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OBSERVATIONS FROM A STUDY TOUR OF BANGLADESH AND INDONESIA ON THEIR FAMILY WELFARE PROGRAMME

Final Report

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BACKGROUND

Bangladesh is often cited as an example of a country with a successful family planning programme where reproductive revolution is occurring despite the absence of significant economic improvements. The country has succeeded in bringing about a demographic transition at a much faster rate than many of its neighbouring countries, such as India and Pakistan. The sharp increase in the contraceptive prevalence rate from 3 percent in 1971 to 45 percent in 1993 and an equally sharp drop in fertility from 7.0 to 3.4 births per woman during the same period is remarkable. It reflects the extensive effort which the Government of Bangladesh, with the help of international agencies, has made to educate couples about family planning, and increase the access and choice of contraceptive methods, even in the remote areas. What makes these achievements noteworthy is the fact that this demographic transition is taking place when the country is considered to be one of the poorest countries in the world, with a high mortality rate and the majority of its population, particularly women, illiterate.

Another predominantly Muslim country that has achieved remarkable success in family planning is Indonesia which had unprecedented economic growth in recent years.

What lessons can be learnt from these success stories for the Indian family welfare programme? Can some of these innovative programmes and management strategies be replicated in India to improve the access, quality and promotion of family planning? A visit to these countries to study their family planning programmes provided opportunities to closely observe activities that have contributed to this success. Programmes of particular interest were: initiatives to bring in large non-government organisations (NGOs) to complement the efforts of the government; administrative mechanisms that have evolved over time to develop and sustain collaboration and partnership between the government and NGOs; strategic planning exercises before taking major initiatives to strengthen the programme; the institutionalisation of operations research (OR) for programme management, and testing alternative strategies to improve the delivery of services; and upscaling local initiative programmes in large areas.

It was thought that firsthand information on these aspects would be far more useful than providing programme managers with a large number of project reports or briefing papers.

In 1993 a similar visit to study Bangladesh's family planning programme was organised by the Population Council for senior managers of Pakistan's family planning programme. Based on a number of successful programmes run by the Bangladesh government, they took several initiatives to strengthen the delivery of family planning services in rural Pakistan. The appointment of a large number of female family planning workers on the pattern of Bangladesh's programme in rural Pakistan is one such example.

The collaboration and sharing of experiences and expertise among countries in the region, particularly South Asian countries with a similar social and cultural background, was beneficial to all participating countries.

Against this background, the Population Council, under the Asia and Near East Operations Research and Technical Assistance (ANE OR/TA) project funded by United States Agency for International Development (USAID), organised a study tour of Bangladesh and Indonesia for Indian officials, comprising of senior and middle cadre programme managers of State Innovations of Family Planning Service Agency (SIFPSA), the Department of Family Welfare, Lucknow and Ministry of Health and Family Welfare (MOH&FW), Government of India (GOI), New Delhi. As the Bangladesh experience was considered to be more relevant for the Indian family welfare programme, it was decided that the visit to Indonesia would be limited to only two days for three senior programme managers, while the rest of the team would spend the entire period in Bangladesh and study the family planning programme in detail. The duration of the tour was nine days from 14 December to 22 December 1997.

Purpose and Team Composition of the Study Tour

The specific objectives of the study tour were:

- To observe the functioning of the government family planning programmes in Bangladesh and Indonesia.
- To sensitise members on how government and NGO programmes can complement each other.
- To discuss the role of operations research and strategic planning in strengthening the government's family planning programme.
- To study the monitoring (MIS) system and supportive supervision model developed by the Matlab Extension Project in Bangladesh and other local initiatives in the two countries.
- To discuss upscaling local initiatives in larger areas.

Hosts, the Team Leader and Participants

Mr. A.P. Verma, Principal Secretary, Health and Family Welfare, Government of Uttar Pradesh was the team leader and Ms. Aradhana Johri, Executive Director, SIFPSA, Lucknow was the coordinator. A broad description of the 12-member study team follows:

- Five senior officials from the Department of Health and Family Welfare, Government of Uttar Pradesh;
- One representative from MOH&FW, Government of India, New Delhi;
- Two representatives from SIFPSA;
- One official from USAID; and
- Three representatives from the Population Council.

The Bangladeshi government, with support from the local Population Council office in Dhaka, and the Population Council office in Jakarta, Indonesia hosted the team.

OVERVIEW OF THE VISIT

Bangladesh

On 14 December 1997 the team members assembled at the Population Council's New Delhi office, and were briefed about their visit. On their arrival at Dhaka, the visiting team was taken to the Local Initiative Project (LIP) office, where they were briefed by Dr. Ubaidur Rob, Representative, Population Council in Bangladesh and the Director of LIP on the Bangladesh family planning programme. The briefing highlighted the main issues of programme, such as strong political commitment, close linkages between NGOs and the public sector, community participation and the use of satellite service clinics to enhance access to family planning services in remote rural areas.

On 15 December 1997, the team visited the Directorate of Family Planning and met Dr. Sirajul Islam, Director General, Family Planning and other officials. Dr. Islam told the team how the government organisation was structured, the involvement of NGOs in the programme, the logistics for contraceptive supply and the effective use of the information, education and motivation (IEM) unit of the programme. He also discussed about the acquisition of contraceptives, community involvement and the effectiveness of LIP.

In discussion, issues such as access to sterilisation services, the role of menstrual regulation in fertility decline, quality assurance measures and community participation were covered. The role and contribution of NGOs to the family planning programme and how the government of Bangladesh coordinates and interacts with these organisations were discussed at length.

Next, the team visited Mohammadpur Fertility Services and Training Centre (MFSTC), which is now being funded by the Government of Bangladesh. Dr. Sabra, the Superintendent, explained that the Centre is involved in providing clinical training to paramedics and medical doctors. On- the-job training in ligation and reproductive tract infection (RTI) is also provided to medical officers. In addition, the Centre also undertakes research on infertility and other aspects of reproductive health. The training centre is well equipped to perform these functions.

At Naraingonj's Bangladesh Mahila Sangha, the Director of the project explained how satellite clinics work in the area. This NGO is largely urban-based and runs six urban clinics in Naraingonj and the surrounding areas.

A dinner was hosted by the Population Council which was attended by Bangladeshi officials and representatives from several donor agencies. The participants had an opportunity to share their experiences with their Bangladeshi colleagues. The following day was a national holiday for Victory Day. The visiting team was taken to the Victory Memorial near Dhaka.

On 17 December 1997, the team left Dhaka for Chouddagram thana in Comilla district to observe the LIP at Debidar Satellite Centre. The team members were impressed by the way registers were maintained, children's weight was taken and health education on EPI, MCH and FP was imparted. What impressed them most was the mapping of the eligible couples (ELCO). Local community volunteers - one for about 50 ELCOs - were enthusiastic, extremely involved in the programme and willing to work for the community. The workers were well trained in counselling. Some of the reasons given for working free were: they had free time, it helps the community, to gain importance in the community, or preferred to loan disbursement or other government programmes. The LIP experiment to introduce cost sharing for contraceptives was also impressive, particularly the option of accepting payment either in cash or kind.

