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LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome	HNPSP	Health, Nutrition and Population Sector Program
CPR	Contraceptive prevalence rate	HPSP	Health and Population Sector Program
CPT	Contraceptive Procurement Tables	IPPF	International Planned Parenthood Foundation
CS	Contraceptive Security	IUD	Intrauterine Device
DFID	Department for International Development, UK	JSI	John Snow, Inc.
DGFP	Directorate General of Family Planning	LMI	Low and Middle Income Countries
DGHS	Directorate General of Health Services	LMIS	Logistics Management Information System
DSW	German Foundation for World Population	LSU	Logistics and Supplies Unit
EDCL	Essential Drug Company Limited	MCH	Maternal and Child Health
FHI	Family Health International	MMR	Maternal Mortality Rate
FP	Family Planning	MOF	Ministry of Finance
FPAB	Family Planning Association of Bangladesh	MOHFW	Ministry of Health and Family Welfare
FWA	Family Welfare Assistant	NGO	Non-Governmental Organization
FWV	Family Welfare Visitor	NIPORT	National Institute of Population Research and Training
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria	NHP	National Health Policy
GoB	Government of Bangladesh	NPP	National Population Policy
HIV	Human Immunodeficiency Virus	PAI	Population Action International

PEPFAR	President's Emergency Plan for AIDS Relief
RHSC	Reproductive Health Supplies Coalition
RMA	Resource Mobilization and Awareness
SMC	Social Marketing Company
SPARCHS	Strategic Pathway to Reproductive Health Commodity Security
SPD	Service Delivery Point
STI	Sexually Transmitted Infection
SWAp	Sector-Wide Approach
TFR	Total Fertility Rate
UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development



A pharmacy in Dhaka sells many products, including socially marketed condoms. (Elizabeth Leahy/PAI)

1

BACKGROUND AND INTRODUCTION

This case study was produced by Project Resource Mobilization and Awareness (“Project RMA”), whose three organizational partners are Population Action International (PAI), the German Foundation for World Population (DSW) and the International Planned Parenthood Federation (IPPF). The Project is funded for a period from October 2006 to April 2010.

Project RMA partners operate at the global, regional and national levels, working in synchronicity with each other and with the project’s overarching goal, which is “to increase tangible financial and political commitment to sustainable reproductive health supplies through international coordination and support of national advocacy strategy development and implementation in developing countries.” Project RMA has three central objectives:

- Promote a supportive political environment for reproductive health (RH) supplies by enabling civil society organizations (CSO) and networks to engage in advocacy at the international and regional levels in a comprehensive and coordinated manner.
- Create a supportive political and financial environment for improving access to RH supplies at the regional level.
- Strengthen national level advocacy on RH commodities supplies in six partner countries in the global south.

The Project adopts the definition of reproductive health supplies established by the Reproductive Health Supplies Coalition, which is: “... any material or consumable needed to provide reproductive health services. This includes, but is not necessarily limited to contraceptives for family planning, drugs to treat sexually transmitted infections, and equipment such as that used for safe delivery.” Use of the term “reproductive

health supplies” is intentionally broad in order to encompass the wide array of supplies necessary for quality reproductive health care, including and beyond family planning. However, the research provided in these six case studies focuses on contraceptives and condoms because of the historical priority placed on these supplies, as well as the challenges in monitoring and tracking the full array of other products and medications. Contraceptives and condoms are the hallmark of many family planning and reproductive health programs and are the primary emphasis of Project RMA’s advocacy efforts at the national, regional and global levels, but the full range of reproductive health supplies extends well beyond the specific commodities discussed in this report.

Bangladesh is one of six countries selected for inclusion for Project RMA-supported in-depth case studies, together with Ghana, Mexico, Nicaragua, Tanzania and Uganda. Countries were selected based on the potential derived from project partners’ work to coordinate country, regional and global level advocacy efforts. This paper, together with five additional case studies from other countries and information from other sources, provides an evidence base for national level advocacy. Each case study is written with generalist advocates in mind. These can include, but are not limited to, civic leaders, parliamentarians, faith-based leaders, and community leaders.

This report provides overview of how RH supplies, specifically contraceptives and condoms, are programmed, managed and funded in Bangladesh. It presents a distillation of information on policies, systems, budgets and key actors to help raise awareness of experienced advocates—who may lack technical knowledge about contraceptives— so that they strategically choose advocacy actions and targets. This information should also facilitate collaboration and coordination with



A rural health clinic in eastern Bangladesh. (Elizabeth Leahy/PAI)

advocacy efforts at the global and regional levels. Information and issues from one country may be useful to other countries facing similar challenges.

Project RMA has identified four indicators by which to assess tangible results at the country level in contraceptive security.¹ These are:

- the existence of a contraceptive supply coordination mechanism;
- the inclusion of contraceptives on the national essential drug list;
- a functioning government budget line item for contraceptive supplies; and
- the integration of contraceptive supplies into a financing mechanism.

This document provides information to help advocates understand aspects of reproductive health supplies in the specific case of Bangladesh. Every family planning program faces different

conditions in ensuring contraceptive availability. For example, programs facing reductions in donor funding may be aware of supply constraints, but have not convened stakeholders in a forum through which they can address these constraints. In other cases, family planning activities may become a lower priority as national officials cope with addressing the HIV/AIDS pandemic. Here, fostering understanding among leaders of the crucial role that RH supplies play in HIV programs is paramount.

A third scenario might be a government that is decentralizing or undergoing health sector reform; officials must anticipate and plan for how to ensure uninterrupted supplies and services as management is moved from the central to local levels. In addition to these structural issues, family planning may be controversial in certain settings. This is particularly true for some identified sub-populations such as adolescents and unmarried

couples. Therefore, advocacy related to contraceptives may be more difficult than that for other public health issues such as maternal health. Linking family planning acceptance, continuation and contraceptive security to other maternal and child health (MCH) outcomes or development and poverty-alleviation goals is an important tactic. Raising awareness and facilitating policy change at the country level requires carefully planned and informed strategies.

This report should be considered as helping to form a bridge between technical experts and advocates, informing the former about RH supplies and, for the latter, highlighting some key supplies issues that are ripe for advocacy. This and the other Project RMA case studies demonstrate to advocates seeking policy change how RH supplies issues can be used to raise awareness of policy needs that can positively affect reproductive health more broadly.

This study identifies some potential entry points, blockages, technical capacities and champions. Among audiences who may find this useful are members of civil society, such as policy advocacy groups, professional associations and youth groups; service providers; officials and staff in various government ministries and agencies; parliamentarians; local and district level government staff; decision-makers in bilateral and multilateral aid agencies, inter-governmental organizations and regional networks; and all advocates interested in changing policy at the country level, or using case examples from country level to change global policy.

COUNTRY CONTEXT

2

The family planning efforts in Bangladesh have long been considered among the most successful in the world. From 1975 to 2007, the total fertility rate (TFR) decreased from 6.3 to 2.7 children per woman, while the overall contraceptive prevalence rate (CPR) increased from 7.7 to 55.8 percent, including traditional methods, among married women of reproductive age. This progress is particularly noteworthy given the high poverty, cultural context and low literacy rates characterized by the country. Much of the success has been attributed to “early and continuous high level government commitment,” investment from the donor community; strong collaboration

between the government and non-governmental organizations (NGOs); a focus on community-based efforts; the use of information, education and communication (IEC) strategies; strong monitoring and logistics systems; and community ownership.²

The progression of the family planning program in Bangladesh is often described as a series of phases. “Family planning efforts in [Bangladesh]... began in the early 1950s with voluntary efforts of a group of social and medical workers” with a focus largely on urban areas.³ Subsequently, the government introduced family planning in the

TABLE 1. SELECTED DEMOGRAPHIC INDICATORS FOR BANGLADESH

Indicator		Source
Population size (millions), 2005	153.1	UN Population Division
Population size (millions), 2025 (projected, medium-fertility variant)	195.0	UN Population Division
Population size (millions), 2050 (projected, medium-fertility variant)	222.5	UN Population Division
Population under age 15 (%), 2005	33.8	UN Population Division
Annual population growth rate (%), 2000-2005	1.7	UN Population Division
Life expectancy at birth (years), 2000-2005	63.0	UN Population Division
Total fertility rate, 2007	2.7	DHS
Contraceptive use among married women, modern methods, aged 15-49 (%), 2007	47.5	DHS
Unmet need for family planning among married women, aged 15-49 (%), 2007	17.1	DHS
Maternal deaths per 100,000 live births, 2005	570	WHO
Infant mortality rate per 1,000 live births, 2007	52	DHS
Population living below national poverty line (%), 1990-2004	49.8	UNDP (Human Development Report 2007/08)

public sector, initially through clinic-based efforts, and later added community-based strategies to improve access among rural populations.

