-NGO collaboration. The roles of the government and NGOs are complementary and there should be no doubt about it.

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