The team also observed the *Uthan Baithak*, where the family welfare assistant (FWA) held literacy classes for women, and the door-step injectable programme. Later one team returned to Dhaka to proceed to Indonesia, while the other team stayed overnight in Comilla.

On 18 December 1997 the team left for Mirrashari, where officials of International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) briefed the team about the project and its linkages with maternal and child health, family planning (MCH,FP) and OR projects. ICDDR,B began with a project on diarrhoea/cholera control that was expanded to cover MCH/FP programme in 1976 with the establishment of a programme unit in Matlab thana. Lessons learned from the Matlab project were upscaled and tested under the Matlab Extension Project which was carried out in two districts. Many of the successful OR projects from the Matlab Extension Project area were adopted in the national family planning programme. Participants were impressed by the role OR has played in strengthening the family planning programme in Bangladesh and testing new approaches before upscaling it at the national level.

Some of the important initiatives of the Matlab Extension Project include improvement in management information system (MIS), upgradation of services at the thana level to provide emergency obstetrics care and the development of operation theatres to provide quality services. Traditional birth attendants (TBAs) are given training to assist domiciliary deliveries. The project also examined sustainability through three strategies - cluster point visits, delivery at service points and one-step shopping (home-based service delivery). Under this programme, while services and contraceptives are provided free at satellite clinics, family welfare centres or the thana health complex, a small fee is charged for services/contraception if it is provided at the door-step of the client. Now the focus of the programme has shifted to providing an essential services package covering RTIs, family health needs and male involvement.

On 20 December 1997, the team visited the Integrated Family Development Programme (IFDP) in Dolia and Feni. This programme is run by the Family Planning Association of Bangladesh (FPAB) with funding from International Planned Parenthood Federation (IPPF) and Japanese Organisation for International Cooperation in Family Planning (JOICFP). The programme covers five unions and 17 villages in two thanas of Feni district. The FPAB runs one static clinic, four mobile centres and 24 service centres with 24 family planning volunteers and supervisory staff. The emphasis of the

programme is on literacy, MCH,FP parasite control and development activities for women. This is a good example of an integrated women's development project in which, apart from the health need, their other needs are also being addressed. Another interesting programme covers income generating activities for women, for which the FPAB arranges training on trade. Even the family planning programme is run on a payment basis, which covers 11 percent of expenditure. Under the programme, two villages were visited - Mashpur Ajim Uddinan Bari and Middle Dholia Radhasham Bari. Hence, the team observed women's involvement in income generating activities, mainly mat making, where they earn about 5-10 takas a day on a part-time basis.

On 21 December 1997, the team visited Tangail district, where the participants first met with the district officer of Tangail, who explained the organisation of the district. This was followed by a visit to the family welfare centre at Kalihathi, where they observed an OR project in which the issue of integration of RTI services with MCH and FP services is being addressed. The screening and examination work is done by a paramedical female welfare visitor (FWV). The workers are provided with a three day training by a medical officer of the centre and are monitored by family planning surveillance teams. The Indian team was impressed by the facilities and the ease with which the FWVs examined the reproductive tract infection cases.

In the last phase the team visited Kumudini Hospital. This 750 bed hospital is run by a private charity trust almost free of charge for service. Dr. B.R. Pati, the Medical Superintendent, gave an overview of the services provided by the hospital, which includes free sterilisation in the operation theatre facility. The team observed mini-lap operations being conducted under fairly hygienic conditions. It was felt that the quality of services provided by the hospital was good.

On 22 December 1997, the team returned to India. On the whole, team was impressed with Bangladesh's achievements in the family planning programme. It was felt that some of these programmes can be replicated in Uttar Pradesh, without introducing any major changes.

Some of the interventions and components that were particularly impressive were:

- The government's commitment to family planning as a priority programme.
- Monitoring Implementation and Evaluation System (MIES) and the coverage of eligible couples.
- ELCO mapping and monitoring for contraceptive acceptance and unmet need.
- Payment for services at the door-step, which is a move towards financial sustainability.
- NGOs and community involvement through LIP.
- Establishment of satellite clinics at the grassroots level.
- The quality of the facilities up to the union level.
- The role of family welfare assistants (FWAs) and an effective system of supervision.
- Collaborative efforts between clinical and paramedical staff for the decentralisation of work responsibilities.

Indonesia

The team members who visited Indonesia were: Mr. A.P. Verma, Ms. Aradhana Johri, Dr. C.R.K. Nair, Dr. M.E. Khan and Dr. Jayanti Tuladhar

The team spent two days in Indonesia and could only cover selected institutions and health facilities. The agenda for the two-day programme is given in Appendix V. The most rewarding experience was meeting with Prof. Haryono, Minister for Population and Chairman of National Family Planning Coordinating Board (BKKBN) and other top programme managers of the Indonesian family welfare programme. The focus of these discussion was strategic planning and detailed preparatory work which are undertaken before taking any major initiatives in the family planning programme, particularly if a new contraceptive is being introduced. Close monitoring of the programme at all levels of implementation and economic sustainability, cost sharing for services and contraceptives are considered important components of the strategic plan.

A visit to health facilities, such as Puskesmas Cilinciry and Koja Hospital (a district-level hospital), which are collaborating in an OR study supported by the Population Council on improving services for reproductive health and sexually transmitted diseases, revealed that in general the clinics are better organised, equipped and cleaner than in the district or sub-district hospitals in India. There was not much opportunity to study the resource input into the health and family welfare programme but at all levels, cost sharing by patients/clients was a dominant theme which also perhaps helps to keep clinics clean, well equipped and efficient managed.

Prof. Haryono maintained that the strong political commitment to the programme on the one hand, and detailed strategic planning of the programme on the other, have contributed significantly to its success. Two other factors which emerged from the discussion with Prof. Haryono and other top programme managers were the emphasis on the accountability of officials at all levels for the performance of the programme and the availability of a wide choice of contraceptive methods both from government channels as well as the social marketing approach.

For any major interventions in the programme such as the introduction of courses on family formation and responsible sexual behaviour in schools, religious leaders are taken into confidence and made partners in approving the programme. This, according to Dr. Haryono, is a part of strategic planning. Once religious and community leaders are taken into confidence, implementation of the programme becomes easier.

The impact of these initiatives can be judged by the fact that, despite being a Muslim country, family life education and responsible sexual behaviour is being taught in all schools, including schools run by Islamic trusts. The team visited one such school, Mohammadiyah III High School in Kebayoran Baru, where a course on family formation is given by a counsellor from the Family Planning Association of Indonesia.

An informal dinner on 19 December with selected senior government officials and professionals from USAID and other donors provided the team with an opportunity to share each others' experience.

Support from USAID and the local Population Council office was excellent. It was only because of their efficient planning that the study team could achieve so much in such a short period.