After independence from Pakistan in 1971, efforts were made to integrate family planning and health services at the field level. In addition, the government recognized the importance of population growth and, in 1976, developed its first Population Policy outline, in which population growth was identified as the main barrier to the country's development. "The Policy stands out as one of the most remarkable achievements of the government" and serves as the basis for and guide to the national family planning program.⁴ Initial barriers to family planning uptake included low levels of knowledge about family planning, large family sizes due in part to the agrarian economy, low levels of women's status, and lack of access in rural areas. In response, the government emphasized community-based outreach by investing in and recruiting full-time Family Welfare Assistants (FWAs), who provide reproductive health information and non-clinical family planning methods to couples through in-home visits, and Family Welfare Visitors (FWVs), who receive 18 months of training, can provide some clinical contraceptive methods, and are posted at union family welfare centers. In addition, the NGO sector and social marketing were additional strategies employed as part of the national family planning program.

The 1980s marked a subsequent attempt to functionally integrate health and family planning, particularly at the upazila (sub-district) level and below. In practice, this meant an emphasis on providing "an essential package of high quality, client-centered reproductive and child health care, family planning, communicable disease control, and limited curative services at a one stop service point."⁵ In 1998, the government, with support from the World Bank and other development partners, introduced the country's first Sector-

Wide Approach (SWAp), the Health and Population Sector Program (HPSP), to support the government in prioritizing "essential basic services, aimed at improving maternal and child health and family planning, and addressing the most pressing communicable diseases."⁶ As part of this strategy, the government made further attempts to integrate family planning and health services at the lower levels of the health system. However, due to the bureaucratic division between the Directorates General of Health Services and Family Planning within the Ministry of Health and Family Welfare (MOHFW), these efforts proved to be politically unfeasible, and were considered by family planning champions to have "contributed to a loss of momentum in RH-FP [family planning] service delivery, and the program became almost paralyzed."⁷

In 2003, a new SWAp was introduced, although its implementation and funding were limited for approximately two to three years due in part to issues related to the previous SWAp (see section 5 for more information). Under the current Health, Nutrition, and Population Sector Program (HNPSPP) 2003–2010, the family planning program is again segregated and reestablished as a vertical program focusing on the components of family planning, safe motherhood, child health care, adolescent health care, male involvement, and gender equity.

According to the most recent demographic data, the country continues to improve in terms of many of its family planning indicators. The total fertility rate has decreased from three children per woman in 2004 to 2.7 in 2007. While the overall CPR decreased from 58.1 (2004) to 55.8 percent (2007), this is attributed to a decline in the use of traditional methods (from 10.8 in 2004 to 8.3 percent in 2007) while modern method CPR has remained unchanged at approximately 47 percent over the past three years. Of particular note in the most recent Demographic and Health Survey



In Bangladesh, 17 percent of married women have an unmet need for family planning. (IPPF /Jenny Matthews)

(DHS) is the increase in unmet need for family planning from 11 (2004) to 17 percent (2007). According to the DHS, this increase in unmet need “may be a reflection of family planning supply related problems and/or an increase in the demand for family planning.”⁸

RH supplies issues are among several challenges that continue to impact the country’s ability to achieve its family planning and population goals. In particular, concerted efforts will be required to meet the growing demand for supplies required to increase the CPR from the current 55.8 percent to the target of 73.2 percent, given the current population growth rate (1.7 percent), young age structure and a reliance on short term, resupply methods. Assuming the fertility rate declines further to 2.0 children per woman, Bangladesh’s population is projected to increase from 153 million to 195 million by 2025, including a 23 percent increase among women of reproductive age.⁹ The increase in associated contraceptive users will require a significant increase in resources (both supply and infrastructure).

3 METHODOLOGY

The Bangladesh case study was conducted using a two-stage research process.

Stage One: Through an initial period of document review, a consultant analyzed policy documents relevant to reproductive health programs and the associated supplies (detailed in section four). A review of each document identified the programmatic emphasis, goals and objectives of the activities described, and indicators of success.

Stage Two: In October 2008, a two-person team travelled to Dhaka and with assistance from the Family Planning Association of Bangladesh (FPAB), interviewed key stakeholders including representatives of the Ministry of Health and Family Welfare (MOHFW) and other governmental agencies; donor agencies; and NGOs active in contraceptive supplies (see Appendix One for a complete list of interviewees). The information contained in the case study was verified and updated as much as possible in March 2009.



A mural about maternal health at a family planning clinic in Dhaka. (Elizabeth Leahy/PAI)

THE POLICY ENVIRONMENT FOR REPRODUCTIVE HEALTH SUPPLIES

4

An enabling national policy environment is a critical indicator of a country's commitment to family planning generally and RH supplies specifically. Understanding the policy environment helps stakeholders identify opportunities for ensuring inclusion of RH supplies into current and future policies.

The government of Bangladesh has prioritized population and family planning in many of its national policy documents. However, several key policies lack concrete indicators that would help ensure commitment to and prioritization of family planning and RH supplies. For example, while the draft National Health Policy identifies the need to increase the contraceptive prevalence rate, there are no indicators for CPR or contraceptive stockouts.

An additional area of focus is the Essential Drug List, which currently only includes two contraceptive methods, condoms and oral contraceptives. While this incomplete list has not yet had an impact on the availability of RH supplies, it could become a barrier especially as the country begins to use internally generated funds for contraceptives.

Following two years of a military-led caretaker government, Bangladesh held general elections in December 2008, with Sheikh Hasina subsequently taking office as prime minister. The state of frequent political change in Bangladesh has affected the policy environment for reproductive health supplies, as well as the implementation of services. A number of key policies are currently under revision. The new government has expressed a desire to integrate the population and health programs, despite unsuccessful past attempts to do so. While waiting to see how these policy decisions play out, providers report that implementation of expanded services and broader momentum for reproductive health programs have slowed.

Draft National Health Policy, August 2008 Update

The goal of the draft National Health Policy is “sustainable improvement in health, nutrition and family welfare status of the people, particularly of the poor and vulnerable groups, including women, children and elderly.”¹⁰ This policy links to the country's Poverty Reduction Strategy Paper (PRSP) and the Millennium Development Goals (MDGs).

Family planning is one of the focus areas identified in the draft policy. Specifically, the policy indicates that “family planning needs to be recognized as a primary national problem.” Similarly, this strategic component references the need to “increase contraceptive prevalence rate and ensure further decline in total fertility rate.” In support of these commitments, the policy specifically mentions the importance of access to contraceptive supplies. “In addition to temporary methods of FP, clinical and permanent methods will be emphasized...”¹¹

The policy includes a target goal of achieving a net reproduction rate (NRR) of one (the average number of daughters per woman under current demographic conditions) by 2010 and refers to increasing CPR and decreasing TFR. However, there are no referenced targets for CPR, TFR, or product availability. Furthermore, the goal of achieving a NRR of one appears to be ambitious. While this has been a goal since 1985, the target date of achievement continues to be extended. At a meeting in October 2008, stakeholders again indicated that this goal was unlikely to be achieved by 2010, underscoring the importance of setting realistic national goals.

Bangladesh Population Policy, October 2004

The population policy cites the growing population as a “burden to the limited national resources making [it] almost impossible to improve the living standard of people” and recognizes the

According to stakeholders, the legal age of marriage for women is 18 and for men is 21. Despite this policy, approximately 50 percent of Bangladeshi women were married by the age of fifteen in 2000.

complexity of the issue and the need for a multisectoral approach.¹² The overall objective is to “improve the status of family planning, maternal and child health including reproductive health services and to improve the standard of the people of Bangladesh through making a desirable balance between population and development.”¹³ Policy objectives include reducing TFR and increasing CPR; attaining a NRR of one by 2010; ensuring availability and accessibility of RH services; developing human resource capacity; and ensuring coordination.

Strategies are comprehensive and client-focused, emphasizing the importance of a “one-stop service” and community-based interventions. There is a focus on reaching those with an unmet need and ensuring a mix of methods to ensure choice. The policy highlights the importance of “an uninterrupted supply of required medicines, equipment for all service centers and strengthening... the contraceptive security system so that supplies are available wherever and whenever they are needed.”¹⁴

The policy mirrors the overarching National Health Policy in its strategies, which include gender equity, human resource development, decentralization, engagement of the whole market (NGO and private sectors), and coordination among relevant ministries. In addition, it highlights the importance of adolescent-focused efforts, integration of population into other development strategies, the importance of data for de-

cision making, ensuring an enabling environment and strengthening policies and procedures, the link between population and the environment, and recognizing the role of doctors in implementing the population policy. However, there are no specific measurable indicators in the population policy related to CPR, unmet need or contraceptive availability.

The Directorate General of Family Planning (DGFP) is responsible for implementing the population policy and the National Population Council is responsible for monitoring its implementation. The policy is currently being revised by the new government, a process that is occurring simultaneously but separately from that of the National Health Policy, presenting a dimension of uncertainty to the government’s stated intention to integrate population and health activities.