CUES FOR ACTION

The family planning programmes in Bangladesh and Indonesia provide many cues to strengthen the family welfare programme in Uttar Pradesh (for country profiles and factors contributing to their success, see Appendix I). They also suggest that many initiatives taken by the Innovations in Family Planning Services (IFPS) project are in the right direction. Observations of the study tour reinforce the necessity of close monitoring and performance analysis of the projects funded by SIFPSA to identify successful interventions and expand them in priority districts. Some important cues for action are briefly discussed below:

1. Political commitment and regular programme review by top programme managers: Observations from both Bangladesh and Indonesia reveal that a strong and sustained political commitment by top political leaders, such as the President of the country, is a key factor in making the programme a success.

A strategy needs to be developed to sensitise political leaders to make them more supportive to the programme and involve them in community mobilisation for social change. A presentation to the Chief Minister and ministers of various departments on family welfare - the programme's current status, the consequences of continued population growth for the economy and development of the state, SIFPSA's initiatives and the Indonesian example of inter-sectoral coordination for family planning - will be useful. Similarly, organising regional meetings on population and reproductive health for MLAs and other influential political leaders, and getting District Collectors to constitute district-level committees of political leaders and zilla panchayat leaders for the mobilisation of community participation could help the programme. District level initiatives could also be planned as a part of a district action planning exercise which, under the IFPS project, has started in a few selected districts.

Apart from political commitment, a regular review of the programme by the top managers, as we have seen in Bangladesh and Indonesia is also instrumental in strengthening the overall supervision system of the programme down to the grassroots workers level. Similar initiatives at the Principal Secretary level and setting up an inter-sectoral coordination committee of secretaries by the Chief Secretary to bring about a coordinated effort to improve the access, quality and promotion of family planning and reproductive health as well as women's empowerment could be explored.

2. Community Mobilisation: In what way can the panchayat system, particularly women panchayat members be involved in community mobilisation and increasing the accessibility of contraceptives at the village level? Their involvement will not only increase the accessibility of pills and condoms at the village level, but may also help to improve the supervision of grassroots workers and expand the programme's support base at the community level. A beginning was recently made in Madhya Pradesh, while Gujarat and Maharashtra have long experience in using panchayats as an organisation to bring about social change.

SIFPSA has initiated a programme to sensitise panchayat members about reproductive health. It is important to analyse how this programme is progressing and identify how panchayat members can be involved in the programme.

3. Accessibility to Services: The operations research carried out by the Population Council and ICDDR/B in the Matlab Extension Project showed that increasing the population worker ratio is crucial for strengthening the outreach programme. Based on these findings, Bangladesh added a new cadre of female workers to provide outreach services. This initiative turned out to be the most important factor in increasing the accessibility of services at people's doorstep. To further enhance the population worker ratio on the outreach programme, NGO-government collaboration was strengthened. The satellite clinic approach was yet another initiative to increase the accessibility and outreach of services in rural areas.

In the public sector of Uttar Pradesh, the population worker (Auxiliary Nurse Mid-wife) ratio cannot be reduced further from the existing norm and alternative strategies need to be developed and initiated. Some initiatives taken under the IFPS project by involving dairy cooperative workers, training doctors of the indigenous systems of medicine, involving private practitioners and encouraging NGOs to establish a network of depot holders can contribute substantially to improve the population provider ratio. It is important that the impact of these projects is closely reviewed by SIFPSA and the Government of Uttar Pradesh to see how far these programmes are achieving their objectives and what modifications need to be made before expanding them to other districts.

The Apna Ghar clinic, a modified version of the link person scheme initiated by the CMO, Agra, is close to the satellite clinic approach in Bangladesh. What is the potential of this approach for upscaling in other districts and whether further improvement is required?

4. Supervision: A committed cadre of workers and effective supervision at all levels are other components of both the Bangladeshi and Indonesian family planning programmes. Political commitment to the programme and a regular review of the performance, logistic support and supplies by top programme managers helped significantly to make the programme effective and functional.

In the context of Uttar Pradesh, supervision particularly at the PHC and subcentre level, is one of the weakest links. This is partly because of the poor infrastructure at the subcentre and PHC level, irregularities in transfers and postings, lack of authority and accountability at all levels and the large number of vacant posts of grassroots supervisors (only 48 percent of lady health visitors are working against 3,761 actually required in the state). This is further compounded by the problem of mobility of workers as well as supervisors (see UPDATE 8 of the Population Council, India).

It is important to discuss how to address bottlenecks in the programme. What can be done to expedite filling the large number of vacant positions of field supervisors? How can the posting of workers be streamlined as that they are not concentrated in developed districts near Lucknow and other urban centres at the cost of less developed districts and remote PHCs and subcentres? What can be done to increase the mobility of workers and supervisors?

To what extent can the supervision of the field staff be improved by making doctors of additional PHCs accountable for the performance and supervision of staff of their area (30,000)? What additional authority do they need to be given while making them accountable for the performance and quality of services provided in their work area?

It is important that supervision goes beyond field visits and checking of performance statistics by supervisors. Changing the mind-set of providers about the quality of service is the biggest challenge. Quality performance indicators developed under the IFPS project and check-lists for field supervisors prepared by the Population Council under the Supportive Supervision Project can be an important input in this effort.

5. Expanding Contraceptive Choice: Both in Bangladesh and Indonesia, easy access and availability of choice to a variety of contraceptives contributed both to the recruitment of new family planning acceptors and continuation of contraceptive use. There may be problems such as sideeffects, lack of supply or clients who dislike the method and switching to another method of contraception is not discouraged. In both countries, the introduction of injectable contraceptives increased the couple protection rate by 5-6 percent three to four years.

In India, though the injectable contraceptive has not been included in the programme, the use and sale of depo-provera (DMPA) a three monthly injectable has been permitted by the MOH&FW, GOI. Several NGOs, such as Family Planning Association of India and Parivar Seva Sanstha, and a few private practitioners already offer this method in selected clinics. It is important that SIFPSA, on an experimental basis, tests the acceptability and operational details of injectable contraceptives in different settings. As providing injectable contraceptives from only static clinics may not be useful for sustained use, NGOs that are selected for the pilot project should have an outreach programme that is well supported by a clinic to provide follow-up care to acceptors, if required. Preferably, services should be provided on a cost-sharing basis. As injectable contraceptives may cause some menstrual disturbance leading to discontinuation, screening and counselling must be an integral part of the programme offering injectable contraceptives. To start with injectable contraceptives should be offered through established NGOs and private practitioners, who can ensure quality of services, good screening and strong counselling. Based on the experience of NGOs, this effort should be followed by a few selected PHCs known for quality services. Apparently, MOH&FW, GOI, will not be against this policy of initiating DMPA with NGOs as one more contraceptive choice.