National Maternal Health Policy (2001-2010)

The aim of the policy is “to strengthen the provision of essential obstetrical care and improve referral and utilization of services.” Objectives include increasing CPR from 53.8 percent to 72 percent (with a particular emphasis on long-term methods) and reducing unsafe abortions. While the maternal health strategy is for ten years, it references the importance of prioritizing specific areas. Related to family planning, the strategy highlights the need for a “3 year rolling plan for uninterrupted supply” of contraceptives. In addition, the document cites a “lack of synchrony

between placement of skilled service providers and the supply of critical drugs” as the basis for a strategy to align procurement and distribution with human resource capacity and strengthen facility level logistics.¹⁵

Health Nutrition Population Sector Program (HNPSP), 2003-2010

The Government of Bangladesh (GoB) has the “largest and oldest health SWAp,”¹⁶ with the first SWAp introduced in 1998-2003. The second SWAp, the HNPSP, was initially developed for 2003-2006, and has been extended until 2010 (some stakeholders report another extension to 2011). However, objections raised in an audit of the previous SWAp and donors’ wish to see a timeline of at least five years in the HNPSP led to delays in implementation. Between 2003 and 2006, the health program relied on surplus funds from the first SWAp as part of the transition to the HNPSP.

The program entails provision of a package of essential and quality health care services responsive to the needs of the people, especially those of children, women, elderly and the poor. Key family planning objectives of the HNPSP, with a target year of 2010, are:

- Maternal mortality ratio: 2.4 (deaths per 1,000 live births)
- Total fertility rate: 2.2
- Net reproduction rate: 1
- Contraceptive prevalence rate: 72.1 percent
- Decrease in discontinuation of family planning from 48.6 to 30 percent

In support of these objectives, the program strategies include providing 17.5 million vasectomies, 23 million IUDs, and 10.5 million implants by 2010 and ensuring the availability of contraceptive supplies.¹⁷

The Procurement, Storage and Supply Management section of the SWAp highlights the importance of ensuring timely procurement, shipment/distribution and storage and notes that this requires financing, capacity, coordination and commitment.

Millennium Development Goals, 2000

Bangladesh’s target for MDG 5 is to reduce maternal mortality to 120 maternal deaths per 100,000 live births by 2015. According to a 2007 study, “this MDG will not likely be met.”¹⁸

Poverty Reduction Strategy Paper, 2005-2008

Bangladesh’s first PRSP, “Unlocking the Potential: National Strategy for Accelerated Poverty Reduction,” covered the period from 2005 to 2008. The PRSP is coordinated and overseen by the National Poverty Focal Person at the General Economics Division in the Planning Commission of the Government. The PRSP contains eight strategies, one of which is maternal health.

The PRSP highlights as a key issue, “an emerging concern... [of] the plateauing of the total fertility rate (TFR) since the mid 1990s particularly among the poorer strata,” attributing some of the decline to an increase in the use of short-term contraceptive methods.¹⁹ Family planning is referenced throughout the document and the monitoring and evaluation plan includes indicators on maternal mortality ratio (MMR), CPR, TFR, male participation, adolescent RH, adequate supply and efficient procurement and distribution of drugs.

In late 2008, the government approved the second National Strategy for Accelerated Poverty Reduction. However, this document was not available for review.

National Reproductive Health Policy

While referenced in one document, multiple stakeholders indicated that the country does not have a National RH Strategy or Policy and that such issues are addressed in the National Health Policy and/or the National Population Policy.

Essential Services Package

Reproductive Health is one of five components of the Essential Services Package.

National Contraceptive Security Strategy, 2002

In 2002, the MOHFW and DGFP, with support from the U.S. Agency for International Development (USAID)-funded DELIVER Project,

developed a 20-point contraceptive security strategy “to increase the efficiency and sustainability of contraceptive distribution.”²⁰ The strategies are organized according to three major themes: 1) reinvigoration of long acting and permanent methods; 2) strengthening public-private sector contributions to the family planning market and 3) investing in supply chain management efficiencies. While some discrete activities have been accomplished, it does not appear that the DGFP is using the overall strategy to guide the country’s contraceptive security efforts.

National HIV/AIDS and Sexually Transmitted Infection (STI) Policy, 1995

While the policy does not explicitly address contraceptive security, it does highlight the importance of linking HIV/AIDS and RH services and strategies. Specifically, the policy states that “one cannot proceed with a HIV/AIDS/STD [sexually transmitted disease] policy by delinking women’s and men’s reproductive and behavioral health issues.”²¹ The policy also states that STI care should be integrated into maternal and child health (MCH) and family planning services.

Age of marriage policy

Several policy documents have referred to strategies to delay age of first pregnancy as a way to reduce TFR and increase CPR. One strategy identified to support this objective is delaying early marriage. According to stakeholders, the legal age of marriage for women is 18 and for men is 21. Despite this policy, approximately 50 percent of Bangladeshi women were married by the age of fifteen in 2000.²²

Adolescent Reproductive Health Strategy, 2006

Two of the objectives of the Adolescent Reproductive Health Strategy contain strategies that

relate to RH supplies. Strategy 3.3, contained under the objective of reducing incidence of early marriage and pregnancy, is to increase access to family planning services. Strategy 4.3b, within the objective of reducing incidence and prevalence of STIs, including HIV/AIDS, is to conduct advocacy at national, regional and local levels “to enable adolescents to have easy access to information and commodities for preventing unsafe sex.”

Essential Drugs List, 2008 Revision

The Essential Drugs List (EDL) was originally published in 1982 and, according to the National Drug Policy of Bangladesh, should be updated in line with the World Health Organization (WHO) list of essential medicines. Although the broader National Formulary list of licensed medications has historically included a range of contraceptives as drugs licensed for distribution, they have not been included in the EDL. However, the EDL was fully revised for the first time in 2008 and an official government notification shows that the updated list now includes condoms and oral contraceptives. The next step is for this change to be reflected in future updates to the National Formulary.

Representation by the DGFP in the process of revising the Essential Drugs List, if any, was limited. In interviews, DGFP staff were surprised that the full range of contraceptives were not included and indicated they would provide their “full cooperation” to rectify this. The next revision of the EDL under the new government may provide an opportunity to expand the list of contraceptive methods in line with the WHO Interagency List of Essential Medicines for Reproductive Health.

THE PUBLIC SECTOR HEALTH SYSTEM STRUCTURE

5

Overall public health system constraints are affecting the family planning program and the DGFP's ability to ensure RH supplies availability. While these constraints are not unique to the DGFP, they result in a lack of decision making, commitment and leadership required to address specific reproductive health programmatic and supply issues. Specific challenges include high turnover of staff, limited capacity building efforts and institutional memory, and a shortage of FWVs and FWAs.

Additionally, the prescribing practice of only allowing FWVs to insert implants under the supervision of the medical officer may be a barrier to uptake of this long acting method. A pilot study was recently completed to explore the use of FWVs to conduct male vasectomies and insert implants. This devolution of prescribing rights could reduce access barriers related to human resource constraints. However, the DGFP will have to ensure adequate number of FWVs are trained and in place to meet this demand.

The government, particularly the DGFP within the Ministry of Health and Family Welfare, is the major stakeholder in ensuring the availability of reproductive health supplies. Unfortunately, recent changes in human resource practices at all levels of government have diminished the strength of the public sector, which has a direct impact on

its ability to ensure RH supply availability. In addition, the new government elected in December 2008 has brought some new policy staff with conservative views into decision-making positions. Reproductive health supplies program managers are in discussions with the new policy staff to advocate for positive policy change.

The draft National Health Policy recognizes that “there is a huge shortage of qualified practitioners and paraprofessionals in the country’s formal system of health care providers.”²³ Compounding the shortage in personnel, human resources and technical capacity in the field of reproductive health are further limited by current staffing trends, with the DGFP operated by civil servants who often lack technical background in family planning and/or procurement. Furthermore, the impact of training and capacity-building strategies is limited due to the high turnover rate of staff. For example, there have been approximately ten directors of the DGFP in the past six years, with the most recent assuming the position in February 2009.

While many of these problems are not unique to family planning program staff, they result in a lack of decision-making, commitment and leadership required to address specific family plan-

The draft National Health Policy recognizes that “there is a huge shortage of qualified practitioners and paraprofessionals in the country’s formal system of health care providers.”

ning programmatic and supply issues. In terms of advocacy, lack of a well-trained cadre also results in a dearth of family planning “champions” who highlight the importance of family planning and call attention to problems in the system. When asked to identify family planning champions in the country, there were so few that one stakeholder began counting them on two hands. This is unfortunate in a country that has long been touted as an international success story in family planning and that for years had many family planning champions. It is important to realize that the root cause of these challenges lies not with individuals within the system, but with the structure of the system itself.

Stakeholders also attribute weaknesses in the family planning program to the aging of FWVs and FWAs. The most significant recruitment and training of these front-line providers occurred more than 20 years ago, and it is expected that 80 percent will retire within the next five years. As the “real orchestra” of the family planning program, often identified as a key reason for the program’s many successes in previous decades, one stakeholder indicated that a loss in this cadre has likely contributed to rising unmet need for family planning and unless speedy recruitment occurs, could continue to do so. According to stakeholders, the government is now advertising for this cadre. However, it takes significant time to recruit, train and post new staff.

National Population Council (NPC)

The National Population Council is chaired by the prime minister with multisectoral representation across relevant ministries and some NGOs. The NPC formulates and monitors implementation of the NPP and is supposed to hold yearly meetings; the last meeting was held in June 2008.

Ministry of Health and Family Welfare (MOHFW)

There are three Directorates within the MO-

HFW: Health Services; Family Planning; and National Institute of Population Research and Training (NIPORT), each headed by a Director General. In 1998, efforts were made under the first SWAp to integrate the family planning and health services arms of the MOHFW. However, these efforts were met with bureaucratic and political resistance and the two branches remain separate.

The DGFP supports the family planning priorities of the current HNPS. It includes the following components:

- Family Planning Field Services Delivery Program
- Clinical Contraception Services Delivery Program
- Maternal Child and Reproductive Health Services Delivery Program
- Logistics and Supply Unit
- Finance Unit
- Audit Unit
- Information, Education and Motivation Unit
- Planning Unit
- Management Information System
- Mohammadpur Fertility Services & Training Centre & MCH Hospital

Directorate of Drug Administration

The mission of the Directorate of Drug Administration (DDA) “is to ensure that the common people have easy access to useful, effective, safe and good quality essential and other drugs at affordable price.”²⁴ The DDA is responsible for regulation of import, procurement, production, sale and pricing of drugs, including contraceptives, for the country.

National Technical Committee

The National Technical Committee (NTC) is an ad hoc committee of doctors from the DGFP, NGO sector and other groups who meet to guide clinical family planning policy decisions. Most recently, the committee had a series of meetings

TABLE 2. HEALTH SYSTEM STRUCTURE FOR RH SUPPLIES IN BANGLADESH

Administrative Level	Health Facility	Cadre	Level of Care
National Level	<ul style="list-style-type: none"> • National and regional training centers • model clinics 	DG line directors, program managers, trainers	Tertiary
District Level	<ul style="list-style-type: none"> • model clinics • Maternal Child Welfare Clinics (MCWC) • district hospitals (MCH-FP clinics) • regional trainings centers 	DDFP, additional Director or Medical Officer, clinical contraception	Tertiary
Upazila Level	<ul style="list-style-type: none"> • MCH-FP units • MCWC 	Family Planning Officers Medical Officer-MCH	Secondary
Union Level	<ul style="list-style-type: none"> • Union Health and Family Welfare Centers • Rural dispensaries • MCWC 	Family Welfare Visitor, SACMO, Family Welfare Assistant, Family Planning Inspector	Primary
Peripheral Level	<ul style="list-style-type: none"> • Satellite Clinics • Domiciliary Services 	Family Welfare Assistant	Community/primary

following the announcement that Norplant, the brand of implants used in Bangladesh, would no longer be manufactured. The committee guided the process of identifying alternative brands, conducting an acceptability trial and approving the new brand, Implanon.

National Institute of Population Research and Training

NIPORT is a capacity-building organization focused on enhancing “the coverage and quality of Health and Family Welfare services through organizing training and undertaking appropriate research studies.”²⁵ In support of the MOHFW, NIPORT provides management training (leadership, program, finance, logistics) to mid-level managers, service providers and field workers through a system of 32 institutes. Together with Family Planning and Health Services, NIPORT is one of the three directorates under the MOHFW.

For family planning, prescribing protocols permit Medical Officers—Maternal Child Health to perform sterilizations; FWVs (under supervision of a medical officer) to insert IUDs and implants; FWVs to insert injectables (supervision not required); and FWAs to distribute pills and condoms. A pilot study has been conducted to test the use of FWVs to insert implants, but as of early 2009 no changes to the prescribing protocols had been enacted, due both to a shortage of implants and delays related to the transition of government. This devolution of prescribing rights could reduce access barriers related to human resource constraints, but will need to be complemented with rapid replacement of large numbers of retiring FWVs and FWAs.

Several coordinating mechanisms within the health system are used to highlight contraceptive supply issues. In late 2008, the central-level

A mural at the entrance to the Ministry of Health and Family Welfare promotes small family size. (Elizabeth Leahy/PAI)



Logistics Coordination Forum (LCF), previously known as the Logistics Coordination Committee, was revived due to sustained pressure from advocates. The committee had previously not been called to meet for approximately three years, but is expected to reconvene quarterly. In addition, the DGFP line directors and program managers meet to coordinate and develop the Operational Plan, in which logistics and supplies are monitored as a “key component” of the family planning program. They also convene a “needs-based assessment committee” in which each of the relevant programs reviews method-specific trends and targets.

At the district level, District Coordination Committees discuss overall district health-related issues and involve representatives from various government sectors and NGO interests. In addition, District FP Committees focus exclusively on family planning. While RH supplies are highlighted when there is a problem, the contraceptive stock-out rate (information that is available through the logistics system) does not appear to be a routine agenda item. Additionally, stakeholders indicate that the effectiveness of these committees varies considerably depending on their leadership.

FINANCING OF REPRODUCTIVE HEALTH SUPPLIES

6

Bangladesh is in a unique position in that the family planning program does not appear to be facing a financing constraint. However, there is a general lack of information regarding the value of and trends in contraceptive financing, which limits the DGFP's ability to plan and coordinate for the long term.

Bangladesh currently relies on donor funds—either World Bank loans or credits or donations from other donors—for reproductive health supplies. In 2008-2009, the government announced plans to use internally-generated funds to procure condoms for the first time, but the funds were shifted because a local manufacturer could not produce the necessary supplies. This missed opportunity shows that it is critical to understand the funding process and potential bottlenecks that may result when using internally-generated funds in order to adequately prepare for and address them.

Lastly, while the volume of donor funding may not be a concern for the country, experience indicates that the process of transitioning from the current to future SWAp may be problematic in terms of disbursement of funding.

HEALTH SECTOR FINANCING

Government of Bangladesh

While the GoB has used internally-generated funds for other essential medicines, thus far, it has relied exclusively on World Bank loans and credits as well as donations from other bilateral and multilateral donors for contraceptives. All stakeholders indicate that there is currently sufficient funding for contraceptives. While stakeholders expressed a high degree of confidence in future funding levels within the SWAp, there is indication that financing may become more of a concern. Specifically, the contraceptive security language of the current HNPSp states that “if donor financing remains at current levels, ... the (financing) gap could” result, implying that there may not be guaranteed long-term funding for contraceptives.²⁶

Several informants indicated that the government has started thinking about long-term funding and trying to address contraceptive security. The government has committed to increasing its contribution to health from seven to 12 percent

While stakeholders expressed a high degree of confidence in future funding levels within the SWAp, there is indication that financing may become more of a concern.

of the national budget, which would increase the funding available to the sector. Other strategies mentioned include segmenting the market to increase the market share of the private sector while focusing public resources on poor and hard-to-reach clients. In support of this strategy, the GoB provided the Social Marketing Company (SMC) with condoms through 2003 to establish a revolving fund.

The government maintains a nominal fee structure (1.25 taka, or about \$0.02, per 12 pieces) for condoms. The funds collected, which are managed by the Director of Finance, are intended to cover “future needs.” They have not yet been used for procurement of contraceptives. In October 2008, DGFP staff participated in a “research priority workshop” to discuss the “feasibility of pricing contraceptives in the near future,” but no changes to the pricing structure have occurred.

In the past, DGFP staff report that the GoB has allocated funds for contraceptives. However, in all but one instance where the funds lapsed due to the delay in disbursement, the government determined that there were sufficient funds for contraceptives through other sources, so its earmarked funds were reallocated for other essential medicines. In fiscal year 2008-2009, the government allocated approximately Taka 50 million (about US\$700,000) for condoms in the Field Services operation plan. These funds were intended to be used for condoms purchased from the Essential Drug Company Limited (EDCL), a government-sponsored manufacturer that currently produces other essential drugs procured using GoB revenue. Only if the EDCL supply is not available can the public health system procure from other sources. Unfortunately, EDCL was unable to provide the necessary quantity of condoms, so the allocated funds were returned to the government.

While it is promising that the GoB is allocating internally-generated funds for the procurement of condoms, the mechanisms may prove problematic. One stakeholder reported that while funds may not be released for up to six months, they must be spent within the fiscal year. These operational procedures and barriers could negatively impact the effective and timely procurement of contraceptives.

Financing for Sector-Wide Approach

In support of the HNPSF, a “large ‘pooled fund’, financed both by government and development partners” has been established.²⁷ For the overall health project, pooled financing includes that from partners including World Bank, the Department for International Development (DFID), the Netherlands, and the European Union (EU). Those providing direct donor funding or donations include: Swedish International Development Cooperation Agency (SIDA)*, Canadian International Development Agency (CIDA)*, GTZ/Kreditanstalt für Wiederaufbau (KfW)*, United Nations Population Fund (UNFPA), United Nations Children’s Fund (UNICEF), the World Health Organization (WHO), Japan International Cooperation Agency (JICA), United States Agency for International Development (USAID), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and Global Alliance for Vaccines and Immunization (GAVI).²⁸ Donors active in the health sector have a regular development partners meeting, but some stakeholders suggested that coordination among them is poor, and donors are increasingly taking a “hands-off” approach toward the government as their financial contributions shrink.