6. Government-NGO Collaboration: How can collaboration between NGOs and the government be enhanced? Information, education and communication (IEC), community based distribution (CBD), social marketing, community mobilisation and testing of alternative delivery models, including cost recovery, are some of the areas where NGOs have shown promising results in Bangladesh. Should the Government of Uttar Pradesh setup a government-NGO coordination committee? SIFPSA is already working closely with several NGOs and could perhaps take the initiative to work as a link agency between the Government of Uttar Pradesh and NGOs. SIFPSA can be designated the secretariat for such government-NGO committee coordination and action. This move will be in agreement with recent initiatives by the MOH&FW, GOI, which is trying to identify a mechanism to coordinate NGO activities at the state level.

7. Strategic Planning of the Programme: Strategic planning and operations research are two important management components in the Bangladeshi and Indonesian family planning programme. Initiatives should be taken to discuss how a culture of strategic planning can be introduced at the state level and operations research should be institutionalised at all levels. Recent initiative of SIFPSA in developing district action plans is a good example of such a planning exercise and should be encouraged in other districts as well.

Appendix I

LIST OF OFFICIALS WHO VISITED BANGLADESH AND INDONESIA

	Name	Designation	Country Visited
1.	Mr. A.P. Verma, IAS	Principal Secretary (H&FW) Govt. of Uttar Pradesh	Bangladesh/Indonesia
2.	Ms. Aradhna Johri, IAS	Executive Director State Innovations in FP Services Agency (SIFPSA) - USAID Sponsored project.	Bangladesh/Indonesia
3.	Dr. C.R.K. Nair	Assistant Commissioner (FW) Govt. of India, New Delhi	Bangladesh/Indonesia
4.	Dr. O.P. Rai	Chief Medical Officer Sitapur District (UP) (OR district)	Bangladesh
5.	Dr. A.K. Saxena	Chief Medical Officer Agra District (UP) (OR district)	Bangladesh
6.	Dr. L.B. Prasad	Chief Medical Officer Jhansi District (UP)	Bangladesh
7.	Dr. Sulabha Swaroop	Project Coordinator SIFPSA, Lucknow	Bangladesh
8.	Dr. R.K. Singh	Medical Officer CHC, Agra	Bangladesh
9.	Dr. P.N. Sushma	Population & Nutrition Division USAID, India	Bangladesh
10.	Dr. M.E. Khan	Associate & Country Advisor Population Council, New Delhi	Bangladesh/Indonesia
11.	Dr. Jayanti Tuladhar	Programme Associate Population Council, New Delhi	Bangladesh/Indonesia
12.	Dr. R.B. Gupta	Evaluation Specialist Population Council, Lucknow	Bangladesh

Appendix II

FAMILY PLANNING Programme IN BANGLADESH

The Land and Population

The people's Republic of Bangladesh is the ninth most populous nation of the world. Bangladesh has a land area of 56,000 square miles and is divided into 64 districts, which are primary units of administration. Districts are in turn divided into thanas, unions, wards, and villages (Table 1). The population of Bangladesh is large and also is growing continuously. The total population of 76 million in 1974 grew to 90 million in 1981 and 111.5 million in 1991. The estimated population size is 124 million in 1997. Bangladesh is one of the most densely populated countries in the world (883 person per sq.km.) and the current rate of population growth is estimated at 1.7 percent per annum.

Table 1: Administrative and other units of Bangladesh

Administrative and other units	Number	Average population (1991 Population Census)
Division	6	20.5 million
District	64	1.92 million
Thana	490	2511020
Union	4451	27634
Mouza	59990	2050
Household	19979932	6.16 (persons)

Economy

The economy of Bangladesh is primarily agricultural and has traditionally depended on the export of agricultural products, especially jute, sugarcane and tea. In the recent years, export-orient textile sectors played a major role in export earnings and employed more than one million women. Approximately two-thirds of the labour force is engaged in agriculture which account's for half of the Gross Domestic product (GDP). Limited information on unemployment suggests that about one-fourth of the labour force is unemployed. Economic growth during the first half of 1990s has been slower than expected. The average annual economic growth rate has been less than 4 percent. Both the Government and NGOs have been trying to provide better access to credit, and to increase education and literacy levels in the rural areas. The per capita income is less than US $300 and half of the population lives below the poverty line.

Social Context

Two characteristics which distinguish Bengali population from the rest of Indian Subcontinent are linguistic homogeneity and Islamization of the local culture and traditions (87 percent of the population are Muslims). These distinctive features can be found in the socio-cultural institutions,

mental outlook, way of life, food, dress and customs of the Bengali people. The family is extended, patrilineal and patrilocal, and the family lineages are extremely important in social structure. Early marriage for females is customary. Most marriages are arranged and brides are generally selected by the couple's parents.

The social indicators are very poor and are not even at the minimum acceptable level. For example, the adult literacy rate is less than 40 percent. More than two-third of the women are illiterate. Based on usual indicators such as infant mortality, life expectancy at birth (58.7 years), level and pattern of morbidity, the overall health status of the population is very poor. Infant and child mortality rates are very high in Bangladesh. One in nine children born in Bangladesh dies before reaching the fifth birthday. Reproductive health care facilities are virtually non-available and approximately six women die per thousand live births every year. These deaths occur mostly due to five major causes related to pregnancies which are abortions, eclampsia, infection, haemorrhage and obstructed labour. Each year approximately one-third of the women seeking menstrual regulation (MR) services are rejected due to longer duration of their pregnancy. Nearly half of the women who are rejected resort to traditional methods for abortion and they suffer serious consequences including death.

The Demographic Goals and Organisational Structure

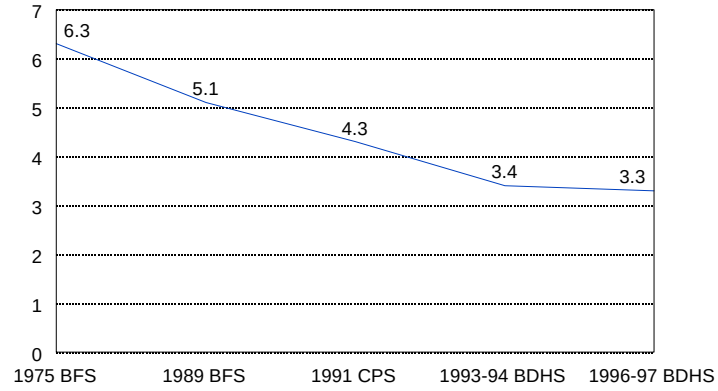
The government of Bangladesh views rapid population growth as a major problem, and the national population programme is an integral component of the country's development plans. The head of the government provides overall leadership to the programme. The government's broad demographic goal is to achieve replacement level fertility by the year 2005. In the public sector, the population programme is implemented by the Ministry of Health and Family Welfare (MOHFW), in coordination with nine other development ministries. In 1997, the government reorganised National Population Council (NPC) for more effective coordination and implementation of the

Service facilities and their approximate population coverage

Maternal and child welfare centre (Urban)	300,000
Thana Health Complex	250,000
Union level Family Welfare Centre	300,000
Satellite Clinic	8,000
Female Family Welfare Assistance	4,500

Figure 2

Trends in Total Fertility Rate in Bangladesh, 1975-1997



Source: 1975 BFS (MHPC, 1978:73); 1989 BFS (Huq and Cleland, 1990:103); 1991 CPS (Mitra et al, 1993:34).