The total budget for the five-year HNPSF is estimated at between US\$4 billion and US\$5 billion, with approximately 50 percent sourced from the

* provide pooled and non-pooled financing.

GoB, mostly for recurrent costs such as salaries and infrastructure. The remaining commitments come from the pooled and nonpooled financing. While the GoB is a major funder of the HNPSP, it relies on World Bank loans/credits and donor contributions for contraceptives.

As indicated above, funding amounts have been sufficient to meet the GoB requirements for contraceptives. In fact, some stakeholders indicated that there has been more than enough financing and that the GoB was having trouble spending its available funds. This is substantiated by a recent review of the HNPSP which found a “limited expenditure of pool fund resources.”²⁹ This is important to note as sometimes, procurement-related issues are mistakenly seen as funding constraints.

However, while the funding amounts through the pooled fund are sufficient, on at least one occasion, the release of funds proved problematic. As the HPSP ended and the HNPSP began, a two to three-year delay in the release of funds resulted in the need for emergency procurements and stockouts in 2005-2006, despite the establishment of a 24 month buffer stock. The establishment of a buffer stock required ongoing advocacy and significant time. In anticipation of the end of the current HNPSP, stakeholders have indicated that they are planning to establish approximately 18 months of buffer stock prior to the next SWAp transition. However, in drawing lessons from the previous transition, it is important for stakeholders to start advocating for the establishment of this buffer stock by early 2009 to help ensure a “seamless” transition.

TABLE 3. ESTIMATED FUNDING FOR CONTRACEPTIVES AND CONDOMS BY SOURCE BASED ON AMOUNT AND YEAR PROCURED FOR PUBLIC SECTOR, 2005-2008 (\$US MILLIONS)³⁰

	2005 Value in USD	2006 Value in USD	2007 Value in USD	2008 Value in USD
CIDA	\$18,155,860	\$1,848,000	\$16,048,000	\$25,560,000
IPPF		\$5,980		
MSI		\$28,712	\$26,011	
UNFPA			\$1,950	
UNICEF/GFATM				\$511,302
USAID	\$8,683,391	\$8,764,579	\$17,829,834	\$8,436,919
World Bank	\$907,200			
GRAND TOTAL	\$27,746,451	\$10,647,271	\$33,905,795	\$34,508,221

Note: GoB procures for public + NGO

TABLE 4. ESTIMATED FUNDING REQUIREMENTS FOR 2008-2010³¹

	2008 Value in USD	2009 Value in USD	2010 Value in USD	Total Estimate
Grand Total	\$ 36,369,000	\$ 37,738,051	\$ 40,007,000	\$ 75,277,729

Trends in Funding for Contraceptives

Prior to 1998, the government relied on direct contraceptive donations provided by donors for the family planning program. Although much funding is now supported by World Bank loans and credits, direct support is ongoing through donors such as CIDA and USAID.

While “obtaining consistent estimates of HNPSP spending is surprisingly difficult,” the following table (Table 3) estimates the amount of contraceptive funding by source of funding.³² It is important to note that these figures represent the year in which the contraceptives were procured rather than the year in which funding was committed; therefore there is no consistent trend in funding.

Contraceptive Financing and Coordination

Contraceptive financing requirements for 2006-2010 are based on a forecast conducted in 2005 by the MOHFW, with support from the USAID | DELIVER Project. Table 4 is an estimate of future funding requirements for contraceptives based on this forecast.

In terms of financing coordination, one stakeholder indicated that numerous donors funded and procured commodities directly under the previous SWAp, which was “not well coordinated.” The establishment of the pooled fund has “rationalized and simplified external health financing, making it more flexible, aligned and predictable than in the past.”³³ As contraceptive financing comes from a limited number of sources, it appears that coordination of contraceptive financing should be fairly straightforward.

Despite this, because the leadership role of the government in funding decisions will only increase, it is still important for DGFP staff to understand the funding requirements, sources and amounts of funding; and to routinely update and monitor this information. Furthermore, if the government plans on using revenue funds for contraceptives in future years, it is even more critical to coordinate these funding sources and amounts to ensure alignment and to prevent gaps.

Some family planning stakeholders raised concerns that free, no logo, HIV/AIDS prevention condoms may be undermining the market for priced condoms that support the family planning program.

Global Fund to Fight AIDS, Tuberculosis and Malaria

Funds received from GFATM in Bangladesh are used in part for generic condoms for the prevention of HIV/AIDS. Condoms funded by the GFATM are procured by UNICEF and distributed to NGOs through SMC. While there is supposed to be a standing quarterly committee meeting on condoms, these meetings have not happened and much of the coordination is informal. Some family planning stakeholders raised concerns that free, no logo, HIV/AIDS prevention condoms may be undermining the market for priced condoms that support the family planning program. While the condoms for the prevention of HIV/AIDS tend to be targeted to high-risk groups other than public health service delivery outlets, it is important that the strategies are well-coordinated to ensure that one effort does not compromise investment in the other.

7 CONTRACEPTIVE FORECASTING, PROCUREMENT AND LOGISTICS

The DGFP has developed a supply chain for contraceptives that serves more than 30,000 service delivery points and manages an enormous volume using state-of-the-art technology such as a web-based logistics management information system (LMIS).

Almost every stakeholder identified procurement as a key challenge affecting contraceptive availability. While many of the procurement-related challenges can be attributed to capacity issues and result from high turnover of staff, there also appears to be incomplete understanding of the impact of stockouts and a lack of accountability on the part of the GoB when the issue is raised. An additional limitation is the lack of an appropriate coordination body that could help raise and address many supply-related issues. The need for such a mechanism was underscored by all stakeholders.

Contraceptive Market

Within Bangladesh, a full range of contraceptive methods are available through several channels, such as public sector clinics, private sector (including pharmacies and shops), NGO facilities and community health workers. According to recent data, it appears that source preference is method-driven. More than half (54 percent) of pill users and 80 percent of condom users rely on the private sector. Conversely, users of longer term and permanent methods primarily rely on the public sector.

The GoB family planning program distributes resupply methods (pills, condoms, injectables and IUDs) to public and NGO facilities. Through government channels, all family planning methods are free with the exception of a nominal fee charged for condoms. Compensation is provided to clients for both male and female sterilization (Taka 500, approximately US\$7, intended to compensate for lost wages plus a garment for infection control post-procedure) and transportation costs are paid to clients of IUDs and implants for follow-up visits. When there

is a stockout of a specific method, public sector providers typically encourage clients to switch to other methods.

For the NGO sector, pricing varies according to the NGO and its cost recovery policies (some have small registration fees for clients) but most appear to provide government-sourced contraceptives for free. When NGOs are not able to access contraceptives from the government due to stockouts or shortages, several reported that they procure from either SMC, their host organization or other outlets. In this situation, some NGOs reported passing on the price of the contraceptive to the client. When NGOs access supplies from these other sources, they inform the DGFP so that it can make the needed adjustments in supply management.

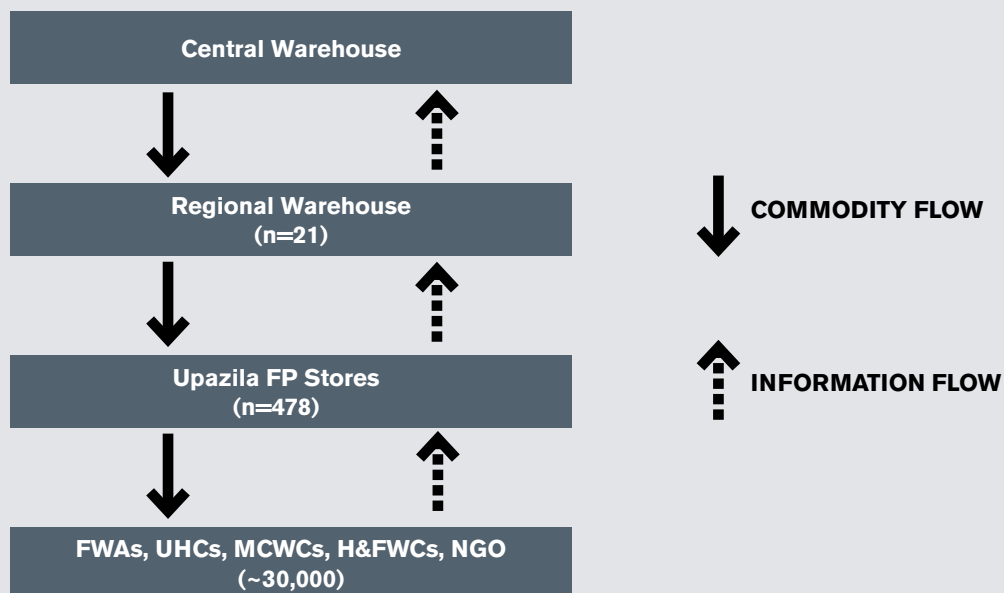
Social Marketing Company (SMC) prices for condoms are based on market research and fall within a range of targeted price points. The government has a pricing policy for drugs. While condoms do not fall within this category, pills and injectables do and therefore SMC prices for these methods are guided by government regulations. Public sector stockouts also affect the SMC. SMC routinely monitors the stock status within the public sector to help predict spikes in demand for their products as a result of public sector stockouts and clients turning to the private sector.

Contraceptive Availability

With the exception of the funding delays during the transition from HPSP and HNPS, stakeholders indicate that stockouts and shortages tend to be caused by procurement-related issues (see below for details) rather than funding or supply chain problems.

Figure 1, which shows data from the Family Planning Monthly Logistics Report, illustrates the stock levels for the entire supply chain for September-December 2008. According to DGFP

FIGURE 1. FAMILY PLANNING SUPPLY CHAIN IN BANGLADESH



Logistics and Supplies Unit (LSU) procedures, there should be between eight and 12 months of stock on hand for each method. On October 1, 2008, the government’s central warehouse in Dhaka reported 1.67 months of stock of implants on hand, nationally. By early 2009, a stockout of implants was underway, although residual supplies at lower levels means that not all facilities were experiencing a stockout. While this assessment is not intended to focus on specific stock issues, the implant scenario serves as an example of general coordination, planning, and procurement challenges facing the DGFP.

SUPPLY CHAIN

The family planning supply chain is managed by the DGFP LSU as shown in Figure 1. It includes one central warehouse, 21 regional warehouses,

and 478 Upazila family planning stores and serves approximately 30,000 service delivery points (both public sector and NGOs).

The supply chain operates on a “push” system for all contraceptives, except implants, with stock amounts determined according to reporting forms. Implants are pulled, due to the cost of the commodity and to the more restrictive prescribing protocols for this method.

According to the LSU, the supply chain procedures include two important policies that help ensure a client-focused system. If there is a shortage of stock in the system, the common practice is for the LSU staff to push the product to the lowest level ensuring that all available product is at the client level. This policy is apparently being carried out during the current shortage of implants. A

major regional warehouse only had two weeks' supply of Norplant on hand in mid-October, but staff reported that service delivery points were stocked with two to three months' supply.

Government policy also recognizes the importance of NGOs in meeting the public sector family planning goals and NGOs are to receive equal priority when government stock is distributed. However, with multiple NGOs reporting that their orders for RH supplies from the government are not completely filled, some stakeholders admitted that perhaps the policy is misunderstood or not appropriately followed in some cases.

Logistics Management Information System

In 2007, with support from the USAID-funded DELIVER project, the LSU established a web-based logistics management information system (LMIS). LMIS forms are uploaded at the regional level, enabling authorized users access to data through the Internet at any time. The system provides information on supply imbalances and automatic warnings of low supply that, if used properly and routinely for decision-making, can provide advance notice of impending shortfalls in sufficient time to take action.



A very small quantity of contraceptive implants remained in stock at a regional warehouse in Comilla. (Elizabeth Leahy/PAI)

Forecasting

In 2005, the MOHFW, with support from the USAID | DELIVER Project, conducted a contraceptive commodity forecast for 2006-2010, following on a longer-term projection to 2015 that had been prepared in 2000. The projection was based on both demographic and logistics data and was completed using two different scenarios, the first reflecting “reasonable and realistic expectations of acceptance of family planning methods by the Bangladeshi population” and the second targeting the achievement of replacement total fertility levels by 2010. As Scenario 2 is ambitious, Scenario 1 was recommended for use for financing decisions.³⁴

While these forecasts tend to guide funding requirements, “actual procurement schedules (are) based upon review of current logistics information on actual distribution and stocks on hand.”³⁵ Although the forecast is meant to be reviewed and updated annually, none has been done since the 2005 revision.

Procurement

With the introduction of the first health SWAp (HPSP) in 1998, policy parameters stipulated that all procurements be conducted following World Bank requirements. In recognition of the complicated World Bank procedures and DGFP’s lack of capacity in operating within these procedures, there was an early expectation that the government would use a private procurement agent. However, stakeholders were not able to resolve this issue, and the responsibility of contraceptive procurement fell to the DGFP beginning in 2001-2002.

Almost every key informant identified procurement as a major challenge for product availability. According to key stakeholders, there have been stockouts or shortages of three major methods

in the past 20 months, and each one was attributed to procurement-related delays. While some stakeholders cited the “inordinately” lengthy and bureaucratic process associated with World Bank procurement procedures, many identified human resource and capacity constraints as well as a lack of commitment, accountability and ownership in the DGFP as the “root” causes of the procurement delays.

As indicated earlier, many of these issues are not unique to the DGFP or to procurement of contraceptives and are broader health system challenges. However, they directly and negatively impact the ability of the government to ensure timely availability of contraceptives at the service delivery level and compromise the family planning program’s effectiveness. According to the mid term review of 2008: “Senior management of the MOHFW does not assume its responsibility for the overall health sector procurement. Although they seem to be aware of most, if not all, of the procurement problems, action to remedy the situation is slow.”

Two mechanisms have been established to address procurement bottlenecks. The Procurement Coordination Committee, headed by the Joint Secretary in-charge of procurement for the MOHFW, meets every two months. The committee focuses on procurement related to all health products and is not specific to contraceptives; by stakeholders’ accounts, it continues to meet regularly. In addition, the Logistics Coordination Forum was recently revived after three years without meeting. It is comprised of donors, NGOs and DGFP stakeholders and focuses exclusively on contraceptives. Stakeholders indicated that in the past, the forum has been effective in addressing issues “on the spot” and that if it had continued meeting regularly in recent years, “many of the problems could have been solved.”

Stockout of Implants

The DGFP has a procurement plan for 2006-2010. Despite this, there are several issues that may negatively affect the efficient procurement and availability of RH supplies. The most critical issue at the time of this assessment involved implants. In responding to the discontinuation of Norplant, the Directorate General-FP convened the National Technical Committee (NTC), which identified several alternative brands for consideration. The manufacturers of Implanon registered their product in the country and the brand, which provides a significant cost savings relative to Norplant, was therefore eligible for an acceptability trial. Following the trial, Implanon was approved by the NTC for use in Bangladesh in September 2008. By this time, stock of Norplant was critically low (approximately three months), just as demand for implants was rising among clients. According to the LMIS, implants were expected to stock out by December 2008, and by early 2009, this had occurred at the central level.

The implant stockout could have been prevented through more expedient action on the part of the DGFP. Several stakeholders highlighted the urgency of the issue and provided ample time to address it. As of March 2009, UNFPA had initiated an emergency procurement of 50,000 pieces, and the regular procurement of 300,000 pieces was underway through the lengthier standard bidding process. Stakeholders were expecting to receive the emergency supplies in late March 2009 and the larger standard shipment in May or June. In the meantime, the DGFP, with external technical assistance, was sending guidelines to providers with instructions on how to manage the small supplies remaining in certain facilities.

Although this is a single issue, the implant situation illustrates several challenges affecting efficient and timely procurement. For example, Bangladesh's LMIS provides user-friendly data on stock levels and stockouts. The LMIS highlighted the

implant issue as early as May 2008, providing policy-makers with ample time to identify solutions and prevent stockouts. Similarly, while there is a routine Procurement Committee that should identify such issues, one stakeholder indicated that the implant issue had not been highlighted in the forum. Additionally, while all stakeholders who operate at the central level seemed aware of the situation, information and understanding of the actions needed to resolve the process was inconsistent among them. In addition, although word of the change to Implanon has spread informally, there were delays in officially notifying government staff at lower levels.

Because Implanon is the only brand of implant being procured by the country and is manufactured by only one manufacturer, there is an inherent risk in relying exclusively on only one company for all national supply of a given method. Policymakers are considering alternate choices such as Sino Implant, UniImplant, and Jadelle. However, any new brand will have to be registered and go through an acceptability trial.

Funding Gaps

In addition to the delays in procuring Implanon, there are other potential challenges to efficient and timely procurement. For example, while the current procurement plan and funds tied to it will cover the period until June 2010, the HNPSP ends in December 2010, leaving a gap of six months. To date, it is unclear whether funding will be committed for this six month period and if not, whether there are plans to mobilize parallel donor funding. In addition, as mentioned earlier, the country's most significant stockout in the past few years occurred during the transition from HPSP to HNPSP. While stakeholders indicate that they have learned from these lessons and are preparing for the end of the current SWAp in 2010, the potential for challenges remains.