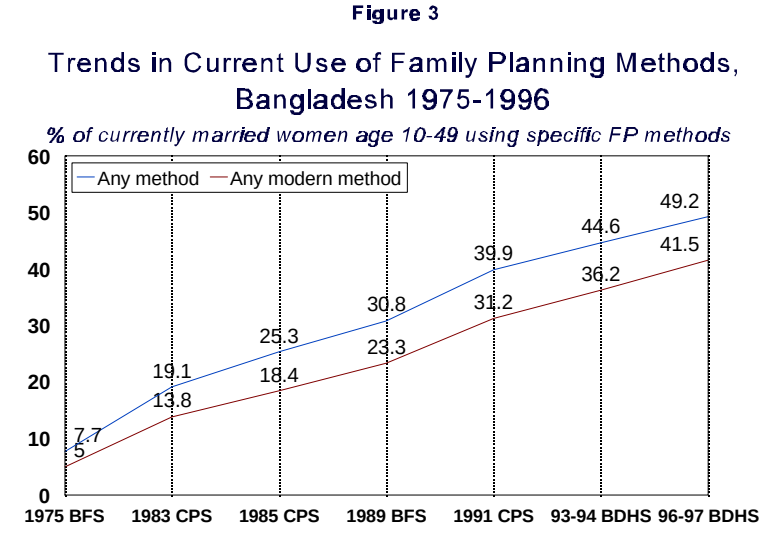
national population activities (see the organisational structure Figure 1).

The national family planning programme, which was launched in 1965 with the recruitment of part-time male and female workers in rural areas, was reorganised in 1976 to include a cadre of full-time field workers and home based delivery of contraceptive methods. Presently, the government programme extends throughout rural Bangladesh, and includes a community-based component provided by 23,000 female field workers (FWAs), as well as clinical services provided at 4,000 union-level Family Welfare Centres (FWCs), 472 Thana Health Complexes (THCs) and 91 Maternal and Child Welfare Centres (MCWCs). In the rural area FWCs is the institutional focal point for maternal and Child health (MCH) and family planning services.

Demographic Scenario and Achievements

Bangladesh has experienced a significant fertility decline due to an effective family planning programme over the past two decades. The crude birth rate (CBR) has declined from 47 per thousand population in 1975 to 27 in 1997. The total fertility rate (TFR) has declined from 6.3 children in 1975 to 3.3 children in 1997 (Table 2). The pace of fertility decline has slowed in the recent years compared to exceptionally rapid decline during the late 1980s and early 1990s (Figure 2). In addition, wide variation has been reported between urban and rural areas in fertility levels.

Figure 3



Source: 1975 BFS (Islam & Islam, 1993:43); 1983 CPS (Mitra & Kamal, 1985:159); 1985 CPS (Mitra, 1987:147); 1989 BFS (Huq & Cleland, 1990:64); 1991 CPS (Mitra, 1993:53); 1993-94 BDHS (Mitra et al, 1994:45).

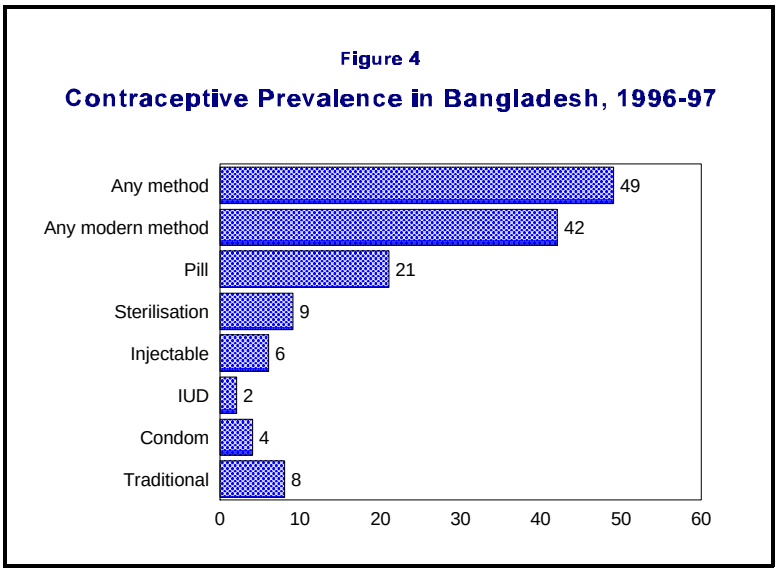
Contraceptive Prevalence

The family planning programme is considered to be a success story of Bangladesh. The contraceptive prevalence rate, at 49 percent for all methods and 42 percent for modern methods, is the highest among South Asian countries. The contraceptive prevalence rate (CPR) has increased sixfold since 1975, from 8 to 49 percent of married women (Figure 3). Bangladesh Demographic Health Survey (BDHS) conducted in 1996-97 suggests that contraceptive use rate is highest among married women in their 30s, almost two-thirds of these women are currently using some methods of family planning. In the recent years, use of non-clinical methods such as oral pills, condoms and injectables have increased, while use of longer-termed methods such as sterilization and IUD has declined (Table 3). During 1991-97, the increase in contraceptive prevalence rate is mainly due to increased use of pills and the injectable contraceptive.

Table 2: Trend in age-specific and total fertility rates, of Bangladesh, 1975-1997

Age group	Survey and approximate time period				
	1975 BFS	1989 BFS	1991 CPS	1993-94 BDHS	1996-97 BDHS
15-19	109	182	179	140	147
20-24	289	260	230	196	192
25-29	291	225	188	158	150
30-34	250	169	129	105	96
35-39	185	114	78	56	44
40-44	107	56	36	19	18
45-49	35	18	13	14	6
Total fertility rate	6.3	5.1	4.3	3.4	3.3

Note: For the 1975 and 1989 BFSs, the rates refer to the 5-year period preceding the survey; for the other surveys, the rates refer to the 3-year period preceding the survey. The two BFSs and BDHSs utilized full birth histories, while the 1991 CPS used an 8-year truncated birth history.
Source: 1975 BFS (MHPC, 1978:73); 1989 BFS (Huq and Cleland, 1990:103); 1991 CPS (Mitra et al., 1993:34).



The contraceptive discontinuation rate is very high in Bangladesh. Approximately half of the users stop using their method within one year of starting use. Discontinuation rates also vary by methods, and side effects of the method is the most commonly reported reason for discontinuation. Government and a number of donor agencies are supporting operations research to develop and test strategies to ensure continuous use of contraceptive methods. Workers' performance is measured by continuous use of a contraceptive by couples, irrespective of method or methods they use over the period.