Boxes of oral contraceptives at a regional warehouse in Comilla. (Elizabeth Leahy/PAI)

Technical Assistance

The routine technical support in procurement to the DGFP provided by the USAID | DELIVER PROJECT was scheduled to end in early 2009, but has been extended. While UNFPA has committed to providing local procurement assistance for the government, it is important for this or other procurement assistance to be well coordinated and continued as needed. Questions remain about the capacity of the DGFP to address ongoing procurement challenges when technical assistance does eventually cease.

Local Manufacturing

There are two government sponsored manufacturers of RH supplies, Khulna Condom and Essential Drug Company Ltd. (EDCL). Khulna is expected to be absorbed within EDCL. While the GoB plans to procure condoms from this source, the company's condom manufacturing conducted a trial production but has had to suspend production due to a lack of raw materials. In addition, the company may not be able to meet international quality standards per donor and loan requirements. As a result, the company may be precluded from bidding on government contracts when funded by World Bank loans or credits or other donor funding.

In addition, there is a private local condom manufacturer, Bangladesh Latex. This company, which is a joint initiative between Germany and Bangladesh, produces mostly for export and the commercial sector.

Pre-Shipment Inspection (PSI)

Currently the GoB outsources pre-shipment inspection to UNFPA using World Bank funds, which results in time-consuming procedures between three parties to arrange payment to UNFPA for this service. In an effort to expedite the process, the GoB is beginning to build PSI into their bid documents so that the manufacturer is responsible for paying for this service.

8

DEVELOPMENT PARTNERS AND CIVIL SOCIETY

While coordination among family planning stakeholders appears to be effective at the lower levels, there is a lack of effective coordination at the central level among and between the government, donors, and NGO stakeholders. Stronger coordination would serve to address many of the challenges affecting family planning and contraceptive supply. Additionally, it appears that the potential of civil society and NGO groups as well as the media to address challenges and serve as champions for RH supplies has not been adequately tapped. However, the institutional capacity varies significantly in the various NGOs and this should be considered when determining roles.

United Nations Population Fund (UNFPA)

UNFPA has worked in partnership with the Government of Bangladesh, providing both technical assistance and commodity support, since 1974. It is currently implementing its seventh country program (2006-2010), which includes the following priority areas: safe motherhood, family planning, adolescent sexual and reproductive health information and services, STI/HIV/AIDS, and gender equity. UNFPA participates in the health sector SWAp mostly with parallel (non-pooled) funding. However, it also contributes approximately US\$1 million to pooled funds.

UNFPA supports RH supplies in several capacities. It acts as a procurement agent for CIDA, donates contraceptives, supports reproductive health programs and plans to help provide procurement assistance to the government at the Directorate General-FP's request. In addition, the UNFPA office has a staff member dedicated to reproductive health commodity security (RHCS) and will be conducting a policy and capacity-building exercise related to RHCS using a "bottom up" approach. This mandate highlights UNFPA's role as a key stakeholder in and advocate for RHCS in the country. In the future, UNFPA does not anticipate serving a major role in procurement, nor in commodity funding. The agency's program with

CIDA ends in 2010, which will limit possibilities for future emergency procurements.

United States Agency for International Development (USAID)

USAID has supported family planning programs in Bangladesh since 1971, initially through the donation of contraceptives and in 1975, expanding to support service delivery programs, social marketing and strengthening the public sector logistics system.

In support of its strategic objective of "a healthier, better educated and more productive population," USAID's family planning portfolio includes service delivery projects such as the ACQUIRE Project and Smiling Sun Franchise Project (SSFP), implemented by local and international agencies. In addition, USAID provides support to the Social Marketing Company to help expand the nonpublic market for contraceptives, although it is reducing its support to SMC over time. The USAID portfolio also includes the USAID | DELIVER PROJECT, which provides technical assistance in supply chain management to the government. This project was scheduled to end in early 2009, but has been extended.

USAID Implementing Agencies

EngenderHealth

EngenderHealth has been active in Bangladesh since 1974 and most recently implemented the USAID-funded ACQUIRE Project. Following the close of the ACQUIRE Project at the end of 2008, EngenderHealth is planning to implement a similar multisectoral project, focusing on improving the quality of services in clinics, particularly for long-acting and permanent methods (vasectomies, tubal ligation, IUDs and implants), and also on maternal health. EngenderHealth is actively involved in the recent pilot testing that would allow FWVs to insert implants.

John Snow, Inc. (JSI)

JSI is the implementing agency for the USAID | DELIVER PROJECT, which has been active for 20 years in Bangladesh. DELIVER led the introduction of the web-based LMIS system, trained government staff on procurement at central and district levels, and assisted the DGFP to forecast contraceptive funding needs to 2015.

Chemonics

Chemonics is the implementing agency for the Smiling Sun Franchise Program (SSFP) (2007-2011) which is funded by USAID. SSFP supports approximately 30 NGOs in developing sustainable health services through a “viable social franchise system.”³⁵ The network of NGOs includes Concerned Women for Family Development (CWFD) and Population Services and Training Center (PSTC).

World Bank

The World Bank Country Assistance Strategy (CAS) covers the period 2006-2009 and is funded for approximately US\$3 billion. Within the broad goal of “empowering the poor,” there is a focus on improving the quality of health services. This is done largely through the World Bank’s support to the Health, Nutrition, and Population Sector

Program. In addition, the CAS focuses on “Core Governance” issues including strengthening public financial management and procurement.

CIVIL SOCIETY/NGOs

Overall, NGO service provision represents approximately five percent of the family planning market share. Of this market share, NGOs are relied on mostly for IUDs and injectables. NGOs report that their working relationships with the government have historically been and continue to be positive, and that the DGFP staff recognize the importance of their role and treat civil society organizations as partners. Some NGOs reported that the government would ration contraceptives when stock levels were low, prioritizing distribution to its own outlets over those of NGOs, despite a policy that the two sectors should receive equal shares of supplies.

Family Planning Association of Bangladesh (FPAB)

Established in 1953, the Family Planning Association of Bangladesh (FPAB) is the oldest family planning NGO in Bangladesh. FPAB’s objective is “to accelerate human development through quality Reproductive Health including Fam-

The UNFPA office has a staff member dedicated to reproductive health commodity security (RHCS) and will be conducting a policy and capacity-building exercise related to RHCS using a “bottom up” approach.

ily Planning services... [to] improve sexual and reproductive health through effective advocacy and service delivery primarily to women, children, adolescents/youths emphasizing on underserved and disadvantaged areas through community ownership.”³⁷ FPAB’s president, a member of parliament, chairs the Parliamentary Standing Committee on women and gender issues.

FPAB has 35 clinics across the country supplemented by more than 2,000 community-based distributors and aims to provide services to those who are missed by other sources. It offers services at three categories of cost depending on client income. As indicated earlier, FPAB receives most of its contraceptives from the government. However, the organization also receives supplies from IPPF and has purchased supplies from SMC when government-donated commodities are not available.

FPAB’s advocacy work has recently been expanding as part of Project RMA. The organization is working closely with a number of former high-level government officials with decades of experience in managing family planning programs, which contributes both to institutional expertise and provides access to current government leaders. FPAB was instrumental in reviving the Logistics Coordination Forum in late 2008 and has petitioned the new government to include additional contraceptive methods in the Essential Drugs List.

Marie Stopes International

The branch of Marie Stopes International in Bangladesh was established in 1988. The organization provides a full range of family planning services and methods and has more than 100 clinics, mainly in urban areas, which together with outreach strategies and roving teams at the regional level serve more than one million clients annually. While many services are included in a cost recovery strategy, family planning services

and supplies are free after an initial registration fee of 25 taka (US\$0.36).

Marie Stopes relies on the GoB as its source of supply of contraceptives and prefers to focus on clinical, long-term methods. When the government has a stockout or low stock, Marie Stopes turns to organizational headquarters to procure contraceptives using contingency funding.

Concerned Women for Family Development (CWFD)

CWFD has 21 clinics around Bangladesh and provides a full range of family planning methods. CWFD is active at the community level, participating in regular district coordination meetings and hosting meetings with local mobilizers such as teachers and religious leaders. CWFD is an implementing partner of USAID’s SSFP.

Population Services and Training Center (PTSC)

PTSC provides child and reproductive health care services, including family planning, maternal care, safe delivery, communicable diseases and limited curative care. PTSC receives contraceptives for free from the government with the exception of condoms, for which the project pays. When condoms or pills are in short supply, PTSC will buy supplies from SMC; when clinical methods run low, service providers will recommend clients use a different method. PTSC is another of 31 NGO implementers of the USAID-funded SSFP project.

Social Marketing Company (SMC)

The Social Marketing Company (SMC) is the largest privately managed not-for-profit social marketing organization in the world. SMC sells pills, condoms, injectables mostly through private sector outlets including pharmacies, kiosks, etc. In addition, SMC also has a network of more than 200,000 outlets throughout the country and a social franchising program, Blue Star, which aims



Injectable contraceptives at a regional warehouse in Comilla. (Elizabeth Leahy/PAI)

to improve quality access to injectables. SMC receives financial and technical support for two of its products from USAID and procures its own RH supplies.