The level of contraceptive use is higher in urban areas (62 percent) than in rural areas (48 percent). The oral pill is the most popular method among both urban and rural women. There is a sharp difference in condom use between urban (13 percent) and rural (3 percent) couples. Regional variation also exists in contraceptive use. The North-Eastern part of the country has lowest level (20 percent) whereas South-Western part has highest level (62 percent).

Despite the success of the family planning programme, the contraceptive acceptance rates remain low among several subgroups of population particularly among males. Efforts are being made to enhance male involvement in family planning and use of condom which has remained low.

Table 3: Trends in Current Use of Family Planning Methods

Percentage of currently married women age 10-49 who are currently using specific family planning methods, selected sources, Bangladesh, 1975-1996

Method	1974 BFS	1983 CPS	1985 CPS	1989 BFS	1991 CPS	1993-94 BDHS	1996-97 BDHS
Any method	7.7	19.1	25.3	30.8	39.9	44.6	49.2
Any modern method	5.0	13.8	18.4	23.2	31.2	36.2	41.5
Pill	2.7	3.3	5.1	9.6	13.9	17.4	20.8
IUD	0.5	1.0	1.4	1.4	1.8	2.2	1.8
Injectables	U	0.2	0.5	0.6	2.6	4.5	6.2
Vaginal Methods	0.0	0.3	0.2	0.1	U	U	U
Condom	0.7	1.5	1.8	1.8	3.0	2.5	3.9
Female Sterilization	0.6	6.2	7.9	8.5	8.1	9.1	7.6
Male Sterilization	0.5	1.2	1.5	1.2	1.1	1.2	1.1
Any traditional method	2.7	5.4	6.9	7.6	8.7	8.4	7.7
Periodic Abstinence	0.9	2.4	3.8	4.0	4.7	4.8	5.0
Withdrawal	0.5	1.3	0.9	1.8	2.0	2.5	1.9
Other Traditional Methods	1.3	1.8	2.2	1.8	2.0	1.1	0.8
Number of women	U	7662	7822	10907	9745	8980	8450

U=Unknown (no information)

Source: 1975 BFS (Islam & Islam, 1993:43); 1983 CPS (Mitra & Kamal, 1985:159); 1985 CPS (Mitra, 1987:147); 1989 BFS (Huq & Cleland, 1990:64); 1991 CPS (Mitra et al., 1993:53); 1993-94 BDHS (Mitra et al, 1994:45).

Factors Responsible for Programme Success

A variety of factors have contributed to the increase in contraceptive use over the past 20 years. The following elements of the programme may be specifically identified to have contributed to the success.

Strong Political Commitment: There has been a strong political commitment in support of the family planning programme. During the mid 1970s the Government officially declared population growth as the number one problem of the country reflecting the seriousness and determination of the government to pursue a vigorous policy and programme. Since then the programme had been receiving active

Major factors contributing to the successes of family planning programme in Bangladesh

- ✓ Sustained political commitment of various governments
- ✓ Availability of services at door step
- ✓ Availability of wide choice of contraceptives - Sterilisation, IUD, OCP, Condom, Injectables, Norplant®
- ✓ Committed field force and strong supervision
- ✓ Close Government - NGOs collaboration and sustained donor commitments.
- ✓ Proper logistic management and assured contraceptive supply.

support in its implementation and resource allocation from the top political level. During the first 5 years of Irshad Government, the then President Irshad himself used to review the programme regularly and provided all the support needed to ensure its proper implementation. A sustained support to the programme from Irshad helped in developing and expanding family planning infrastructure in rural areas and establishing a close collaboration in government - NGO efforts.

Easy Access to Workers and Services: The substantial rise in the number of field workers providing family planning services has been a major factor contributing to the increase in contraceptive use over the past decade. Since women's access to family planning services outside the home is limited by socio-cultural traditions in Bangladesh, it is crucial that family planning and MCH services be made available to women in their homes. 23500 female field workers provide door-to-door family planning and MCH services. *Satellite Clinic,* which was introduced by the government in 1988, is one of the unique innovations in social delivery network in rural Bangladesh. The accessibility and availability of services is further enhanced by a large network of CBD workers established by NGOs and commercial outlets stocking pills and condom under the social marketing programme.

Availability of wide choice of contraceptives: The Bangladesh family planning programme offers a cafeteria approach to services in its true sense. All efforts are made to give the clients as wide choice of contraceptives as possible. The programme offers a wide range of contraceptive services including sterilisation, IUD, pills, condoms, injectables and Norplant®. Because of the limited number of trained doctors, sterilisation is offered mainly at the Thana level, while, pills, condom, and injectable contraceptives are delivered at the door step of the clients. The IUD is generally provided at FWC and clinics of higher level. The availability of wide variety of contraceptives gives the clients a chance to switch over to other methods if a method does not suit the couple or one of the partners is against a particular method. Thus a wider range of contraceptives increases the chance of continuation of contraceptive use, though discontinuation of an individual method may be high.

To increase the availability of trained doctors in rural areas Government is making it mandatory that all recent medical graduates must work for three years in rural areas. Their application for admission in post-graduate class will be accepted only if they have already served three years in rural areas.

Strong Supervision and Accountability to the Programme: The programme over time has developed a cadre of dedicated workers up to the lowest level of the delivery system. The regular review of the programme by the top political leaders (e.g. President Irshad) as well as the top programme managers (Secretary, Director General) has made each worker accountable for the performance of the programme in his/her area. Field supervision is sustained and regular. Involvement of Thana level Local Self Government in the administration of the programme and decentralisation of decision making power, by giving more authority at district and thana level, has helped in community mobilisation and over all improvement in supervision of the staff.

Logistics: Over the past decade energetic efforts to improve the logistics system for family planning and MCH commodities in Bangladesh produced excellent results. Considerable financial investment led to improved warehouse facilities and strengthened transportation capabilities from the Central Warehouse in the capital to district-level storage depots. In addition, a logistics management information system was introduced that finally provided the Government with the capability to

monitor commodity stock flows and to quickly identify emerging regional scarcities and stock shortages. The increasing efficiency of the commodity logistics system in Bangladesh is an often overlooked but is critical element contributing to gains in contraceptive use during the 1980s.

***Close Government NGO Collaboration**:* From the inception of the Bangladesh Family Planning Programme, NGOs have been allowed to function without extensive public sector control and regulation. In fact, many current features of the Government's Family Planning Programme e.g., curriculum development for the training of Government field workers, the introduction of door-to-door injectable contraceptive services, the building of satellite clinics, and streamlining of record keeping procedures, were innovations initially developed and field tested by the Population Council/ICDDR/B under Matlab Extension Project, funded by USAID.

In addition, the Third Five Year Plan (19985-90) laid great emphasis on introducing innovative NGO activities in order to make the Population and Health Programme more dynamic and to generate additional demand for MCH-FP services. The government followed a policy for the promotion of NGOs and looked at it as a strong partner in progress. Generally, NGOs were engaged in CBD type of activities, but a few of them were carrying out specialised function.

During this period, NGOs accounted for around 37 percent of the contraceptive distribution and supply of modern methods in Bangladesh. The bulk of that contribution is by two agencies: the Social Marketing Project (SMP) and the Bangladesh Agency for Voluntary Sterilisation (BAVS). SMP provided around half of the NGO contraceptives (condoms and pills). It supplied around 66 percent of all the condoms and 18 percent of all oral contraceptives - through a network of 89,000 commercial outlets. BAVS performed about one-third of all sterilisations, thereby accounting for around more than one-third of the NGOs contribution. Since the mid 80s, NGOs started addressing sensitive issues, such as the relationship of religion to family planning and targeting of newly married couples and underserved population. Moreover, involvement of community leaders and community participation were encouraged and emphasised.

However, the co-ordination between NGOs and government had been a concern to avoid overlaps and to capitalise on their individual skills. In this respect, the government and NGOs undertook various steps and NGO Co-ordinating Committee (NGOCC) came into being. The government also setup a subvention committee, headed by the Secretary, Ministry of Health and Family Planning (MOHFP), with NGO representation primarily, to consider NGO project proposals and review NGO performance.

The relationship between the government and NGOs in the population and development sphere have now become a model of networking with the development partners. As complementary and supplementary of the government programme efforts, NGOs have been encouraged to evolve innovative, cost effective and nationally replicable models of family planning and maternal child health service delivery. The NGOs were encouraged to devote their efforts towards creation and crystallisation of demands. In practice, the primary mode of NGO involvement in service provision is to take responsibility of community-based activities in defined geographical areas under the authority of the government. In doing so, NGOs have adopted geographical areas under the authority of the government. In addition, NGOs have adopted the model for house-to-house motivations and

services, operating standards, record-keeping procedures, similar to that of the governmental programmes. Social mobilisation by a number of NGOs has contributed to making local institutions effective in enlisting community support for the small family norm and social legitimacy for family planning.

Appendix III

FAMILY PLANNING Programme IN INDONESIA

Background

The Republic of Indonesia is the fourth most populous country in the world after China, India, and United States of America. The estimated population of the country in 1996 is about 198 million, of which 34 percent live in urban areas and the rest live in rural areas (CBS, 1993). The country's population is unevenly distributed among 17,000 islands of 27 provinces. The estimated population density ranges from 12,500 persons per square kilometre in Metropolitan Jakarta to 678 persons per square kilometre in East Java, while the national average is 93 persons per square kilometre in 1990. Among the provinces, Java, which has seven percent of the total land area of Indonesia, has 60 percent of the country's population.

Over the past 24 years, the country's population growth, fertility, and mortality rates have declined significantly. Between 1968 and 1997, the country's economy has improved, from per capita income of US$50 to US$1,086. The population growth rate was 2.1 percent per annum in 1971 and was around 1.76 percent in 1993 (Table 1). The total fertility rate declined from 5.6 children per woman in 1971 to 2.9 children per woman in 1993. During the same period (1971-1993), there was a sharp decline in an infant mortality rate (142 deaths per 1000 live births in 1991 to 58 deaths per 1000 live births in 1993).

Table 1: Basic Demographic Indicators

Index	1971 Census	1980 Census	1985 Intercensal Survey	1990 Census	1993 Projection
Population (million)	119.2	147.5	164.6	179.4	189.1
Groth Rate(%)	2.10	2.32	2.22	1.98	1.76
Density (pop/sq.km.)	62.4	77.0	85.0	93.0	98.5
Percent Urban	17.3	22.3	26.0	30.9	34.0
Reference period	1967-70	1976-79	1981-84	1986-89	1993
Crude Birth Rate	40.6	35.5	32.0	27.9	24.5
Crude Death Rate	19.1	13.1	11.4	8.9	7.9
Total Fertility Rate	5.6	4.7	4.1	3.3	2.9

Infant Mortality Rate (per 1000 births)	142	112	71	70	58

Source: Central Bureau of Statistics, State Ministry of Population/National Family Planning Coordinating Board, Ministry of Health, and Demographic and Health Surveys, Macro International Inc., USA,' Indonesia and Health Survey, 1994'. October, 1995.

The sharp decline in the fertility rate has been widely attributed to the successful implementation of the family planning programme which brought the contraceptive prevalence rate from less than 10 percent in 1971 up to the level of 55 percent among currently married women aged 15 - 49 years in 1994 (CBS, et al., 1995).

Total 2: Trend in Total Fertility Rate and contraceptive prevalence Rate

	1976	1987	1991	1994
Total Fertility Rate	5.2	3.39	3.02	2.85
Contraceptive Prevalence	26*	47.7	49.7	54.7

* Only for Java-Bali islands. National estimate was not available.

Table 2 shows that the CPR has increased several fold during the period 1976-1987 when many innovations to increase accessibility of services were underway. Hard to reach groups and inaccessible areas had become the major focus after 1987, while several movements to sustain interest were initiated such as the self reliant, family welfare movement, and expanding contraceptive choice. Several provinces have reached more than 60 percent of contraceptive prevalence and they are now at or near the replacement level.

Organizational Structure

The family planning programme was initiated by the government in 1970 when the National Family Planning Coordinating Board, popularly known as BKKBN, was established. The Chairman of BKKBN reports directly to the President. In 1994, the Ministry of Population was created and the Chairman of BKKBN became the State Minister of the Ministry. The role of BKKBN involves planning, coordinating, and monitoring in addition to the implementation of field level activities conducted by its field workers and female community volunteers. BKKBN has its own administrative structure, from the central to the field level. Family planning (KB) services are provided through the KB clinics of the public hospitals, army hospitals, teaching hospitals, health centres, and private clinics. BKKBN does not have its own service providers. The Department of Health (DEPKES), which has its own parallel structure, is the main implementing agency for the clinic-based family planning services. Doctors, nurses and midwives working for the family planning clinics at the government hospitals and health centres belong to DEPKES. DEPKES's responsibilities include policy formulation, planning, coordination and supervision of health services, provision of contraceptive information and services, as well as medical back up for complications and fertility

related health interventions. BKKBN provides training for service providers, contraceptive supplies, medicines, and equipment. Also it provides support costs for family planning services to hospitals and health centres of the DEPKES.

Elements of success

Political Commitment: The support for family planning has been received from the highest political body, the People's Consultative Assembly which elects the President of the Republic of Indonesia. This in turn helps the President to provide full support to the movement. The government has adopted the policy of family planning to promote the "small, happy, and prosperous family" which is widely accepted by the Indonesian population. The President himself honours persons who contribute to the family planning programme in their respective provinces. These persons are from all walks of life, including governors, religious leaders, and family planning acceptors. It is a great honour for simple village women to have them invited at the presidential palace and to receive an award from the *Bapak* [1] President. The family planning acceptors who have been using the contraceptive method for a long period of time get this opportunity.