ADVOCACY GROUPS

NGOs have been identified as potential advocates for RH supplies, although those providing services must address the challenge of balancing this role with that of advocate. Service provider NGOs are at the mercy of the government as their source of contraceptives, and such a dependence may put them in a precarious position as advocates who call attention to government problems. Other stakeholders, such as donors, admit their own tendency to focus on NGOs' role as service providers rather than political pressure points. Some stakeholders questioned whether the advocacy role should be assumed by NGO service providers or those "outside the system" who may be more effective and have a less complicated role in advocacy.

The media has also been identified as an effective advocate for supplies. Recently, a Bengali-language newspaper published a front page article related to challenges in the family planning system. In response, the chief advisor (the highest position in the caretaker government) quickly convened a meeting of directors and health advisors to discuss some of the problems identified in the article. While this is an example of effective advocacy on the part of the media, one stakeholder suggested that media coverage tends to only focus on the negative but the family planning "program has a lot of positives" that should also be highlighted.

Other potential advocates identified include:

- Professional associations (medical, OB-GYN, etc.)
- Grassroots or civil society groups such as Answer and Village Defense Party (VDP)
- Religious leaders
- Women's groups (Women in Development)

9

FINDINGS AND POTENTIAL ADVOCACY ENTRY POINTS

In addition to some specific issues identified in the above sections, the following advocacy entry points were gleaned from discussions with stakeholders in Bangladesh, and are based on recommendations for future advocacy around RH supplies that were solicited in interviews. However, these entry points should not be considered to prescribe or in any way direct the strategies and plans for advocacy devised by civil society organizations and others in Bangladesh.

Project RMA has identified four indicators by which to assess national readiness in contraceptive security. These are:

- the existence of a contraceptive supply coordination mechanism;
- the inclusion of contraceptives on the national essential drug list;
- a government budget line item for contraceptive supplies; and
- the integration of contraceptive supplies into a financing mechanism.

The legacy of family planning success in Bangladesh is now confronted with the challenges of weakened government capacity to carry out essential functions, which provides ripe opportunities for advocacy. As one observer said, “I am hearing from so many people wherever I go that the momentum of family planning and reproductive health from decades ago has slowed down.” Additionally, a donor commented on being “surprised that there are still stockouts in such a mature family planning program.” Indeed, although NGOs and other potential advocacy partners readily prioritize problematic policies and practices, there does not appear to be a history of coordinated action by the family planning community to effect change.

Donors could provide a role in more effective advocacy regarding RH supplies. Several key informants indicated that donors have the “ear of the government” and could be doing more to raise

attention of the supply situation and procurement issues. There appears to be agreement that donors are currently not well coordinated with one stakeholder reporting that “each has its own agenda” and that they tend to work in parallel to each other.

While many indicated that the donors could do more to “raise the red flag” related to supplies, others felt that there are sufficient mechanisms to identify potential supply shortfalls and that the DGFP is not acting on information that already exists. For example, the electronic LMIS provides timely information on stock imbalances. Its color coded categories provide user friendly information and allow program managers to identify the most urgent issues. One logistics expert noted that not all procurement issues can be fixed, but good governance and transparency—qualities that can be encouraged and promoted through advocacy—can minimize the impact of these problems.

However, procurement issues are complex, and advocates must develop their own capacity to routinely monitor the procurement process and to predict and highlight potential issues. In response, many stakeholders identified the USAID | DELIVER PROJECT as being an appropriate advocate for supply issues as they have the technical mandate as well as the evidence needed to generate action. However, this project has faced repeated closure dates; although the work has been extended, it is likely that this critical technical support will end in the relatively near future.

Advocacy can also target specific policy concerns. For example, stakeholders could use the findings from the pilot study on allowing FWVs to insert implants to advocate from broadening access to RH supplies at lower levels of service providers. An important group to engage in this process—and one that often resists such efforts—is the medical association.

The legacy of family planning success in Bangladesh is now confronted with the challenges of weakened government capacity to carry out essential functions, which provides ripe opportunities for advocacy.

1 The existence of a contraceptive supply coordination mechanism

While there are coordination mechanisms at lower levels of the health system as well as one specific to procurement of health commodities overall, the DGFP only recently reconvened the Logistics Coordination Forum. The need and support for such a committee was endorsed by many key informants and was judged an effective way to address pressing issues “on the spot.” However, due to turnover of staff, time constraints, and other factors, it did not meet for a three-year period.

In order to support efforts to reinstate the LCF, FPAB identified agendas and minutes from previous meetings to prove its existence and show its relevance, and committed to providing administrative support to the committee. FPAB is now among the members of the committee.

The contraceptive coordination committee is only one of a number of active and inactive coordination mechanisms at the central level. It may be worthwhile for a stakeholder to inventory these groups clarifying membership, terms of reference, etc., and use this information as the basis to identify gaps in coordination and to analyze overlap. There are important coordination functions that could be used to more prominently and routinely highlight stockout issues. For example, stockout indicators could be formally included in the agenda of coordination forums at the district, upazila and national levels.

2 The inclusion of contraceptives on the national essential drug list

To date, only pills and condoms are included on the current Essential Medicines List in Bangladesh. Unfortunately, the recent revision of the list offered a missed opportunity to include the other methods. The WHO model list of essential medicines, which includes contraceptives, is the “best practice” standard in developing essential drug lists, and is mandated as the foundation of Bangladesh’s national list.³⁸ It could serve as evidence to justify inclusion of contraceptives in any future revision of the list.

Another opportunity or entry point may be following up and advocating directly with the DGFP team. These key stakeholders were not included in the recent revision process and were unaware that the full range of RH supplies are not on the current list. When this gap was called to their attention, they offered their “full cooperation” in making any future revisions. Advocacy is already underway to promote another revision of the list under the new government.

3 A government budget line item for contraceptive supplies

Although funding for RH supplies is programmed through the HNPSF, to date it appears that no internally generated funds have been allocated to contraceptives in Bangladesh. Although it was unsuccessful, there was an attempt in the most

recent fiscal year to allocate internal funds for condoms. If this succeeds in the future, it may become more important for the DGFP to have a budget line item to help earmark and prioritize funding specifically for RH supplies. This line item will also assist family planning staff to monitor government commitment to contraceptives and track overall funding trends.

The use of internally generated funding often comes with its own set of challenges. Therefore, in addition to allocation of funds within a line item, it would be important for advocates to help the DGFP understand operational issues that may be barriers to efficient use of this funding. Experience from other countries using internally generated funds illustrates that it is advisable for stakeholders to monitor indicators such as funding trends, commitment versus disbursement amounts, reallocation, etc. Similarly, advocating for funding requires a skill set that may be lacking within the DGFP and other watchdog groups.

A government budget line item is also an indicator supported in UNFPA's reproductive health commodity security mandate. As such, it may surface as a weakness and recommendation in the upcoming UNFPA-supported RHCS activities.

4 The integration of contraceptive supplies into financing mechanisms

The current Health Nutrition and Population Sector Program highlights family planning and contraceptive supplies both in terms of their inclusion (as part of RH) in the essential health package and the overall program objectives. As such, they are supported through the overall HNPSF funding (both pooled and non-pooled).

To date, it appears that funding amounts have been adequate to meet government requirements for contraceptives.

While references to family planning and RH supplies in policy documents are critical steps, it is imperative that stakeholders monitor implementation and hold the country accountable for achieving their stated goals and targets. Family planning and the availability of RH supplies could be highlighted as key strategies as policy makers identify ways to improve maternal mortality. Also, the first PRSP ended in 2008. The revision/update process provided an opportunity to highlight contraceptive security (including indicator for stockout of tracer contraceptives), although the second PRSP could not be evaluated for this case study. Such an indicator is included in PRSPs in other countries.

While stakeholders fully anticipate continued and sufficient resources for contraceptives supplies, there may be an increasing expectation on the part of donors that the DGFP become more efficient in its use of funding. For example, it will be important for the DGFP to conduct timely and routine forecasts and quantifications to be used as the basis of their budget requests for contraceptives. Similarly, in many countries, advocacy groups are demanding that their governments be more transparent in their funding decisions. Advocates in Bangladesh may take on a similar role, requiring the government to justify the costs and benefits of some of their priorities and commitments, such as method/brand selection, using a local government sponsored manufacturer, etc.

APPENDIX 1: INTERVIEWS AND CONTACTS

In preparation for and during a trip to Bangladesh in October 2008, the Project RMA research team met with the following individuals. We are very grateful for the time and information each of them shared with us.

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Perveen Rasheed, Managing Director & CEO,
Social Marketing Company (SMC)

Andur Razzak, Family Planning Inspector
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Dr. Govinda Saha, Medical Officer (Comilla)

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Marie Stopes

Lubna Yeasmin, Coordinator, RMA Project,
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Select staff at the Central Warehouse, DGFP,
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