The slogan of the **"small, happy, and prosperous family"** consolidates many government functionaries including the armed forces which enforce stability and harmony in the country, and other agencies which work for agricultural development, improve literacy, and greater access to health care. All government institutions, particularly the armed forces and the Department of Health actively participate in the fulfilment of the "small, happy, and prosperous family" along with BKKBN. Other ministries and departments, such as Internal Affairs, Information, Religion, Education and Culture also support the implementation of family planning activities.

Organizational Strengths: As an organization, the National Family Planning Coordination Board (BKKBN) has several strengths as compared to the regular government ministries. Two important strengths are: (1) BKKBN's chairman is under direct command of the President; and (2) by virtue of being coordinating agency, it engages the other government machineries into the programme implementation. Another very important strength of the BKKBN is the ability to capitalize on the political system of the country, the government structure, and the local cultural values and traditions.

Reaching consensus is a very important step in the implementation of a programme in the Indonesian culture. BKKBN gets the support of village councils. Once the council agrees on the programme, it is expected that the entire village will make it a success by participating in the programme.

Strategic planning is an integral part of the BKKBN's activities. It was perhaps a necessary process at the start of the family planning in Indonesia when there was a firmed commitment to the population reduction on one side and other side there was opposition from the Islamic leaders to adoption of modern contraceptive methods. Strategic planning takes place twice in a year at the BKKBN headquarter on regular basis. The success of strategic planning of BKKBN can be noted in terms of: (a) it has become a regular exercise within BKKBN; and (b) planning for the programme is no longer the speciality of experts. It is now an institutionalized process in which staff at all levels contribute.

[1] It refers to father having the role of the leader.

The continuous evaluation of what and how the programme is doing is an important element of the success of the family planning programme.

In Indonesia, **a broad range of services** are available either through the public sector or private sector. The national family planning programme recognizes as many as eleven different contraceptive methods (combined oral pills, progesterone only pills, IUD, three-monthly injection, two-monthly injection, once-a-month injection, NORPLANT® implants, condoms, no-scalpel vasectomy, vasectomy, tubectomy). The government has already brought two interventions to integrate into the existing programme after the ICPD. **STD/ RTI** services and counselling have already been underway to test out the feasibility to place programme in the public sector. Additionally, **a family life education** programme to educate young boys and girls in high school on reproductive health of man and woman has been integrated into the school curriculum in a few selected schools, including Islamic high school in Jakarta.

Community Participation: The national consensus inspired the relatively smooth running of the family planning programme, and it is the major factor in developing community participation. The community participation policy brought the variety of skilled leaders and prominent individuals into the family planning programme. In each of the 200,000 sub-villages, at least 1 out of 20 villagers does some unpaid volunteer work each month to promote family planning. The community participation involves (1) the village head with his development council, sub-village heads, and neighbourhood leaders; (2) members of the Women's Family Welfare Movement; (3) the village family planning motivator, with her assistants and other cadres; and (4) BKKBN, which has only 1 employee at this level, the family planning field worker.

The mobilization of massive number of community members was successfully done by developing several innovative programmes, such as -- (1) the Integrated Family Planning and Health Services, known as *Posyandu*, an Indonesian acronym; (2) Family Planning Acceptor Group; (3)Village Contraceptive Distribution; (4) The Role of Formal and Informal Leaders; (5) The Role of Religious Institutions; and (6) The Role of Muslim Women's Organizations.

Self - Reliant Family Planning: Widespread community involvement is one of the elements for the success of the Indonesian family planning programme. To sustain the community involvement and reduce burden on the government, the shifting of responsibility to communities for the family planning programme was planned by introducing the self - reliant family planning (*KB Mandiri)* programme in 1987. *C*ouples are encouraged to pay partially or fully for contraceptive methods and related services. At present none of the family planning services is available free and most of family planning users want to make small amount of payment in return for service.

APPENDIX - IV

Bangladesh Programme Agenda for Observational Tour
Officials from Uttar Pradesh, India
December 14-22, 1997

Bangladesh

December 14, 1997 (Sunday)	Arrive Zia Airport By **BA145**
4:30 Hours	Pickup from the Airport and stay at Hotel Sheraton, Dhaka
7:00 Hours	LIP presentation
December 15, 1997 (Monday)	
9:00 Hours	Minister of Health & Family Welfare, DG, NIPORT, DG, FP and Other GOB Officials
10:30 Hours	NGO activities MFSTC
12:00 Hours	ACCORD Tongi/Dhaka
15.00 Hours	NGO Project (BMS, Narayanganj)
December 16, 1997 (Tuesday)	Government Holiday (**VICTORY DAY**) Meeting with NGO Officials
December 17, 1997 (Wednesday)	
7:30 Hours	Leave Dhaka FPMD/LIP Injectable programme, Debidar, Comilla stay at BARD Guest House, Comilla
22:00 Hours	One group (Six Officials) leaves for Indonesia.
December 18, 1997 (Thursday)	
8:00 Hours	Leave Comilla ICDDR, B project, Mirrashari stay at Hotel Agrabad, Chittagong
December 19, 1997 (Friday)	**Government Holiday** stay at Hotel Agrabad, Chittagong
December 20, 1997 (Saturday)	
7:30 Hours	Leave Chittagong FPAB Project Dolia, Feni stay at Hotel Sheraton, Dhaka
December 21, 1997 (Sunday)	
8:00 Hours	Leave Dhaka Male Involvement/RTI project, Kalihathi
December 22, 1997 (Monday)	Meeting with GOB Officials

Appendix V

MEETING AGENDA IN INDONESIA

for Senior Programme Managers of SIFPSA and Ministry of Health & Family Welfare Uttar Pradesh, Population Council, 18-20 December 1997

Date/Time	Place	Agenda
Thursday 18 Dec. 1997		
08.30	Arrive at Soekarno Hatta Airport	
11.00-12.00	J1. Pisangan Baru III, Jatinegara	Visiting YKB's Clinic
13.00-14.00	MOH, J1 Rasuna Said	Meeting with Dr. Rachmi Untoro, MPH (Director of Directorate of Family Health) & Dr. Ardi Kaptiningsih, MPH (Chief of Subdirectorate of Maternal Health)
14.00-15.00	Menara Tower, J1, Rasuna Said	Lunch
19.00-		Dinner with USAID officials, Government officials and CAs
Friday 19 Dec. 1997		
08.30	Grand Melia Hotel	Pick-up at the Hotel
09.00-10.00	Field Visit: Puskesmas Cilincing	Visiting PC's OR study "Improved RH and STD Services at Family Planning Services"
10.30-11.30	Field Visit: Koja Hospital	Visiting PC's OR study "Improved RH and STD Services at Family Planning Services"
12.00-13.00	Kuningan Seafood Restaurant	Lunch
13.30-	BKKBN	Meeting Prof. Dr. Haryono Suyono, Dr. Pudjo Rahardjo, Dr. R. Hasan M Hoesni and Mr. Andarus Darachim, MPA.
Saturday 20 Dec. 1997		
10.30	Grand Melia Hotel	Pick-up at the Hotel
11.00-12.30	Mohammadiyah III High School Kebayoran Baru	Visiting PC's Youth Programme